

welfare: implementation

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No response  
necessary

September 30, 1996

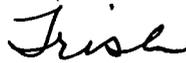
Chris Jennings  
Special Assistant to the President  
for Health Policy Development  
Domestic Policy Council  
Old Executive Office Building  
Room 213  
1700 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Chris:

As a follow-up to our recent telephone conversation, I have enclosed a copy of a letter and memorandum sent to Bruce Vladeck last week regarding the impact of welfare reform on the Medicaid program. The memorandum, written by myself and Claudia Schlosberg of the National Health Law Program, identifies several key "first order" issues and provides an analysis to support the President's policy objective to minimize the harmful effects of welfare reform and protect Medicaid beneficiaries' access to health care.

We understand that HCFA intends to issue guidance to the states by mid-October. Under the circumstances, we would like to set up a meeting with you at your earliest convenience to discuss our concerns and explore the various options that are currently under consideration. Claudia or I will call your office to follow-up.

Sincerely,



~~Patricia Nemore~~

encls.





# National Health Law Program, Inc.

September 24, 1996

Bruce Vladeck, Administrator  
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Dear Mr. Vladeck:

Since the inception of the Medicaid program in 1965, eligibility for benefits has been closely linked to receipt of cash assistance under Title IV-A (AFDC) and Title XVI (SSI) of the Social Security Act. As a general rule, families with children on AFDC and aged, blind and disabled individuals receiving SSI were deemed categorically needy and therefore eligible for Medicaid benefits. The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-192) (hereinafter the "welfare law") however, ended the AFDC entitlement, limited eligibility rules for children's SSI and introduced major restrictions on receipt of public benefits by legal immigrants. Notwithstanding these "enormous changes in the cash assistance programs on which Medicaid was originally based," as you recently noted, "the Congress explicitly protected current Medicaid eligibility, coverage, and other policies."<sup>1</sup> Thus, "Medicaid's essential role as a health care safety net for all American families has been overwhelmingly reaffirmed, as has its basic structure as a federal-state partnership."<sup>2</sup>

However, the welfare law is complex. States that do not fully understand their options or their legal obligations to Medicaid beneficiaries who lose cash assistance under the welfare law may take action that will result in the loss of benefits for millions. The Congressional interest in preserving Medicaid thus will be undermined. To minimize the risk that states will act precipitously, HCFA must issue guidance to states to clarify these ambiguities and assure that beneficiaries' rights are not abrogated.

The attached memorandum identifies several key "first order" issues and reflects the analysis and experience of Medicaid and immigration experts from around the country who represent the interests of a broad spectrum of Medicaid beneficiaries. Based on our analysis, we believe that HCFA should issue policy directives to states that encompass the following:

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<sup>1</sup>HCFA Healthwatch, Vol. 2, No. 1, at 2 (September 1996).

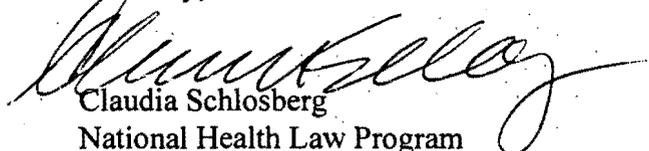
<sup>2</sup>Id.

Bruce Vladeck, Administrator  
Page 2  
September 24, 1996

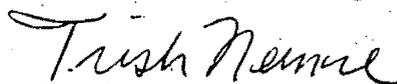
- ▶ The loss of cash assistance under the AFDC or SSI programs does not result in automatic termination from the Medicaid program. States must undertake an automatic, ex parte redetermination of eligibility and, if a beneficiary's eligibility is not otherwise established, issue timely and adequate notice and provide an opportunity for hearing. Pending final determination, Medicaid benefits must be continued.
- ▶ Qualified legal aliens who lose SSI cash assistance remain categorically needy and therefore eligible for Medicaid unless a state opts to end coverage. This is because the state's authority under Section 402(b)(1) to determine the eligibility of nonexempt qualified aliens to Medicaid relates only to the general issue of eligibility or ineligibility on the basis of alienage. States do not need to expand their existing Medicaid programs to continue coverage for these otherwise qualified aliens.
- ▶ As a matter of sound public health policy, reporting and verification requirements in the welfare law must be construed narrowly.
- ▶ HCFA must instruct states that aliens, regardless of immigration status, remain eligible for emergency medical care *including* care and treatment for labor and delivery.
- ▶ Under Section 114, states with waivers that affect eligibility for medical assistance have the option to continue the waiver after the date the waiver would otherwise expire *or* determine eligibility based on AFDC criteria in effect as of July 16, 1996. Section 114, however, does not repeal Title XIX.

It is our hope that HCFA will give our analysis due consideration and incorporate it into its policy directives to states. We are also requesting that HCFA establish a mechanism for continued dialogue around these and other pressing issues so that we can continue to share our expertise and provide HCFA with analysis and commentary throughout the implementation process.

Sincerely,



Claudia Schlosberg  
National Health Law Program



Trish Nemore  
National Senior Citizens Law Center

## WELFARE REFORM IMPLEMENTATION: ISSUE PAPER 1

*Continuing Medicaid Coverage for Qualified Aliens, SSI Children and former AFDC Recipients*

by

Claudia Schlosberg, National Health Law Program

Trish Nemore, National Senior Citizens Law Center

### Introduction

This memorandum identifies several key "first order" issues concerning the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, (P.L. 104-192) and its effect on Medicaid. The analysis is premised on the principle that while the welfare law makes radical changes in the structure of welfare programs and creates major new restrictions on receipt of public benefits by legal immigrants, the structure of the Medicaid program was left intact. In order to implement the new welfare policies and restrictions, states need not and cannot alter or amend their Medicaid programs beyond the narrow changes authorized by this law.

### ISSUE ONE - DUE PROCESS REQUIREMENTS

*Policy:* The loss of cash assistance under the AFDC or SSI programs does not result in automatic termination from the Medicaid program. States must undertake an automatic, *ex parte* redetermination of eligibility and, if a beneficiary's eligibility is not otherwise established, issue timely and adequate notice and provide an opportunity for hearing. Pending final determination, Medicaid benefits must be continued.

*Rationale:* Under the welfare law, families with dependent children, certain children on SSI and lawful aliens will no longer be eligible for cash assistance under the AFDC and SSI programs. The loss of cash assistance, alone, however, does not result in automatic termination from the Medicaid program. To the contrary, federal regulations establish that Medicaid beneficiaries must continue to receive benefits until they are found ineligible. 42 C.F.R. Section 435.930. The general rule is that states must redetermine eligibility before finding that a recipient can be terminated. Specifically, 42 C.F.R. 435.916 requires that the state agency responsible for administering the Medicaid program must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his or her eligibility. 42 C.F.R. 435.916(c)(1). Under 42 C.F.R. Section 435.916(c)(2), "[i]f the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes." (Emphasis supplied). In other words, states cannot terminate Medicaid based on an anticipated change in a recipient's status. States must wait for the change to actually occur and then proceed with the required redetermination. Redetermination reviews, moreover, are conducted *ex parte*. Massachusetts Ass'n of Older Americans v. Sharp, 700 F.2d 749, 753 (1983).

If the Medicaid agency reviews the recipient's case and makes a determination that the recipient is no longer eligible, the Medicaid agency must still provide the beneficiary with notice

and an opportunity for hearing, prior to the actual termination of benefits. 42 C.F.R. Sec. 435.919. Specifically, "[t]he agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid." 42 C.F.R. Section 435.919(a). The notice also must meet the requirements of 42 C.F.R. Section 431, Subpart E. *Id.* at Section 435.919(b). The requirements of Subpart of E of Section 431 set forth in detail the notice and fair hearing requirements of the Medicaid program. These procedural requirements are based on the Constitutional requirements of due process of law, Goldberg v. Kelly, 397 U.S. 254 (1970), and are fundamental requisites of the Medicaid program. Federal regulations therefore provide that at the time of any action affecting a recipient's claim, the State must provide the recipient with written notice stating 1) what action the agency intends to take, (2) the reasons for the intended action, the specific regulations that support the action and the recipients right to a hearing. 42 C.F.R. Section 421.210. With limited exception, recipients must be notified at least 10 days before the date of action, 42 C.F.R. Section 431.211, and the state must provide a hearing to "[a]ny recipient who requests it because he believes the agency has taken action erroneously." 42 C.F.R. Section 431.220(a)(2).

Significantly, Medicaid benefits must continue during the redetermination process, 42 C.F.R. Section 435.930(b), and at least ten days after notice of ineligibility is mailed to the recipient. 42 C.F.R. Section 431.211. If the recipient requests a hearing before the date of action, however, Medicaid benefits must continue pending a decision following the hearing. 42 C.F.R. Section 431.230. The agency also has discretion to reinstate benefits pending a hearing decision if the request for hearing is made not more than 10 days after the date of action. 42 C.F.R. Section 431.231. These procedural protections in the Medicaid program have not been abrogated by any provisions of the welfare law. Furthermore, they apply to all individuals who qualify for Medicaid under any eligibility category. Massachusetts Ass'n of Older Americans, supra at 753.

Accordingly, HCFA must notify States that the loss of cash assistance does not trigger an automatic termination from the Medicaid program. Instead, states must conduct an ex parte redetermination of eligibility. If it is determined that Medicaid eligibility is not otherwise established, the state must comport with due process and issue notice and provide the beneficiary with the opportunity for a fair hearing.

## ISSUE TWO - THE STATUS OF QUALIFIED LEGAL ALIENS WHO LOSE SSI CASH ASSISTANCE

*Policy:* Qualified legal aliens who lose SSI cash assistance remain categorically needy and therefore eligible for Medicaid unless a state opts to discontinue coverage. This is because the state's authority under Section 402(b)(1) to determine the eligibility of non-exempt qualified aliens to Medicaid relates only to the general issue of eligibility or ineligibility on the basis of alienage. States do not need to expand their existing Medicaid programs to continue coverage

for these otherwise qualified aliens.

- a. States need only act affirmatively if they opt to discontinue coverage.

Section 402 (a) makes clear that only qualified aliens who are refugees and asylees, veterans or on active duty or who have worked for 40 quarters remain eligible for SSI cash benefits. Under Section 402(b)(2), these same qualified aliens remain categorically needy and therefore "shall be" eligible for Medicaid (as well as other "designated federal programs"). The question of whether other qualified aliens who lose SSI cash assistance under Sec. 402 (a) remain eligible for Medicaid is controlled by Sec. 402 (b)(1). In pertinent part, Section 402(b)(1) provides: "Notwithstanding any other provision of law and except as provided in section 403 and paragraph (2), a State is authorized to determine the eligibility of an alien who is a qualified alien (as defined in section 431) for any designated Federal program (as defined in paragraph (3))." Section 403 bars new legal immigrants (with some exceptions) who enter the country on or after the date of enactment from receiving most federal means-tested benefits for five years. Section 402(3) defines the term "designated Federal program." In pertinent part, "Medicaid" is defined as "[a] State plan approved under title XIX of the Social Security Act, other than [emergency] medical assistance described in section 401(b)(1)(A).

"As in all cases involving statutory construction, the 'starting point must be the language employed by Congress.'" Lynch v. Rank, 747 F.2d 528, 531 (1984), quoting Reiter v. Sonotone Corp., 442 U.S. 330, 337. 99 S. Ct. 2326, 2330, 60 L.Ed. 2d 931 (1979)). Faced with a statute containing "plain and unambiguous language," a court should ordinarily simply "enforce it according to its terms." Ciampa v. Secretary Of Health and Human Services, 687 F.2d 518, 524 (1st Cir. 1982), citing Mass. Financial Services, Inc. v. SIPC, 545 F.2d 754, 756 (1st Cir. 1976), quoting Caminetti v. U.S., 242 U.S. 470 (1917), cert. denied, 431 U.S. 904 (1977).

Here, the language of the statute clearly authorizes states to determine the Medicaid eligibility of qualified aliens (other than those excepted under Section 402(b)(2)). In other words, states can decide to continue Medicaid eligibility of qualified aliens under the state's Medicaid plan. Some have argued however that section 402(b)(1) automatically terminates benefits for qualified aliens and that states desiring to continue coverage will have to take affirmative action including enacting legislation to do so. The language of Section 402(b)(1) however does not plainly address this issue. Where, as here, the meaning of the statutory language is ambiguous, congressional intent is ascertained by examining materials extrinsic to the statute such as the statute's legislative history. Moore Bayou Water Ass'n Inc. v. Town of Jonestown, 628 F. Supp. 1367 (N.D. Miss. 1986).

As that legislative history reveals, the original House-passed version of HR-3437 barred qualified aliens (with some exceptions) from receipt of SSI, food stamps and Medicaid. Included within the House bill were provisions that allowed beneficiaries who were receiving benefits on the date of enactment to continue to receive them for at most one year. If, after a review, the qualified alien failed to meet an exceptional category, benefits would cease immediately. States

were also given "the option of ending cash welfare payments and social service benefits for current recipients after January 1, 1997." H. R. Conf. Rep. No. 725, 104th Cong. 2nd. Sess 380 (1996). The blanket bar to Medicaid however was rejected by the full Congress in the final vote on the bill. Instead, Medicaid was included with cash welfare and social services as benefits that states could opt to terminate. Furthermore, the final version of the law retains the House provision prohibiting states from taking action to terminate benefits for current enrollees prior to January 1, 1997. Sec. 402(D)

The language of Section 411 is further evidence that Congress did not intend States to terminate qualified aliens' Medicaid benefits automatically or to require states to enact legislation in order to provide Medicaid benefits to these enrollees. Under Section 411(a), Congress clearly pronounces that illegal aliens are not eligible for most State or local public benefits. In Section 411(d), however, Congress authorized states to opt to provide such benefits but makes clear that states can exercise this option "only through the enactment of a State law after the date of the enactment of this Act which affirmatively provides for such eligibility." Section 411(d). Had Congress wanted to require States to enact legislation in order to provide Medicaid benefits to non-exempt qualified beneficiaries, Congress clearly knew how to draft such a provision.

Finally, as is discussed in Issue #1 above, due process and the explicit requirements of the Medicaid program require that States conduct redetermination reviews and provide notice and an opportunity for a fair hearing before Medicaid benefits are terminated. Nothing in the welfare law nullifies these procedural protections. The only provision which is arguably relevant is the phrase in Section 402(b)(1): "Notwithstanding any other law. . . ." This provision however cannot be read to mean that the procedural due process protections of Title XIX and the U.S. Constitution are nullified. As the Supreme Court has noted on frequent occasion, "such indefinite congressional expressions cannot negate plain statutory language and cannot work a repeal or amendment by implication." St. Martin Lutheran Church v. South Dakota, 451 U.S. 772, 788, 68 L.Ed. 612, 623, 101 S.Ct. 2142 (1981). This long-established canon of construction moreover, "carries special weight when an implied repeal or amendment might raise constitutional questions." Id. See NLRB v. Catholic Bishop of Chicago, 440 U.S. 490, 59 L.Ed. 2d 533, 99 S.Ct. 1313 (1979); Brown v. Consol. Rail Corp., 605 F. Supp. 629 (N.D. Ohio 1985) (where a statute is created to afford protection, passage of a later piece of legislation that at first glance may be construed to defeat earlier protections should not be deemed to repeal earlier conferred benefits).

In sum, qualified legal aliens remain eligible for Medicaid, unless states opt to discontinue coverage. States need not take any affirmative action to maintain the status quo.

b. States opting to cover qualified aliens under Section 402(b)(1) must comply with requirements of the Medicaid program.

Section 402(b)(1) provides "Notwithstanding any other provision of law . . . a state is authorized to determine the eligibility of an alien who is a qualified alien . . . ." Section

402(b)(1), however, does not give states authority to selectively repeal provisions of the Medicaid statute. As noted above, if Congress wanted to repeal the Medicaid statute or give states authority to do so, it must act "with clear and manifest intent." Watt v. Alaska, 101 S. Ct. 1673, 451 U.S. 259, 68 L.Ed. 2d 80 (1981). Thus, Section 402(b)(1) must be construed narrowly. Rather than a broad grant of authority to rewrite the Medicaid statute, it merely gives states the option of restricting eligibility on the basis of alienage or not. Support for this position is found in Section 433(a)(1), which provides:

Nothing in this title may be construed as an entitlement or a determination of an individual's eligibility or fulfillment of the requirements for any Federal, State, or local governmental program, assistance, or benefits. For purpose of this title, eligibility relates only to the general issue of eligibility or ineligibility on the basis of alienage.

(Emphasis added).<sup>3</sup> Accordingly, the only question for states is whether they intend to continue to provide Medicaid coverage for qualified aliens or not. If a state chooses to continue coverage, it must comport with all Medicaid provisions (unless waived) including those regarding eligibility, statewideness and comparability.

c. States continuing coverage for qualified aliens who lose SSI cash assistance may continue Medicaid coverage under the state's existing state plan.

Under Section 402(a), qualified aliens who are neither refugees nor asylees, veterans nor on active duty in the armed forces or who have not worked 40 qualifying quarters lose SSI cash assistance. Since SSI cash assistance recipients are deemed categorically needy under the Medicaid program, the loss of SSI will trigger a redetermination and could lead to a loss of Medicaid benefits. The loss of SSI benefits however is linked solely to the status of the recipient as an alien and not on any program eligibility requirement of Medicaid program. Thus, non-exempt, qualified aliens who lose SSI cash assistance are in much the same situation as "Pickle" people who lost Medicaid because a Social Security cost of living increase made them ineligible for SSI, or families with stepchildren who lost Medicaid because AFDC deeming rules made them ineligible for AFDC cash assistance. In both situations, Medicaid was restored for these beneficiaries by "deeming" them eligible for the respective cash assistance programs. Through this mechanism, these beneficiaries retained eligibility as "categorically needy."<sup>4</sup> The difference

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<sup>3</sup> Thus, the phrase "notwithstanding any other provision of law," must also be construed only to preclude operation of any law that would prohibit a state from not providing Medicaid benefits on the basis of alienage.

<sup>4</sup> Medicaid regulations incorporating the "deeming" requirements are found at 42 C.F.R. Section 435.113 (AFDC) and 42 C.F.R. Section 435.122 (SSI).

in the instant case is that Congress has delegated its authority to the States and given each state the option to continue providing Medicaid benefits to these enrollees.

The decision of a state to opt to continue coverage of non-exempt, qualified aliens, therefore, is effectively a decision to deem these individuals categorically needy and to continue to provide Medicaid as before. Stated alternatively, a state can continue to provide Medicaid benefits to qualified aliens who, "but for" their status as aliens, would be eligible for SSI cash assistance.

Absent the deeming approach, states would have to redetermine eligibility of those qualified aliens losing SSI under another existing category of their Medicaid program. However, only 35 states and the District of Columbia provide coverage to medically needy individuals, and only 29 states and the District of Columbia include optional categorically needy coverage in their state plans. At least six states have neither a medically needy nor optional categorically needy program. Thus, qualified aliens who lose SSI and who live in states without the full scope of optional Medicaid eligibility categories would lose Medicaid benefits unless the state amended its State Plan. Under Medicaid rules, however, if the state provides Medicaid to any individual in an optional group, the state must provide Medicaid to all individuals who apply and are found eligible in that group. 42 C.F.R. Section 435.201(b). Thus, in order to continue covering qualified aliens who lose cash assistance, states would actually have to expand Medicaid eligibility to all individuals within those other optional eligibility categories. Clearly, neither the automatic loss of Medicaid by recipients nor the mandated expansion of programs by states was intended by Congress.

In sum, states should not have to expand Medicaid eligibility to order to exercise the option to continue to provide Medicaid benefits to non-exempt, qualified aliens who previously received SSI. To require states to do so would effectively nullify Congress' intent and would produce extraordinarily harsh results. Instead, HCFA must issue guidance to the states informing them that if they opt to continue coverage for non-exempt qualified aliens, and such aliens qualify for SSI "but for" their alien status, they remain categorically needy under the Medicaid program.

### ISSUE THREE: VERIFICATION AND REPORTING REQUIREMENTS

*Policy:* As a matter of sound public health policy, reporting and verification requirements in the welfare law must be construed narrowly.

*Rationale:* The welfare law contains new provisions relating to reporting and verification of the legal status of immigrants. These provisions are already raising concerns in immigrant communities and will deter aliens from seeking and obtaining treatment, even when they are lawfully entitled to care. To minimize the adverse impact of these provisions, HCFA must issue guidance to the States clarifying that these provisions do not impose any new requirements on

health providers and do not eliminate the confidentiality protections in the SAVE program. Of particular importance is the need to instruct states that persons seeking Medicaid emergency medical care including women in active labor are exempt from verification requirements. This interpretation is clearly supported by the language and structure of the statute itself.

In relevant part, Section 404 amends Title IVA of the Social Security Act, 42 U.S.C. Section 601 et. seq. by adding a new section which states:

Each state to which a grant is made under section 403 [of the Social Security Act, 42 U.S.C. Section 603] shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information, on any individual who the State knows is unlawfully in the United States.

The welfare law contains similar reporting requirements for the Social Security Administration and Department of Housing and Urban Development. Significantly, however, there is no similar provision amending Title XIX or imposing any new reporting requirements on any health provider. Thus, by its terms, Section 404(b)'s mandatory reporting requirements apply only to the reporting of persons seeking AFDC services, not Medicaid services or health care.<sup>5</sup>

Section 432 provides additional support for maintaining the status quo with respect to undocumented aliens seeking health services. Under Section 432, the Attorney General, after consultation with the Secretary of Health and Human Services, must promulgate regulations requiring verification that an alien, who is not a qualified alien, is eligible to receive services under Section 401(b)(1). Section 432 further provides that "[s]uch regulations, to the extent feasible, require that information requested and exchanged be similar in form and manner to information requested and exchanged under section 1137 of the Social Security Act."

Section 1137 codifies the requirements of the current verification system, the Systematic Alien Verification for Eligibility (SAVE) program. Recognizing that access to emergency care is a public health imperative, SAVE exempts Medicaid emergency medical care from the verification requirements. 42 U.S.C. Section 1320b-7(f). In addition, the statute prohibits INS from using information obtained through the verification system for civil immigration law

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<sup>5</sup>Arguably, these mandatory reporting requirements apply only when a person has sought AFDC benefits to which they were not entitled. See Doe v. Miller, 573 F.Supp. 461 (N.D.Ill 1983)(A provision requiring state AFDC agencies to report to the INS [persons who are ineligible to receive food stamps because they are unlawfully present were anti-fraud measures, requiring state to only report persons fraudulently seeking food stamps). In any event, Section 404(b) requires agency knowledge.

enforcement. 42 U.S.C. 1320(c)(1) .

Although Section 434<sup>6</sup> of the welfare law appears to authorize an "open season" for reporting to INS, the language of Section 434 fails to evidence a clear and manifest intention to repeal SAVE. Nor does any other provision in the law repeal SAVE. Thus, Section 434 and SAVE must be read together. Read in this manner, Section 434 merely authorizes states and localities to exchange with the INS the information that they are currently authorized to collect.

In sum, nothing in the welfare law changes current reporting requirements or restrictions with respect to unqualified or qualified aliens seeking health care and benefits.

#### ISSUE FOUR: EMERGENCY MEDICAL CARE

Policy: HCFA must instruct States that aliens, regardless of immigration status, remain eligible for emergency medical care including care and treatment for labor and delivery.

Although undocumented aliens are barred from most public benefits, Section 401(b)(1)(A) makes an exception for "[m]edical assistance under Title XIX of the Social Security Act . . . for care and services that are necessary for the treatment of an emergency condition (as defined in section 1903(v)(3) of such Act)." Section 403(c)(2)(A) recognizes a similar exception for lawful aliens entering the country after the act takes effect.

Section 1903(v)(3) defines an emergency medical condition as "a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -- (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part." 42 U.S.C.b(v).

Although the conference report contains some language that might be construed to narrow this definition to exclude women in active labor, such an exclusion is not apparent on the face of the statute. In fact, the statute is unambiguous. The definition of emergency medical condition is the definition currently in effect under Title XIX. Under well-established rules of statutory construction, indefinite Congressional expressions cannot negate the plain language of a

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<sup>6</sup>Section 434 provides:

Notwithstanding any other provision of Federal, State or local law, no State or local government entity may be prohibited, or in any way restricted, from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status, lawful or unlawful, of an alien in the United States.

statute. The language of the statute, and not the conference report, controls. St. Martin Lutheran Church v. South Dakota, *supra*. Accordingly, states must be instructed that FFP for treatment of aliens who are experiencing an emergency medical condition, including active labor and delivery, will be provided under the same terms and conditions as before the passage of welfare reform.

#### ISSUE FIVE: WAIVERS

*Policy:* Under Section 114(d), states with waivers that affect eligibility for medical assistance have the option to continue to apply the eligibility criteria under the state's waiver after the date the waiver would otherwise expire. Section 114(d), however, does not repeal Title XIX.

*Rationale:* Section 114, the "Chafee-Breaux Amendment," contains critically important provisions designed to assure that low-income families continue to receive Medicaid. According to its chief sponsor, Senator Chafee, the amendment was designed to "assure that no low-income mothers and children who are eligible for Medicaid under current law, under the existing law, will lose their health care coverage under Medicaid if the state lowers its eligibility standards for cash assistance or AFDC." Congressional Record, S8345, July 19, 1996.

Sections (a) and (b) direct states to use AFDC criteria in effect as of July 16, 1996. Section (c) addresses the treatment of transitional Medicaid, while section (d) refers to the effect of waivers. Specifically, Section 114(d) provides:

In the case of a waiver of a provision of part A of title IV with respect to a State as of July 16, 1996, or which is submitted to the Secretary before the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and approved by the Secretary on or before July 1, 1997, if the waiver affects eligibility of individuals for medical assistance under this title, such waiver may (but need not) continue to be applied, at the option of the State, in relation to this title after the date the waiver would otherwise expire.

By its plain language, Section 114(d) merely gives states with waivers flexibility to continue using eligibility standards established in their approved waivers in lieu of rigidly applying the July 16, 1996 income and asset standards and methodologies. Thus, if a state has established resource limits or income standards for purposes of qualifying for welfare under a waiver that are different than the resource and income standards in effect as of July 16, 1996, and those standards also provide a basis for receipt of medical assistance, the state can opt to continue applying the standards as modified by the waiver.

Section 114(d) does not authorize states to utilize eligibility criteria for Medicaid that is not now permitted under Title XIX, nor can Section 114(d) be read to give states the option of applying TANF eligibility criteria to the Medicaid program. Such an interpretation would effectively give states authority to selectively repeal requirements of the Medicaid program and

would undermine the Congressional intent to preserve Medicaid eligibility even if a state applies more restrictive criteria for TANF.

# FAX TRANSMISSION

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**To:** Chris Jennings, Jen Klein

**Date:** September 30, 1996

**Fax #:**

**Pages:** 5, including this cover sheet

**From:** Cindy Mann

**Subject:** AFDC/Medicaid issues

### COMMENTS:

I know that Judy Waxman and Sara Rosenbaum have raised the issue of the interpretation of the waiver provision in the Chafee-Breaux language with you. I thought you might be interested in the analysis that was sent over to HCFA.

September 24, 1996

### Interpretation of the Waiver Provision in Section 1931 — Legal Analysis

This paper briefly summarizes the interpretation of section 1931, as added to title XIX by section 114 of PL 104-193, and specifically the waiver provision in subsection (d) of section 1931, that Senator Chafee and Senator Breaux believe was intended by their amendment.

Subsection (b) of 1931 sets forth the general rule on how eligibility for Medicaid will be determined for those who have qualified for Medicaid based on their receipt of AFDC. It provides that persons shall be eligible for medical assistance if they meet (1) the income and resource standards for determining eligibility under a state plan approved under title IV-A, using the standards and methodologies in effect on July 16, 1996, and (2) the state plan "deprivation", or family composition, rules as of July 16, 1996. (Variations of these standards and methodologies are permitted under section 1931(b)(2).)

While the meaning of the waiver provision in section 1931(d) is open to some interpretation, it is clear that section 1931(b) is the general provision establishing the rules for how eligibility will be determined and that subsection (d), addressing the issue of how waivers may affect eligibility determinations, is ancillary to that general provision. This interpretation is consistent with the construct of section 1931; subsection (b) is set forth as the general rule and does not state that it is the rule except as provided in subsection (d). Indeed, there is nothing in section 1931 to suggest that subsection (d) was intended to be applied in such a way as to override and eliminate the guarantees established by the eligibility criteria set forth in subsection (b).

The understanding of the lead sponsors of the Chafee-Breaux amendment is that subsection (d) grants states the flexibility to rely on their waiver policies *in applying the eligibility criteria established in subsection (b)*. In light of the fact that subsection (b) establishes the general rules for determining eligibility for Medicaid (for the formerly AFDC-related population), the most reasonable construction of subsection (d) is that the AFDC waivers described in that subsection (i.e., waivers that "affect the eligibility of individuals for medical assistance under this title") refer to those waivers that relate to the specific eligibility rules — the income and asset standards and methodologies and family composition rules — that must now be applied to determine eligibility for medical assistance pursuant to subsection (b). In other words, under subsection (b) states must apply AFDC income and asset standards and methodologies and family composition rules to determine eligibility for Medicaid. However, under subsection (d), states have the option to apply the rules they have developed through the waiver process in lieu of the standard state plan rules that pertain to these eligibility criteria.

Thus, states with waivers that expand or restrict standard earned income disregard rules, asset requirements, two-parent family rules, or rules regarding countable income could apply those waiver policies in lieu of the standard, July 16, 1996 income and asset standards and methodologies and family composition rules. The waiver provision allows states to substitute waiver rules for the standard rules *while maintaining the basic criteria that must be applied to determine Medicaid eligibility.*

While this is the most reasonable interpretation of the two subsections of 1931, it is possible to read subsections (b) and (d) as independent provisions. However, even if one were to read these subsections as independent provisions, there is no basis for reading section 1931(b) out of the law as some states are urging. If the provisions were independent, subsection (d) would allow states to determine Medicaid eligibility pursuant to its waiver policies linking to its block grant, but states would still be required to evaluate whether any child or parent who is not eligible under those policies meets the requirements of section 1931(b). This would assure that the intent of the Chafee-Breaux amendment is accomplished in that no person who meets the AFDC family composition requirements whose income and assets are below state standards as of July, 1996 will be denied Medicaid coverage.

The fact that Congress made available up to \$500 million to defray the costs associated with making separate eligibility determinations under the criteria set forth in subsection (b) suggests that Congress clearly understood that separate evaluations of Medicaid eligibility would be required under section 1931. It is also particularly revealing that the Senate explicitly and overwhelmingly rejected, on a vote of 68 to 31, a substitute amendment offered by Senator Roth that would have eliminated the eligibility standards set forth in section 1931(b), relying instead on a grandfather provision that would only have guaranteed coverage to current recipients of AFDC and Medicaid. As Senator Roth correctly pointed out during the debate, "The difference (between the Roth substitute and the Chafee-Breaux amendment) is that the Chafee-Breaux amendment applies to categories rather than people." Congressional Record, S8347, July 19, 1996. Subsection (b) is the provision in the Chafee-Breaux amendment that defines the categories of people who must be covered. Any interpretation of section 1931 that allows states to disregard the eligibility criteria set forth in subsection (b) and to deny Medicaid coverage to parents and children without regard to whether those parents and children meet those criteria would accomplish much of what the Roth substitute proposed and which 68 Senators voted not to accept.

September 24, 1996

## Implementation of the AFDC-related Medicaid provisions — General Discussion

The welfare law includes a provision that protects Medicaid eligibility for people who have qualified for Medicaid based on their receipt of AFDC. This provision was adopted pursuant to an amendment sponsored by Senator Chafee and Senator Breaux, among others, but a question relating to how a subsection in that provision relating to waivers is interpreted threatens to undo the guarantee of coverage that this amendment was intended to establish. Some states apparently have suggested that the waiver provision in section 1931 allows them to link Medicaid eligibility to eligibility under their TANF program (assuming they follow AFDC waiver policies in both programs) and permits them to disregard that portion of section 1931 that makes children and parents who meet July, 1996 AFDC income and asset standards and family composition rules eligible for Medicaid.

This interpretation undermines the central thrust of the Chafee-Breaux amendment in that it would leave Medicaid eligibility subject to restrictions imposed by states under their TANF programs. Nothing in the language or legislative history of section 1931 supports the view that states do not have to apply the general eligibility criteria established in section 1931 if a state chooses to continue its AFDC waiver policies.

A more reasonable reading of section 1931, and the reading that both Senator Chafee and Senator Breaux believe is the correct reading of this section, is that section 1931 sets forth the criteria that states must apply to determine the eligibility of children and parents who otherwise would have qualified for Medicaid based on their receipt of AFDC. It provides, in general, that children and parents who meet a state's AFDC income and asset standards and family composition rules, as they were in effect on July 16, 1996, shall be eligible for Medicaid. The waiver provision in section 1931(d) modifies this general rule by allowing states that have waivers *pertaining to these eligibility criteria* to apply their waiver rules rather than the July 16, 1996 rules.

For example, with respect to the income criteria that must be applied, if a state has a waiver that provides for more generous earned income disregards, that state may apply its expanded disregard rule in lieu of the standard earned income disregard in effect on July 16, 1996. Similarly, if a state has a waiver that expands coverage for two-parent families by eliminating the standard AFDC-UP "100-hour rule", the state could apply its two-parent family rule rather than the standard family composition rule in effect on July 16, 1996.

The waiver provision was included in the Chafee-Breaux amendment to allow states flexibility and the opportunity to achieve cross-program coordination. It permits states that choose to continue their waiver policies under TANF to use the same income

and asset standards and methodologies and family composition rules to determine Medicaid eligibility. Even though the programs are technically "delinked", a single application can be used for both programs and one eligibility determination can apply to both programs.

While the Chafee-Breaux provision allows for and encourages cross-program coordination, it also assures that children and parents who are not eligible for TANF due to tightened eligibility rules or restrictions such as time limits are separately considered with respect to Medicaid eligibility based on the criteria established by section 1931. As you know, Congress made funds available to states for the specific purpose of defraying the costs associated with these Medicaid eligibility determinations.

Both Senator Chafee and Senator Breaux believe that it was well understood that their amendment, which adopted by the Senate by a vote of 97 to 2, established standards for determining Medicaid eligibility for children and parents to assure that their eligibility for Medicaid was not dependent on state action under TANF. To quote the chief sponsor of the amendment, Senator Chafee, during the Senate debate, "(U)nder our amendment, we make sure that no low-income mothers and children who are eligible for Medicaid under current law, under the existing law, will lose their health care coverage under Medicaid if the state lowers its eligibility standards for cash assistance or AFDC." Congressional Record, S8345, July 19, 1996. Any interpretation of section 1931 that would allow states to disregard the eligibility criteria established in section 1931 runs directly counter to this common understanding of the meaning of this provision.

Table 2

**Annual Dollar Loss of Federal Medicaid  
Payments to States under a Five Percent Cap\***

State	1996	1997	1998	1999	2000	2001	2002
<b>Total</b>	<b>\$4,970</b>	<b>\$10,346</b>	<b>\$16,445</b>	<b>\$22,948</b>	<b>\$29,483</b>	<b>\$37,046</b>	<b>\$45,624</b>
Alabama	53	107	170	238	301	375	460
Alaska	14	28	43	58	73	90	108
Arizona	70	143	227	320	414	521	643
Arkansas	80	162	251	344	429	526	636
California	394	826	1,320	1,852	2,488	3,247	4,109
Colorado	52	106	166	229	291	361	440
Connecticut	41	85	138	199	260	349	449
Delaware	10	20	32	45	58	73	89
District of Columbia	25	52	83	117	153	193	239
Florida	315	645	1,000	1,354	1,683	2,054	2,474
Georgia	197	404	627	853	1,062	1,299	1,566
Hawaii	19	38	59	81	101	124	151
Idaho	17	35	54	75	96	120	147
Illinois	179	370	590	834	1,087	1,373	1,697
Indiana	125	260	414	581	754	951	1,173
Iowa	36	75	119	169	221	280	347
Kansas	19	39	63	91	120	153	195
Kentucky	114	234	371	518	664	829	1,016
Louisiana	174	355	549	744	917	1,117	1,346
Maine	17	37	61	91	122	162	213
Maryland	80	165	262	367	472	591	726
Massachusetts	122	256	414	589	773	982	1,219
Michigan	169	352	565	798	1,043	1,322	1,638
Minnesota	59	125	205	296	396	509	637
Mississippi	78	157	245	338	427	527	640
Missouri	36	73	119	173	229	294	369
Montana	28	58	89	118	143	172	204
Nebraska	21	44	70	99	129	162	201
Nevada	15	31	49	68	89	113	141
New Hampshire	1	3	7	11	16	21	29
New Jersey	110	226	360	508	654	823	1,016
New Mexico	42	87	136	186	234	289	351
New York	451	1,017	1,695	2,469	3,296	4,233	5,294
North Carolina	236	480	738	992	1,216	1,468	1,751
North Dakota	12	24	38	53	69	87	107
Ohio	216	444	706	992	1,287	1,619	1,995
Oklahoma	74	151	235	320	400	490	591
Oregon	63	128	196	265	327	398	477
Pennsylvania	147	330	568	829	1,102	1,411	1,761
Rhode Island	26	53	86	122	160	203	252
South Carolina	76	154	240	327	404	492	593
South Dakota	11	23	37	53	70	89	110
Tennessee	139	288	476	667	842	1,040	1,264
Texas	345	707	1,095	1,486	1,848	2,351	2,924
Utah	32	65	102	140	178	221	269
Vermont	9	19	31	44	58	74	93
Virginia	94	192	298	406	506	619	746
Washington	124	252	390	531	666	819	991
West Virginia	110	225	348	472	585	714	859
Wisconsin	88	180	286	403	524	660	815
Wyoming	8	16	25	34	43	53	65

\*Dollars are in millions

Source: Unpublished data developed by the Urban Institute for the Kaiser Commission on the Future of Medicaid

A cap on federal Medicaid spending also could lead to an inequitable distribution of federal funds among states.

- A formula that distributes federal payments to states based on past state spending levels would lock in historical differences in Medicaid spending among states and have substantially disparate impacts from state to state. For example, according to the Urban Institute's analysis, over five years a five percent cap could cause Missouri to lose 6.3 percent of its federal funds, while Florida, Georgia, Montana, North Carolina and West Virginia could lose close to or more than 19 percent of their federal funds.
- A cap or block grant distribution formula that locks in current or recent spending patterns can penalize states that have been more successful in controlling their costs as well as those that have not taken advantage of federal options to expand coverage or otherwise to maximize federal reimbursements. It would also fail to take adequate account of different levels of need that develop among states over time.

Thus, even with added flexibility, a Medicaid block grant or a cap on federal Medicaid payments could have serious consequences for states and leave them with grim choices. States either will have to impose deep cuts in benefits or eligibility, jeopardize access by driving down payments to providers such as doctors, hospitals and nursing homes even further, or free up additional state funds to finance health care services. If state Medicaid programs are severely constrained, the number of state residents who join the ranks of the uninsured likely will grow, and state efforts to help families move from welfare to employment will suffer. Substantial cost shifting to local communities, to public health facilities and to other payers in the state, principally business, would likely occur.

The Medicaid program is not without its problems, and changes are warranted. However, states can be allowed much greater flexibility to achieve program savings without exacting so heavy a price on states' finances and the vulnerable populations served by their Medicaid programs.

### **A Federal Cap Would Result in Deep Cuts That Grow Sharply Over Time**

If a cap is imposed on federal Medicaid payments to states, states (and, in some cases, local governments) would have to bear the full risk of any costs beyond the capped amounts, even where added costs were necessitated by factors beyond a state's control. A sharp rise in the number of people who become uninsured due to a recession or an unexpected rise in health costs — due, for example, to a rise in the number of HIV-infected — persons cannot be accommodated adequately by a pre-set

limit on federal funding. The federal funding for block grants or caps would be set at levels that accommodate federal deficit reduction goals rather than respond to the multitude of factors that drive up health care costs for states.

While there is no one proposal on the table, one frequently discussed option would allow federal Medicaid payments to grow by five percent each year. A state's federal grant would be set at five percent above its prior year's grant, regardless of actual or projected program costs. At the request of the Kaiser Commission on the Future of Medicaid, the Urban Institute prepared an analysis detailing how such a cap might impact states.<sup>1</sup> It shows that a cap imposed beginning in fiscal year 1996 would reduce total federal Medicaid payments to states by \$84.2 billion between fiscal years 1996 and 2000. (See Table 1.) By fiscal year 2000, the states would receive 20 percent less federal funds as compared to current law. The cuts would be deep for virtually all states.<sup>2</sup>

- In fiscal year 2000, more than half of the states would lose at least 20 percent of the federal Medicaid funds they would receive under current law. Five states — Florida, Georgia, Montana, North Carolina and West Virginia — would lose more than a quarter of their federal funds.
- Federal payments to each of ten states would be reduced by more than a billion dollars in fiscal year 2000. In dollar amounts, the cut would be greatest for New York, California, Texas, Florida, North Carolina, and Ohio.

Because a fixed cap compounds the cuts over time, even states that expect to have lower-than-average Medicaid growth rates would sustain deep reductions in federal payments. Table 2 shows the year-by-year loss of federal funds to states under a five percent cap imposed beginning with fiscal year 1996. A five percent cap would cut federal payments to states by \$5 billion in fiscal year 1996. By fiscal year 1998, federal cuts grow to \$16.5 billion and by fiscal year 2000, the reduction in federal payments to states amounts to \$29.5 billion — almost six times the cost size of the cuts

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<sup>1</sup> This paper relies on data developed by John Holahan and David Liska at the Urban Institute for the Kaiser Commission on the Future of Medicaid and published in the Commission's report, *The Impact of a Five Percent Medicaid Expenditure Growth Cap — A State Level Analysis*, Policy Brief, March 1995, as well as on unpublished data developed by the Urban Institute.

<sup>2</sup> The major exception is New Hampshire, which would only lose 2.7 percent of its funds in 2000. This is largely because of New Hampshire's exceptionally high reliance on disproportionate share hospital payments. Since growth in such payments was capped by Congress in reforms enacted in 1993, New Hampshire's federal Medicaid payments are not expected to grow much over the next few years under current law. Accordingly, an overall cap on growth will not significantly affect New Hampshire.

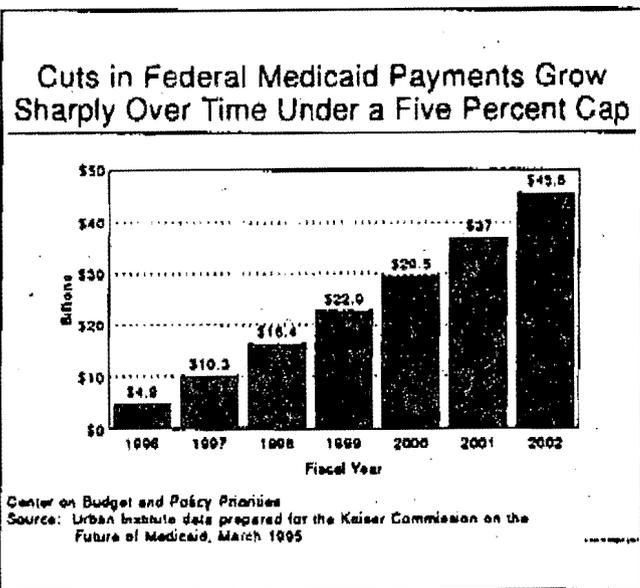
in the first year. The escalating nature of the cutbacks in federal payments are unavoidable under a fixed cap. For example, Maine, Missouri and Kansas are among the states with the slowest expected rates of growth in spending. Yet, Maine's cuts would jump from \$17 million in fiscal year 1996 to \$122 million in fiscal year 2000. In Missouri and in Kansas, the cuts in fiscal year 2000 would be 6.3 times greater than in fiscal year 1996.

### Even with Added Flexibility, Large Federal Cost Shifts Will Be Unavoidable

Some states may believe that they will be able to hold their Medicaid spending growth below 4 or 5 percent per year if they are given increased flexibility to convert to managed care systems and to lower reimbursement rates to medical providers. Even with added flexibility, however, expected savings are unlikely to fill the gap that would be created over time by reductions of this magnitude in federal contributions.

Use of managed care plans is one potential avenue for savings. Managed care, however, has demonstrated its potential only with respect to acute care services used by children and by adults who are neither disabled nor elderly. This spending accounts for about 19 percent of all Medicaid expenditures. The evidence to date suggests that managed care can achieve Medicaid savings on the order of 5 to 10 percent in acute care costs for the non-elderly, non-disabled Medicaid populations.<sup>3</sup> This is less than the 15 to 20 percent savings potential in the private sector because Medicaid fee-for-service payment rates already are below private sector rates.

A five to ten percent reduction in the acute care costs of nondisabled, nonelderly adults and children will, at most, amount to savings of \$10 billion to \$21 billion over five years. These would be substantial savings, but it means that even if states quickly could move all nonelderly, nondisabled beneficiaries into managed care, the savings would make up for only 12 percent to 25 percent of the \$84 billion reduction in federal



<sup>3</sup> Robert Hurley, Deborah Freund, and John Paul, *Managed Care in Medicaid*, 1993; Lawrence Joseph and Henry Webber, *Medicaid Myths and Realities, An Analysis of the Illinois Medicaid Program*, March 1995; Congressional Budget Office, *The Effects of Managed Care and Managed Competition*, February 1995.

funds that states could expect over five years under a five percent federal spending cap. Furthermore, even these projected savings may overestimate the extent to which managed care will allow states to operate under such a cap.

- Several states have implemented broad-based managed care programs and others soon will be proceeding under waivers to enroll many of their Medicaid beneficiaries into managed care. Projected savings already have been calculated into the expected growth rate of the Medicaid program and are partly responsible for estimates that Medicaid spending will grow more slowly over the next five years. If expected savings from managed care are already factored into a state's projected growth rate, large additional savings would likely not be available from this strategy to help the state keep its costs under the federal cap.
- States differ in the amounts they spend on acute care and on long-term care, as well as in the rates of growth in those expenditures. States that spend less on acute care as opposed to long-term care will stand to save less through managed care.

Some states have begun to broaden the scope of their managed care programs to cover disabled and elderly beneficiaries and long term care services. However, evidence from Arizona, the state with the longest experience operating a broad-based managed care program, suggests that massive savings from implementing managed care for these populations and services are not likely. Arizona's program is often cited as a model of an efficient system that holds down annual growth. Yet even this mature, fully capitated system is projected to experience average annual spending increases of 12 percent for its program as a whole between fiscal years 1993 and 1996, according to data provided by Arizona to the Health Care Financing Administration. The same data projects Arizona's average annual rate of growth in long term care spending will be 17.9 percent between 1993 and 1996, despite extensive use of managed care.

Another frequently suggested avenue for achieving program savings is the elimination of the Boren amendment — the federal mandate requiring "reasonable and adequate" payment for inpatient hospital and nursing home services. Repeal of the Boren amendment would give states flexibility to freeze, reduce, or otherwise constrain payments to hospitals and nursing homes. However, it is unlikely that this flexibility would enable most states to protect themselves from a federal cost shift under a block grant or a federal spending cap.

First, there is the problem of double counting savings. Managed care is, in effect, a repeal of the Boren amendment, at least as applied to hospitals. Medicaid managed care plans generally are not required to pay participating hospitals at rates that comply with the Boren requirements, and states are not required to set their

capitation payments to plans on the assumption that they will do so. Thus, savings that states achieve through managed care cannot be realized again through repeal of the Boren amendment.

Second, there is a practical limit on the amount of savings achievable by lowering provider reimbursement rates. The ratio of Medicaid payments to hospital costs of treating Medicaid patients in 1992, the latest year for which such data are available, was 89 percent according to data developed by the Prospective Payment Assessment Commission. In 1989, prior to some states' aggressive use of the disproportionate share hospital (DSH) payment adjustment, this ratio was 78 percent. Even if Boren amendment savings were possible with respect to half of all inpatient hospital costs, assuming that half of all Medicaid beneficiaries were *not* enrolled in managed care, and even if one assumed, as a practical political matter, that states could drive the Medicaid payment-to-cost ratio down as low as 75 percent, the savings nationally would be in the order of \$17 billion over a five-year period. This amounts to about 20 percent of the \$84 billion reduction in federal payments under a five percent cap. It is important to note, moreover, that since Boren amendment hospital savings can only come about if at least some acute care services remain fee-for-service, these savings are at the expense of savings that may be realized through an expansion of managed care.

The Boren amendment could be repealed with respect to nursing homes as well, allowing states to freeze, or reduce payments to these facilities in addition to hospitals. Such actions, however, could not be easily taken by states without substantially affecting the care available to elderly and disabled people. Although no national data exist to show the Medicaid-to-cost ratio for nursing home care, nursing home services are highly dependent on Medicaid payments. In 1993, Medicaid covered 69 percent of all nursing home residents and accounted for 52 percent of all nursing home revenues. Medicaid patients and revenues were not evenly distributed among homes; some had relatively few Medicaid patients, while others relied almost exclusively on Medicaid payments. Under these circumstances, decreases in Medicaid reimbursement to nursing homes are likely to increase economic discrimination against Medicaid patients on the part of those facilities that serve substantial numbers of private pay patients, while reducing the quality of care in those facilities that serve predominantly or exclusively Medicaid eligibles. Some homes that serve a high proportion of Medicaid beneficiaries might not survive a substantial rate cut.

### **Deep Federal Cuts Will Rob States of Savings They Might Otherwise Realize Through Managed Care and Other Initiatives**

Because the financial responsibility for Medicaid program costs under current law is shared between the states and the federal government, program savings are

thirds — 64 percent — of federal DSH payments in fiscal year 1993 went to eight states. Virtually all states with high DSH payments will lose considerable federal funds under a cap, but generally they will be disadvantaged less than other states. This is because they already have brought their federal DSH payments to the federal maximum and are subject to a cap on growth of DSH payments enacted in 1993. States that have not yet taken full advantage of the DSH provision effectively will be prevented from doing so under a four or five percent aggregate cap.

Another variation results from different actions having been taken by states over recent years to cover children. Under current law, states must cover children whose family income is below certain levels, depending on the child's age. Coverage of all children whose family income is below the federal poverty line is being phased-in by age of the child; by 2002, all poor children under age nineteen are to be covered. States have the option, however, to accelerate the phase-in and to cover children at higher income levels. Some states have taken advantage of these federal options and receive federal reimbursement to cover children with family incomes well above the poverty level. Other states only receive federal funds to cover children up to the federal minimum standards. Many older children in these states may not be currently eligible for Medicaid even if their family income is below the federal poverty line. A cap on federal spending would tend to lock in these different levels of coverage. It would penalize states and poor children in states that have not drawn upon federal Medicaid dollars to expand coverage because of state fiscal constraints or other reasons.

An aggregate cap or a block grant that bases future federal payments to a state on prior years' payments to that state would roll these and other historical differences into the federal funding base and then ignore varying needs that surface over time. Additionally, a distribution formula that applies the same limit on federal payments to all states fails to consider that some states have less ability than others to contribute to program costs. Under current law, federal Medicaid match rates take states' ability to finance costs from their own revenues into account because the match rates are based on a state's per capita income. The Urban Institute's analysis shows that under a five percent cap, many of the poorer states that now have a favorable federal match rate would suffer a high percentage reduction of federal funds. Four out of the eight states that would suffer the largest percentage loss of federal funds in fiscal year 2000 — West Virginia, Montana, Arkansas, and New Mexico — are among the ten states with the highest federal match rate.<sup>4</sup>

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<sup>4</sup> A state with a high federal match rate but significant DSH funds might not suffer as great a loss. For example, the five-year impact of a five percent cap on Alabama, a state with a high federal match and a high proportion of DSH payments, is not as great as the impact on New Mexico, a state that also has a similarly high federal match but relatively low DSH payments.

## **A Cap Will Make it Extremely Difficult for States to Moderate Increases in the Number of Uninsured Residents and Undertake Welfare-To-Work Initiatives**

In recent years, Medicaid has proven to be a very important influence in moderating the rise in the number of uninsured people. According to calculations by the Urban Institute, because employer-sponsored health insurance coverage declined from 67 percent to 61 percent of the nonelderly population between 1988 and 1994, the number of uninsured would have risen to 47 million if it were not for Medicaid. The increase in Medicaid coverage among the poor and near-poor reduced the rise in the number of uninsured people by about 20 percent.

Some states have sought to use federal Medicaid funds to help reduce the number of uninsured people even more aggressively by expanding coverage under their Medicaid program. Tennessee, for example, has extended basic health care coverage to over 400,000 previously uninsured residents under a section 1115 Medicaid waiver. The treatment under an aggregate cap of Tennessee and other waiver states is, of course, a matter for discussion by Congress. But it is clear that states that have not yet used federal Medicaid funds to expand coverage would have enormous difficulty in doing so under a block grant or an aggregate cap, regardless of how much new flexibility they receive.

A federal cap that constrains the Medicaid program's ability to extend coverage to uninsured workers will be particularly problematic for states. Trends in health insurance coverage from 1987 to 1993 show that the decline in employer-based health insurance coverage is accelerating. According to Census Bureau data, both the number of people and the proportion of the population that lack health insurance for the entire year have increased steadily since 1987.<sup>5</sup> This trend is not expected to reverse itself or level off. Thus, more state residents can be expected to join the ranks of the uninsured in the years ahead, but under a cap or block grant, federal Medicaid funds may no longer be available to help states moderate the impact of further declines in employer-based coverage.

In addition, the severe reductions in federal Medicaid payments to states that would result from a cap or a block grant would come at the same time states will be expected to move large numbers of women and children who receive AFDC into employment. The welfare-to-work transition will be particularly difficult to accomplish and maintain if health insurance is not available in the workplace and Medicaid funds are so constrained as to make it difficult, if not impossible, for states to cover low-wage earners. Much of the growth in the Medicaid program in recent years

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<sup>5</sup> For a fuller discussion of the Census Bureau data, see Center on Budget and Policy Priorities, Laura Summer and Isaac Shapiro, *Trends in Health Insurance Coverage, 1987 to 1993*, October 1994.

has occurred among low-income working families. According to a recent GAO analysis, in 1993, more than half the children enrolled in Medicaid had a parent who was employed. The program's potential to continue to accommodate more children in families where a parent works at a low-wage job could be severely jeopardized by a tight cap on federal Medicaid spending. This will make state efforts to move families from welfare to work considerably more difficult to accomplish.

### **Conclusion**

Medicaid growth rates have been intolerably high. States already have a powerful incentive to reduce the rate of growth in Medicaid spending as it affects their budgets, and many states have been actively working to slow down costs through a variety of approaches. Added flexibility can afford states more room to achieve program savings. Enhanced flexibility, however, will not allow states to meet their program goals or their savings targets if it comes at the price of a radical change in the nature and the level of the federal government's commitment to share the cost of the program.

**Table 1**  
**The Impact of a Five Percent Cap**  
**On Federal Medicaid Payments to States**

State	Fiscal Year 1996-2000 5% Federal Cap			Fiscal Year 2000 5% Federal Cap		
	Baseline	Loss*	% Change	Baseline	Loss*	% Change
Total	\$615,975	\$84,193	-13.7%	\$146,462	\$29,483	-20.1%
Alabama	9,142	869	-9.5%	2,121	301	-14.2%
Alaska	1,278	215	-16.8%	307	73	-23.7%
Arizona	7,786	1,175	-15.1%	1,869	414	-22.2%
Arkansas	7,219	1,266	-17.5%	1,739	429	-24.7%
California	56,287	6,879	-12.2%	13,356	2,488	-18.6%
Colorado	5,271	845	-16.0%	1,265	291	-23.0%
Connecticut	8,649	724	-8.4%	2,004	260	-13.0%
Delaware	1,127	166	-14.7%	269	58	-21.5%
District of	2,945	429	-14.6%	706	153	-21.6%
Florida	26,390	4,996	-18.9%	6,389	1,683	-26.3%
Georgia	16,846	3,144	-18.7%	4,077	1,062	-26.1%
Hawaii	1,772	298	-16.8%	425	101	-23.8%
Idaho	1,916	277	-14.5%	457	96	-21.1%
Illinois	21,731	3,060	-14.1%	5,194	1,087	-20.9%
Indiana	15,105	2,133	-14.1%	3,608	754	-20.9%
Iowa	5,151	621	-12.1%	1,218	221	-18.2%
Kansas	3,963	331	-8.4%	919	120	-13.0%
Kentucky	11,923	1,901	-15.9%	2,869	664	-23.1%
Louisiana	22,461	2,739	-12.2%	5,255	917	-17.4%
Maine	3,975	328	-8.3%	925	122	-13.2%
Maryland	8,767	1,345	-15.3%	2,105	472	-22.4%
Massachusetts	16,576	2,155	-13.0%	3,946	773	-19.6%
Michigan	20,656	2,927	-14.2%	4,943	1,043	-21.1%
Minnesota	9,705	1,080	-11.1%	2,293	396	-17.3%
Mississippi	8,189	1,244	-15.2%	1,954	427	-21.8%
Missouri	9,943	629	-6.3%	2,277	229	-10.0%
Montana	2,268	436	-19.2%	546	143	-26.2%
Nebraska	2,923	363	-12.4%	692	129	-18.6%
Nevada	1,887	251	-13.3%	449	89	-19.8%
New Hampshire	2,538	38	-1.5%	565	16	-2.7%
New Jersey	18,527	1,858	-10.0%	4,321	654	-15.1%
New Mexico	3,943	687	-17.4%	951	234	-24.7%
New York	77,313	8,928	-11.5%	18,339	3,296	-18.0%
North Carolina	18,781	3,662	-19.5%	4,542	1,216	-26.8%
North Dakota	1,643	195	-11.9%	388	69	-17.8%
Ohio	26,707	3,645	-13.6%	6,360	1,287	-20.2%
Oklahoma	7,249	1,180	-16.3%	1,735	400	-23.0%
Oregon	5,825	980	-16.8%	1,393	327	-23.5%
Pennsylvania	25,165	2,975	-11.8%	5,983	1,102	-18.4%
Rhode Island	3,584	447	-12.5%	850	160	-18.9%
South Carolina	10,072	1,201	-11.9%	2,355	404	-17.1%
South Dakota	1,559	195	-12.5%	370	70	-18.9%
Tennessee	15,807	2,412	-15.3%	3,789	842	-22.2%
Texas	39,767	5,482	-13.8%	9,390	1,848	-19.7%
Utah	3,329	516	-15.5%	797	178	-22.3%
Vermont	1,307	161	-12.3%	310	58	-18.8%
Virginia	8,506	1,496	-17.6%	2,048	506	-24.7%
Washington	11,910	1,963	-16.5%	2,855	666	-23.3%
West Virginia	8,919	1,739	-19.5%	2,165	585	-27.0%
Wisconsin	10,840	1,482	-13.7%	2,583	524	-20.3%
Wyoming	831	126	-15.2%	198	43	-21.8%

\* Dollars are in millions

Source: John Holahan and David Liska, Urban Institute, *The Impact of a Five Percent Medicaid Expenditure Growth Cap*, prepared for Kaiser Commission on the Future of Medicaid, March 1995

THE WHITE HOUSE  
WASHINGTON

October 18, 1996

MEMORANDUM FOR LEON PANETTA

From: Carol H. Rasco *CHR*

Subject: Weekly Report for October 12 - 18, 1996

UPDATES ON KEY INITIATIVES

WELFARE REFORM IMPLEMENTATION

HHS Review of TANF State Plans -- New Jersey and South Carolina submitted TANF plans to HHS this week, bringing the total number of states that have filed to enter the program to 28. HHS did not certify any plans as complete this week, leaving the total number of state plans approved to date at three. In their plans, most states are indicating that, for now, they will operate their programs as they were under the old law or under their waivers. More changes are expected in the spring when state legislatures convene.

Guidance to States on "40 Quarters" Exemption -- Advocates and states have responded positively to our plan to offer guidance to states on how to determine whether legal immigrants still qualify for food stamps because they have worked for 40 quarters in this country. We expect to release this guidance in the next few days.

Options on Medicaid/SSI Linkage -- Legal immigrants on SSI could lose Medicaid even in states that take advantage of their option to continue Medicaid coverage of legal immigrants. This is because they are eligible for Medicaid by virtue of their SSI eligibility, and they may not qualify for other entry points to Medicaid such as having dependent children. HHS is investigating whether it is possible to construct a mechanism by which legal immigrants could automatically keep Medicaid, but has not yet determined whether this is legally feasible.

Determining Cost Neutrality for Old Waivers -- We have begun the process of sorting through how to revise our waiver agreements with states regarding cost neutrality. We always insisted that welfare waivers must be cost neutral, considering the combined effects of AFDC, food stamps, and Medicaid changes. The switch from AFDC to TANF makes it necessary to revisit each of these agreements. We are determining the policies that will guide us in this process.

Letter to Advocacy Community and States on Timing of SSI Changes -- We are working with the Social Security Administration on a letter to advocacy groups and to states to clarify that SSA will not drop legal immigrants or children from the SSI program until the middle of next year at the earliest. There has been some misinformation in communities that the cuts could be coming much sooner.

Housing Issues -- One of the areas of most serious concern among service providers to low-income communities is the impact of the welfare bill on affordable housing. On the one hand, they are worried that those families losing income -- e.g., immigrants, food stamp recipients -- will have greater difficulty paying rent and will lose their housing. On the other hand, they are worried that housing rent policies do not support welfare-to-work efforts. Those leaving welfare for work in public housing or Section 8 housing will find their rents increasing and a large percentage of their disposable income going toward housing costs. HUD is looking at possible action to address both of these problems.

Welfare to Work -- OMB has convened a working group to develop the specifications of the \$3 billion Welfare to Work plan announced at the convention. They hope to have the details finalized for decision meetings in early December. There will be some difficult issues concerning the extent of public vs. private sector jobs, targeting, and who should administer the program. DPC, NEC, and OMB will be preparing issue papers and decision memos to move the program forward.

Department of Education Outreach -- The Department of Education has been working with HHS and constituency groups in the education and disability communities to discuss provisions of the new welfare law affecting them. Disability groups are concerned that schools may have reduced access to Medicaid funds in the face of the children's SSI cuts and the changeover from AFDC to TANF. Many schools rely on Medicaid to fund special education therapies. Education groups are concerned about restrictions in the law on the amount of vocational training which can count toward the work participation requirements.

## CHILD WELFARE

Child Welfare Waivers. The Department of Health and Human Services will likely soon approve child welfare waivers for Oregon, North Carolina and Ohio. If approved, the total number of approved child welfare waivers would reach five out of 10. Delaware's waiver was the first to be approved.

## CHILD SUPPORT

On Thursday, October 17, 1996 the Solicitor General filed a brief in the *Blesing v. Freestone* Supreme Court case supporting a private right of action (under 42 U.S.C. 1983) to seek redress against states for violating federal child support regulations. The Administration took this position for three reasons: 1) a general belief that private citizens should have access to the court system; 2) welfare reform time limits increase the need for states to be more effective in their collection efforts; and 3) Congress has clearly emphasized the responsibility of states to provide child support services and has provided

them the tools needed to deliver services to children and families.

The American Public Welfare Association, the National Governor's Association, and the National Conference of State Legislatures strongly disagree with the Administration's decision to file a brief. These three organizations have filed a brief opposing a private right of action. These groups are concerned that litigation will divert resources away from implementing their programs. They view the Administration's action on this issue as contrary to our commitment to work with them on welfare reform implementation.

### **FAMILY PLANNING**

International Family Planning -- The Omnibus Appropriations bill requires the President to submit a report to Congress by Feb. 1, 1997 regarding international family planning programs. DPC staff are convening a series of meetings with State Department (Global and Leg Affairs), USAID (Population and Leg Affairs) and relevant EOP staff to discuss process and strategy around the submission of Presidential findings.

### **TEEN PREGNANCY**

National Campaign to Prevent Teen Pregnancy -- The Campaign just sent out its latest update. More Campaign Task Force groups have met -- most recently the Religion and Public Values Task Force and the Media Task Force. The Campaign is also building its resource capacities as it works to become a clearinghouse for innovative teen pregnancy prevention efforts in communities across the country.

### **EDUCATION**

Tribal Colleges Executive Order -- A proposed Executive Order establishing a White House Initiative on Tribal Colleges, housed in the Education Department and patterned after similar initiatives for Historically Black Colleges and Universities and Hispanic Serving Institutions, will be presented to the President over the weekend. Secretary Babbitt will announce this order at the National Congress of the American Indian on Monday, Oct. 21.

### **ENERGY AND ENVIRONMENT**

Air Tanker Legislation -- firefighters across the country are relieved to have in place the air tanker legislation signed by the President on October 14. Secretary Glickman is working to acknowledge the broad bipartisan support that made this new law possible.

Dredging in the Port of New York and New Jersey -- The first major dredging permit has been issued for the channel that the Queen Elizabeth II uses when it comes to New York. However, Representative Pallone hosted a community meeting to oppose one of the major long-term options to dispose of contaminated material from the harbor. About 250 members of the community attended, and local press coverage was sympathetic.

## EXTERNAL ACTIVITIES

### MEETINGS AND SPEECHES

Wednesday, I was in Flint, Michigan where I participated in the Mott's Children's Health Center's 24th annual Tuuri Day Conference and gave the keynote address.

Friday, I met with representatives from the American Association of University Women, Women's Legal Defense Fund, and the Leadership Conference on Civil Rights regarding welfare reform implementation. I also met with representatives from the National Recreation and Park Association regarding the need to encourage and support local parks and recreation.

During the events surrounding the display of the AIDS quilt, Patsy Fleming met with a number of groups and keynoted the opening of the conference of LLEGO, the national lesbian and gay Latino organization. Patsy Flemming also keynoted the National Conference on HIV/AIDS Hotlines.

### PRESS

Patsy Flemming did press interviews during the AIDS quilt display regarding the Administration's response to HIV/AIDS, and appeared on PBS's America's Talking with Dennis Wholey.



# CENTER ON BUDGET AND POLICY PRIORITIES

April 26, 1995

## THE IMPACT OF CAPPING FEDERAL MEDICAID PAYMENTS TO STATES

by Cindy Mann

### Overview

Proposals have been advanced to limit severely the federal government's Medicaid payments to states in order to reduce the federal budget deficit. To date, most proposals have suggested either imposing an aggregate cap on the amount by which federal reimbursements would grow each year or turning the Medicaid program into a block grant. Under either approach, states' ability to draw down funds to help pay for health care and long-term care services for poor families and for elderly and disabled people would be limited by a fixed cap on federal contributions. Once in place, a cap would set federal payments to states at levels that accommodate federal spending targets rather than respond to changes in states' health care costs. States would be expected to change their programs to lower costs and to absorb all program costs that exceeded the capped federal funds.

A cap on the rate of growth of federal Medicaid payments of the magnitude now under discussion would have severe consequences for states. Estimates developed by the Urban Institute for the Kaiser Commission on the Future of Medicaid show that under current program projections, a five percent cap on the growth of federal payments would cause states to lose more than \$84 billion in federal funds between fiscal years 1996 and 2000. Another proposal, advanced by Senator Judd Gregg, to turn the program into a block grant and cap federal funding growth at four percent is projected to cut federal payments to states by \$115 billion over five years. Under either of these scenarios, states would have to reduce program costs drastically or finance some or all of these cuts by raising taxes or cutting other programs.

Cost savings of this magnitude could be very difficult for states to achieve.

- Although the growth in federal and state Medicaid expenditures has moderated considerably relative to the period between 1988 and 1993, Medicaid spending is still expected to grow by about 10 percent per year over the next several years, according to Congressional Budget Office estimates.

- The rising cost of the program is attributable to a number of factors, including medical inflation and growth in the number of eligible persons. Enrollment growth accounted for more than two-thirds of total Medicaid spending growth between 1992 and 1993. The expansion in the number of disabled beneficiaries was principally responsible for enrollment-related increases. Growth in the number of disabled beneficiaries is expected to continue. CBO estimates that caseload growth alone will cause Medicaid spending to increase by 20 percent between 1995 and 2000.
- Under a cap, states would have to contend with rising Medicaid costs while sustaining federal spending restraints that tighten over time. Under a five percent cap, the Urban Institute analysis shows that states would lose \$4.9 billion in federal funds in the first year of implementation. Within five years, the annual cut in federal payments to states would balloon to \$29.5 billion — a 20 percent reduction in the federal funds states would receive that year under current projections.
- These projected reductions in federal funds do not include the impact on states of a recession. If a state's economy goes into a downturn, Medicaid enrollment could be expected to increase, widening the gap between capped federal funds and the actual cost of providing health care coverage.

While states are likely to be granted added flexibility that could help them achieve savings, the savings that might be realized from increased flexibility will not be sufficient to allow states to offset federal cuts of this magnitude without making deep cuts in eligibility and services. For example, the five-year savings that might be realized from managed care and from lowering provider reimbursements is not likely to offset more than one-third to one-half of the level of cuts in federal funds now under discussion. Moreover, under a cap or block grant, any savings a state is able to achieve through managed care and other means will only offset federal cuts. It is highly unlikely that savings would be sufficient to relieve states of any of their Medicaid burden.

A cap on federal payments effectively ends the federal-state partnership in terms of shared financial responsibility for the Medicaid program. The federal government is guaranteed savings, and the state is left with all of the risks. If costs rise above capped amounts, the states pay 100 percent of the increased costs. If savings are less than a state's share of the federal cuts, only the federal government enjoys the benefit of the savings.



"CBO: Baseline"

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: ..... CHAS

FAX Number: .....

FROM: ..... June

Pages:

Comments:

FUNNY YOU SHOULD ASK FOR THIS;  
IT WAS THE SECOND SUCH REQUEST OF  
THE DAY (COMMON FROM HCFB).

ATTACHED IS:

- 1- SUMMARY SHEET
- 2- BASELINE DEC '95
- 3- CBO Issues.

I CANNOT FIND THE DASCHLE  
§123 b. I THINK I SENT IT TO  
Pamela at some point if you're  
DESPERATE. OR you COULD  
CALL HCFB OR OMB.

**MEDICARE: DRAFT PRELIMINARY CBO Medicare December 1996 Baseline (Dollars in billions; fiscal years)**

	1996	1996	1997	1998	1999	2000	2001	2002	1996-2002 Total	Growth 96-02	Growth 96-02
<b>BASELINE (CBO FACTSHEET: 12/22/95) (1)</b>											
Total (Gross) Spending	177.4	196.4	215.9	236.4	259.1	280.7	305.3	331.8	1824.6	9.4%	9.1%
Spending per capita (2)	4,795	5,223	5,652	6,109	6,584	7,053	7,595	8,152		7.9%	7.7%
Federal (Net) Spending	157.2	176.5	195.0	213.1	233.3	254.8	278.3	303.6	1654.6	9.9%	9.5%
Spending per capita (2)	4,249	4,694	5,105	5,508	5,952	6,402	6,923	7,459		8.4%	8.0%
		10.5%	8.7%	7.9%	8.1%	7.6%	8.1%	7.8%			
<b>REPUBLICANS' CONFERENCE AGREEMENT (CBO SCORING 12/13/95)</b>											
Total Spending	177.4	192.9	206.8	218.6	230.3	248.0	267.0	288.6	1652.0	7.2%	6.9%
Spending per capita (2)	4,795	5,130	5,408	5,649	5,875	6,231	6,642	7,091		5.7%	5.5%
Federal Spending	157.2	170.1	181.2	190.3	199.1	213.0	228.3	245.8	1427.8	6.6%	6.3%
Spending per capita (2)	4,249	4,524	4,743	4,917	5,079	5,352	5,679	6,039		5.2%	4.9%
		6.5%	4.9%	3.7%	3.3%	5.4%	6.1%	6.3%			
Savings	0	-6.4	-13.8	-22.8	-34.2	-41.8	-50.0	-57.8	-226.8		
Premium Savings		-2.9	-4.5	-5.0	-6.4	-9.1	-11.7	-14.6			
<b>REPUBLICANS' \$168 billion (CBO 1/30/96)</b>											
Total Spending	177.4	196.4	210.9	224.2	237.7	254.9	271.8	290.6	1686.5	7.3%	6.7%
Spending per capita (2)	4,795	5,223	5,521	5,793	6,064	6,405	6,761	7,140		5.9%	5.3%
Federal Spending	157	177	189	200	210	223	237	251	1456.5	6.9%	6.0%
Spending per capita (2)	4,249	4,694	4,953	5,160	5,360	5,613	5,886	6,167		5.5%	4.7%
		10.5%	5.5%	4.2%	3.9%	4.7%	4.9%	4.8%			
Savings		0	-5.8	-13.4	-23.2	-31.4	-41.7	-52.6	-168.1		
Premium Savings		0	-0.8	-1.2	-2.8	-5.6	-8.2	-11.4			
<b>RESIDENT (CBO SCORING 12/13/95)</b>											
Total Spending	177.4	195.2	212.6	229.6	245.9	263.9	284.6	306.3	1738.0	8.1%	7.8%
Spending per capita (2)	4,795	5,191	5,565	5,933	6,273	6,631	7,077	7,526		6.7%	6.4%
Federal Spending	157.2	175.3	191.8	206.7	220.9	236.1	253.9	272.7	1557.4	8.2%	7.6%
Spending per capita (2)	4,249	4,662	5,021	5,341	5,635	5,932	6,318	6,700		6.7%	6.2%
Savings		-1.2	-3.2	-6.4	-12.4	-18.7	-24.4	-30.9	-97.2		
Premium Savings		0	0.1	0.4	-0.2	-1.9	-3.6	-5.4	-10.6		
<b>RESIDENT (CBO SCORING 1/18/96)</b>											
Total Spending	177.4	196.4	210.1	227.1	241.9	258.1	276.7	298.4	1708.7	7.7%	7.2%
Spending per capita (2)	4,795	5,223	5,500	5,868	6,171	6,485	6,883	7,332		6.3%	5.8%
Federal Spending	157	177	180	204	217	231	247	266	1531.6	7.8%	7.1%
Spending per capita (2)	4,249	4,694	4,961	5,282	5,543	5,804	6,142	6,536		6.3%	5.7%
		10.5%	5.7%	6.5%	5.0%	4.7%	5.8%	6.4%			
Savings		0	-5.5	-8.7	-16	-23.8	-31.4	-37.6	-123.0		
Premium Savings		0	0.3	0.6	0.2	-1.2	-2.8	-4.2			

TE: If you are using the nominal spending per beneficiary please round to the nearest \$100.

Mandatory spending, including PROs.

Spending divided by CBO's March 1995 Part A enrollment

# CBO December Baseline: MEDICARE

Outlays by fiscal year,  
In billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002
<b>PART A: HOSPITAL INSURANCE (HI)</b>								
<b>TOTAL HI OUTLAYS</b>	114.9	126.5	137.6	148.8	160.8	173.0	186.1	199.7
Annual Growth Rate		10.4%	9.2%	8.4%	8.1%	7.7%	7.5%	7.3%
<b>TOTAL HI BENEFITS</b>	113.6	124.8	136.0	147.2	159.0	171.2	184.2	197.7
Annual Growth Rate		10.4%	9.3%	8.4%	8.1%	7.7%	7.6%	7.4%
<b>Hospitals/HMOs</b>	87.7	94.2	100.8	108.0	116.1	124.6	133.6	143.1
Annual Growth Rate		7.8%	7.5%	7.4%	7.5%	7.3%	7.3%	7.1%
<b>Hospitals</b>	80.2	84.5	88.8	93.8	99.5	105.2	111.0	116.7
Annual Growth Rate		6.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
<b>HMOs</b>	7.5	9.8	12.0	14.1	16.8	19.4	22.8	26.4
Annual Growth Rate		30.3%	23.7%	17.6%	17.3%	16.9%	16.9%	16.7%
<b>Hospice</b>	1.9	2.5	3.1	3.7	4.2	4.7	5.2	5.7
Annual Growth Rate		32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
<b>Home Health</b>	14.7	17.2	19.8	22.2	24.2	26.2	28.3	30.6
Annual Growth Rate		17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
<b>SNF</b>	9.0	10.8	12.2	13.3	14.5	15.7	17.0	18.4
Annual Growth Rate		19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
<b>Discretionary Administration</b>	1.0	1.2	1.3	1.4	1.4	1.5	1.6	1.7
Annual Growth Rate		4.2%	5.1%	5.0%	5.0%	5.0%	5.2%	5.3%
<b>Mandatory Administration</b>	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3
<b>Total HI Mandatory</b>	113.9	125.2	136.3	147.4	159.3	171.5	184.5	198.0
<b>Part A Information:</b>								
PPS Hospitals	68.9	72.4	75.8	79.3	83.2	87.2	91.2	95.3
Non-PPS Hospitals/Units	11.3	12.1	13.2	14.6	16.4	18.0	19.7	21.4
Indirect Teaching Payments	4.3	4.6	5.2	5.8	6.4	7.0	7.7	8.5
Direct Medical Education Payments	1.9	2.1	2.3	2.5	2.7	2.8	3.0	3.2
Inpatient Capital Payments	7.9	8.6	10.4	11.1	11.8	12.6	13.1	13.6
Disproportionate Share Payments	3.4	3.5	3.6	3.8	3.8	4.1	4.3	4.4

Notes: Assumes same fiscal year. Part A enrollment as March 1993 baseline.

# CBO December Baseline: MEDICARE

Outlays by fiscal year,  
in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002
<b>PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)</b>								
<b>TOTAL SMI OUTLAYS</b>	65.2	73.0	81.5	90.9	100.6	111.3	123.1	136.3
Annual Growth Rate		11.9%	11.6%	11.6%	10.9%	10.4%	10.6%	10.7%
<b>TOTAL SMI BENEFITS</b>	63.5	71.2	79.6	88.9	98.7	109.1	120.8	133.8
Annual Growth Rate		12.1%	11.8%	11.7%	11.1%	10.5%	10.7%	10.6%
<b>Benefits paid by Carriers /1</b>	41.7	45.7	50.0	54.7	59.4	63.9	68.9	74.0
Annual Growth Rate		9.5%	9.4%	9.5%	8.6%	7.6%	7.7%	7.5%
<b>Physician Fee Schedule</b>	33.2	36.0	38.8	42.1	45.2	47.9	50.8	53.8
Annual Growth Rate		8.6%	7.7%	8.5%	7.4%	6.0%	6.1%	5.8%
<b>Benefits paid by Intermediaries /2</b>	15.4	17.4	19.7	22.4	25.3	28.5	32.2	38.2
Annual Growth Rate		13.3%	13.2%	13.2%	13.1%	12.9%	12.7%	12.5%
<b>HMOs</b>	6.4	8.1	9.9	11.8	14.0	16.6	19.6	23.6
Annual Growth Rate		25.6%	22.2%	20.0%	18.5%	18.6%	19.1%	19.3%
<b>Program Administration</b>	1.7	1.8	1.9	2.0	2.1	2.2	2.3	2.4
<b>Part B Information:</b>								
<b>Deductible (calendar year, in dollars)</b>	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
<b>MEI Update (calendar year)</b>	2.1%	2.6%	2.6%	2.8%	2.7%	2.7%	2.7%	2.8%
<b>Physician Update (calendar year)</b>	7.4%	1.5%	-0.7%	0.3%	-2.3%	-2.3%	-1.8%	-2.2%
<b>Laboratory Update (calendar year)</b>	0.0%	3.0%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%
<b>DME Update (calendar year)</b>	3.2%	3.0%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%
<b>Monthly Premium (in dollars)</b>	\$46.10	\$42.50	\$45.80	\$50.70	\$52.20	\$53.70	\$55.30	\$56.80
<b>SMI Premium Receipts (in billions)</b>	19.2	18.8	19.6	22.1	23.4	24.4	25.4	26.5
<b>Fiscal Year Enrollment (in millions)</b>	35.7	36.3	36.8	37.2	37.7	38.1	38.5	39.0

1/ Includes all services paid under the physician fee schedule, durable medical equipment, independent and physician in-office lab services, ambulance services paid by carriers, and other services.

2/ Includes outpatient hospital services, lab. services in hospital outpatient departments, hospital-provided ambulance services and other services.

# CBO December Baseline: MEDICARE

Outlays by fiscal year,  
in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002
<b>MEDICARE TOTALS:</b>								
Mandatory Outlays	177.4	196.4	215.9	236.4	258.1	280.7	305.3	331.8
Discretionary Outlays	2.7	3.1	3.2	3.4	3.5	3.7	3.9	4.1
Total Outlays	180.1	199.5	219.1	239.7	261.6	284.4	309.2	335.9
Total Premium Receipts	-20.2	-19.9	-20.9	-23.3	-24.7	-25.8	-27.0	-28.2
Net Outlays (Total-Receipts)	159.9	179.6	198.2	216.4	236.9	258.5	282.2	307.7
Net Outlays, (Mandatory-Receipts)	157.2	176.5	195.0	213.1	233.3	254.8	278.3	303.6

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REPUBLICANS'

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**Title VIII, Medicare, as reestimated under December 1995 baseline**

13-Dec-95

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
<b>CHANGE IN DIRECT SPENDING</b>								
<b>Subtitle A--Medicare Plus Program /1</b>	-0.1	-0.3	-0.7	-1.8	-3.5	-5.2	-7.1	-18.6
<b>Subtitle B--Preventing Fraud and Abuse</b>								
Payment Safeguards and Enforcement	0.3	-0.2	-0.5	-0.7	-0.8	-0.7	-0.8	-3.4
New and Increased Civil Monetary Penalties	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
Additional Exclusion Authorities	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Criminal Provisions	-0.0	0.0	0.0	0.1	0.2	0.2	0.2	0.7
Other Items	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
<b>Subtotal, Subtitle B</b>	<b>0.3</b>	<b>-0.2</b>	<b>-0.5</b>	<b>-0.8</b>	<b>-0.8</b>	<b>-0.7</b>	<b>-0.7</b>	<b>-3.4</b>
<b>Subtitle C--Regulatory Relief</b>								
Physician Ownership Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
<b>Subtotal, Subtitle C</b>	<b>0.0</b>	<b>0.2</b>						
<b>Subtitle D--Graduate Medical Education</b>								
Indirect Medical Education Payments	-0.5	-1.0	-1.2	-1.6	-2.0	-2.5	-2.8	-11.5
Direct Medical Education	0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.4	-1.4
<b>Subtotal, Subtitle D</b>	<b>-0.5</b>	<b>-1.1</b>	<b>-1.3</b>	<b>-1.7</b>	<b>-2.2</b>	<b>-2.8</b>	<b>-3.2</b>	<b>-12.9</b>
<b>Subtitle E--Medicare Part A</b>								
<b>Chapter 1-- General Provisions Relating to Part A</b>								
PPS MB-25 in FY96, -2.0 thereafter	-0.3	-1.1	-2.4	-3.9	-5.5	-7.2	-9.1	-29.5
PPS Exempt Update Reduction	-0.0	-0.1	-0.2	-0.2	-0.4	-0.5	-0.8	-1.9
Targets for Rehabilitation and LTC Hospitals	-0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.7
Rebasing for Certain LTC Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
LTC Hospitals Within Other Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Reduce nonPPS capital by 10%	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-1.0
Reduce DSH Payments	-0.1	-0.3	-0.6	-0.8	-1.1	-1.2	-1.2	-5.3
Reduce PPS Capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.5	-1.5	-9.2
Rebase PPS Capital Payment Rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7
Reduce Payments for Hospital Bad Debt	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-1.0
Preferential Update for Certain MDH Hospitals	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.6

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**Title VIII, Medicare, as reestimated under December 1995 baseline**

13-Dec-95

By fiscal year, in billions of dollars

	1996	1997	1998	1999	2000	2001	2002	Total
<b>Chapter 2--Skilled Nursing Facilities</b>								
Skilled Nursing Facilities	-0.2	-0.6	-1.1	-1.6	-1.9	-2.2	-2.4	-10.0
<b>Chapter 3 - Other Provisions Related to Part A</b>								
Hemophilia Pass-Through Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hospice	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
<b>Subtotal, Subtitle E</b>	<b>-2.1</b>	<b>-2.9</b>	<b>-6.3</b>	<b>-9.9</b>	<b>-11.6</b>	<b>-13.9</b>	<b>-16.3</b>	<b>-62.9</b>
<b>Subtitle F--Medicare Part B</b>								
<b>Part 1--Payment Reforms</b>								
Reduce payments for physicians' services	-0.4	-0.8	-1.5	-2.3	-2.7	-2.6	-2.2	-12.6
Eliminate formula driven overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.0
Reduce updates for durable medical equipment	-0.0	-0.2	-0.4	-0.5	-0.7	-0.8	-1.0	-3.8
Reduce updates for clinical labs	-0.0	-0.3	-0.6	-0.8	-1.0	-1.2	-1.4	-5.4
Extend outpatient capital reduction	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.2	-0.8
Extend outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.3	-0.4	-1.3
Freeze payments for ASC services	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Anesthesia Payment Allocation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Limit payments for ambulance services 4/	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.7
Direct payment to PAs and NPs 2/	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3
Payments to primary care MDs in shortage areas 2/	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
<b>Part 2--Part B Premium</b>								
Increase Part B premium	-2.9	-4.1	-4.1	-5.1	-7.5	-9.6	-12.4	-45.9
Income-related reduction in medicare subsidy	0.0	-0.4	-0.9	-1.3	-1.8	-1.9	-2.2	-8.3
<b>Subtotal, Subtitle F</b>	<b>-4.2</b>	<b>-7.8</b>	<b>-9.0</b>	<b>-12.5</b>	<b>-18.7</b>	<b>-20.6</b>	<b>-24.8</b>	<b>-94.8</b>
<b>Subtitle G--Medicare Parts A and B:</b>								
Payment for home health services	0.0	-1.3	-2.3	-2.7	-3.1	-3.6	-4.0	-17.0
Medicare second payer improvements	0.0	0.0	0.0	-1.3	-1.6	-1.7	-1.8	-6.3
Coverage of Oral Breast Cancer Drug	0.1	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
<b>Subtotal, Subtitle G</b>	<b>0.1</b>	<b>-1.3</b>	<b>-2.3</b>	<b>-4.0</b>	<b>-4.7</b>	<b>-5.3</b>	<b>-5.9</b>	<b>-23.4</b>

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**Title VIII, Medicare, as reestimated under December 1995 baseline**

13-Dec-96

By fiscal year, in billions of dollars	1996	1997	1998	1999	2000	2001	2002	Total
<b>Subtitle H—Rural Areas:</b>								
Medicare-Dependent Payment Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Critical Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Establish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Classification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Expand Access to Nurse Aide Training 3/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subtotal, Subtitle H</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.7</b>
<b>Change in Net Mandatory Medicare Outlays before Fallsafe</b>	<b>-5.4</b>	<b>-13.8</b>	<b>-20.4</b>	<b>-28.6</b>	<b>-39.2</b>	<b>-48.3</b>	<b>-57.8</b>	<b>-215.2</b>
<b>Additional Outlay Reductions Required by Fallsafe, Net of Premiums</b>	<b>0.0</b>	<b>0.0</b>	<b>-2.7</b>	<b>-4.6</b>	<b>-2.6</b>	<b>-1.7</b>	<b>0.0</b>	<b>-11.5</b>
<b>Total, Medicare</b>	<b>-6.4</b>	<b>-13.8</b>	<b>-22.8</b>	<b>-34.2</b>	<b>-41.8</b>	<b>-50.0</b>	<b>-57.8</b>	<b>-226.7</b>

**MEMORANDUM: Monthly Part B Premium (By calendar year)**

Estimated premium under proposal	\$61.40	\$54.90	\$58.60	\$62.80	\$70.70	\$77.20	\$84.80
Estimated premium under current law	\$42.50	\$45.80	\$50.70	\$52.20	\$53.70	\$55.30	\$58.80

**FOOTNOTES:**

- 1/ Estimate includes medical savings accounts provision.
- 2/ These items are included in Subtitle H (Rural Areas)
- 3/ CBO estimates that this provision would cost less than \$50 million over seven years.
- 4/ CBO assumes that the freeze on reasonable costs or charges would apply to all ambulance services.

**NOTES:**

Details may not sum to totals because of rounding.  
 The estimates assume an enactment date of November 15, 1995.  
 The estimates do not incorporate changes in discretionary spending for administration.  
 Estimates reflect minor revisions made subsequent to those shown in the Economic and Budget Outlook.

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Conference Medicare, December 1995 baseline, House 168 option

30-Jan-96

By fiscal year, in billions of dollars

1996 1997 1998 1999 2000 2001 2002 Total

CHANGE IN DIRECT SPENDING

NOTE: Assumed policies begin in FY 1997, except as noted.

Subtitle A--MedicarePlus Program /1	0.0	-0.2	-0.7	-1.7	-3.4	-4.8	-6.7	-17.7
Subtitle B--Preventing Fraud and Abuse /2								
Payment Safeguards and Enforcement	0.0	0.3	-0.2	-0.5	-0.7	-0.8	-0.7	-2.0
New and Increased Civil Monetary Penalties	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Additional Exclusion Authorities	0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2
Criminal Provisions	0.0	-0.0	0.0	0.0	0.1	0.2	0.2	0.6
Other Items	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Subtotal, Subtitle B	0.0	0.3	-0.2	-0.6	-0.8	-0.8	-0.7	-2.7
Subtitle C--Regulatory Relief /10								
Physician Ownership Reform	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Subtotal, Subtitle C	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Subtitle D--Graduate Medical Education								
Indirect Medical Education Payments	0.0	-0.0	-1.2	-1.6	-2.0	-2.6	-2.8	-10.0
Direct Medical Education	0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.4	-1.4
Subtotal, Subtitle D	0.0	-1.0	-1.3	-1.7	-2.2	-2.8	-3.2	-12.2
Subtitle E--Medicare Part A								
Chapter I-- General Provisions Relating to Part A								
PPS MB -2.0	0.0	-0.7	-2.0	-3.6	-5.1	-6.8	-8.6	-28.7
PPS Exempt Update Reduction	0.0	-0.0	-0.1	-0.2	-0.3	-0.4	-0.6	-1.6
Targets for Rehabilitation and LTC Hospitals	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.0
Rebasing for Certain LTC Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
LTC Hospitals Within Other Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
==> Reduce nonPPS capital by 6%	0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
Reduce DSH Payments /8	0.0	-0.3	-0.6	-0.6	-1.1	-1.1	-1.1	-5.0
Reduce PPS Capital by 15%	0.0	-1.1	-1.3	-1.3	-1.4	-1.6	-1.6	-8.1
Rebase PPS Capital Payment Rates	0.0	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-2.4
Reduce Payments for Hospital Bad Debt (dropped)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
==> Preferential Update for Certain MDH Hospitals	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.9

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**Conference Medicare, December 1995 baseline, House 108 option**

20-Jan-98

By fiscal year, in billions of dollars

	1995	1997	1998	1999	2000	2001	2002	Total
<b>Chapter 2--Skilled Nursing Facilities</b>								
Skilled Nursing Facilities	0.0	-0.3	-1.0	-1.5	-1.8	-2.1	-2.4	-9.2
<b>Chapter 3 - Other Provisions Related to Part A</b>								
Hemophilia Pass-Through Extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hospices (dropped)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subtotal, Subtitle E</b>	<b>0.0</b>	<b>-2.8</b>	<b>-5.4</b>	<b>-8.8</b>	<b>-10.4</b>	<b>-12.9</b>	<b>-15.2</b>	<b>-44.7</b>
<b>Subtitle F--Medicare Part B</b>								
<b>Part 1--Payment Reforms</b>								
==> Reduce payments for physicians' services 6/	-0.0	-0.1	-0.9	-1.7	-2.4	-3.3	-4.1	-12.6
==> Anesthesiologists other nonswg updates 6/	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.6
Surgical phase-down 6/	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.4
Eliminate formula driven overpayment	0.0	-0.8	-1.5	-2.0	-2.6	-3.3	-4.5	-14.7
==> Reduce updates for durable medical equipment 8/	0.0	-0.2	-0.3	-0.4	-0.6	-0.7	-0.9	-3.0
==> Reduce updates for clinical labs 13/	0.0	-0.1	-0.3	-0.4	-0.8	-0.9	-1.0	-3.1
Extend outpatient capital reduction	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.2	-0.6
Extend outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.3	-0.4	-1.3
==> ABC - 1.5%	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.6
Anesthesia Payment Allocation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
==> Limit payments for ambulance services 6/	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.3
Direct payment to PAs and NPs 3/	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3
Payments to primary care MDs in shortage areas 3/	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.4
==> Mammograms 11/	0.0	0.0	0.0	0.0	0.7	0.7	0.7	2.1
==> Colorectal cancer screening 11/ 12/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
==> Prostate cancer screening 11/	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.4
==> Diabetes education and supplies 11/	0.0	0.0	0.0	0.0	0.8	0.3	-0.0	1.0
<b>Part 2--Part B Premium</b>								
==> Increase Part B premium 7/	0.0	-0.4	-0.2	-1.3	-3.0	-5.6	-6.7	-20.0
==> Income-related reduction in medicare subsidy	0.0	-0.4	-1.0	-1.5	-2.0	-2.4	-2.7	-10.0
<b>Subtotal, Subtitle F</b>	<b>-0.0</b>	<b>-1.7</b>	<b>-3.9</b>	<b>-7.7</b>	<b>-10.4</b>	<b>-16.6</b>	<b>-21.6</b>	<b>-60.8</b>

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**Conference Medicare, December 1995 baseline, House 168 option**

30-Jan-96

By fiscal year, in billions of dollars

1996 1997 1998 1999 2000 2001 2002 Total

**Subtitle G--Medicare Parts A and B:**

Payment for home health services	0.0	-0.7	-2.2	-2.7	-3.1	-3.5	-4.0	-16.1
Medicare second payer improvements	0.0	0.0	0.0	-1.3	-1.5	-1.7	-1.8	-6.3
==> Coverage of Oral Breast Cancer Drug 14/	0.0	0.2	0.2	0.3	0.3	0.3	0.3	1.6
<b>Subtotal, Subtitle G</b>	<b>0.0</b>	<b>-0.4</b>	<b>-2.0</b>	<b>-2.7</b>	<b>-4.3</b>	<b>-4.9</b>	<b>-5.5</b>	<b>-20.7</b>

**Subtitle H--Rural Areas:**

Medicare-Dependent Payment Extension	0.0	0.1	0.1	0.1	0.1	0.0	0.0	0.3
Critical Access Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Establish REACH Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Classification of Rural Referral Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Expand Access to Nurse Aide Training 4/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subtotal, Subtitle H</b>	<b>0.0</b>	<b>0.1</b>	<b>0.1</b>	<b>0.2</b>	<b>0.2</b>	<b>0.1</b>	<b>0.1</b>	<b>0.7</b>

**Change in Net Mandatory Outlays**

	<b>0.0</b>	<b>-0.3</b>	<b>-1.9</b>	<b>-2.5</b>	<b>-4.1</b>	<b>-4.7</b>	<b>-5.4</b>	<b>-19.9</b>
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Conference Medicare, December 1995 baseline, House 168 option  
By fiscal year, in billions of dollars

30-Jan-96  
1996 1997 1998 1999 2000 2001 2002 Total

MEMORANDUM: Monthly Part B Premium (By calendar year)

Premium specified under proposal	942.60	947.00	961.00	966.00	963.00	969.00	977.00
Estimated premium under current law	942.60	945.90	950.70	952.20	953.70	955.30	958.90

MEMORANDUM: Medicare Benefit Budget

Once Onlys for Medicare Benefits Under Proposal	190.0	210.7	223.9	237.4	254.5	271.6	290.3
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FOOTNOTES:

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- 1/ Estimate assumes present law payment rates for 1998.
- 2/ Assumes BBA policy shifted 1 year later.
- 3/ These items are included in Subtitle H (Rural Areas)
- 4/ CBO estimates that this provision would cost less than \$50 million over seven years.
- 5/ CBO assumes that the update of CPI - 1.5% on reasonable costs or charge limits would apply to all ambulance services.
- 6/ Single CF of \$30.42 implemented Jan. 1, 1997. Surplus CF of \$38.10 in 1997, but does not effect cumulative targets. Asseth gets other non-surg updates.
- 7/ Premiums would be specified as in Memorandum above. Note that specified premiums imply no premium offset to the Fallsch.
- 8/ Freeze DME updates, P+O 1% update, Oxygen 20% cut in 1997.
- 9/ Assumes 10% reduction beginning 1997.
- 10/ Not updated.

- 11/ Assumes an effective date of October 1, 1998.
- 12/ CBO estimates that this provision would cost less than \$50 million over seven years.
- 13/ Freeze update beginning in 1997, reduce limit from 70% to 72% in 1997.
- 14/ Revised estimate.

NOTES: Based on BBA language as modified in discussions with staff.

10/10/96

PRESIDENT'S \$ 97 b.



# President's Proposal Title XI--Health Care, estimated under December 1995 baseline

By fiscal year, in billions of dollars

cc-00

	1996	1997	1998	1999	2000	2001	2002	Total
<b>Part 3--Provisions Relating to Parts A and B</b>								
11141 Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
11142 Maintain Home Health Freeze	Included in total for Home Health below							
11143 Interim Payments for Home Health	Included in total for Home Health below							
11144 PPS for Home Health	Included in total for Home Health below							
11148 Location of Home Health Service	Included in total for Home Health below							
11145 Elimination of PIP for Home Health	Included in total for Home Health below							
11147 Delete Certain Home Health as Part B /B	Included in total for Home Health below							
11148 Medicare Secondary Payer	0.0	0.0	0.0	-1.2	-1.3	-1.8	-1.7	-5.8
<b>Total, Provisions Relating to Parts A and B</b>	<b>0.0</b>	<b>-0.6</b>	<b>-0.9</b>	<b>-1.0</b>	<b>-1.9</b>	<b>-2.2</b>	<b>-2.8</b>	<b>-9.1</b>
<b>Part 4--Part B Premium</b>								
	0.2	0.1	0.4	0.2	1.9	3.6	5.4	10.6
<b>Subtotal, Subtitle A</b>	<b>-1.6</b>	<b>-0.9</b>	<b>-4.6</b>	<b>-0.9</b>	<b>-1.7</b>	<b>-1.9</b>	<b>-2.1</b>	<b>-7.8</b>
<b>Subtitle B--Expanded Medicare Choices</b>								
	-0.1	-0.2	-1.4	-2.8	2.5	3.4	19.9	17.7
<b>Subtitle C--Medicaid</b>	<b>-2.3</b>	<b>-3.4</b>	<b>-3.9</b>	<b>-5.1</b>	<b>-8.7</b>	<b>-6.3</b>	<b>-7.9</b>	<b>-37.8</b>
<b>Subtitle D--Preventing Fraud and Abuse</b>								
<b>Part 1--Amendments to Enforcement Authorities</b>	0.4	-0.0	-0.3	-0.5	-0.0	-0.1	-0.1	-1.4
<b>Part 2--Resources for Anti-Fraud Activities</b>	Included in total for preventing fraud and abuse above.							
<b>Part 3--Amendments to Criminal Law</b>	Included in total for preventing fraud and abuse above.							
<b>Part 4--Medicare Improvements</b>	Included in total for preventing fraud and abuse above.							
<b>Subpart A--Coordination of Benefits /B</b>	0.0							
<b>Subpart B--Contractor Reform</b>	0.0							
<b>Subpart C--Provisions Relating to Part B /B</b>	0.0							
11461 Fee Schedules	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11462 Surgical Dressings	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11463 Competitive Bidding Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11464 Competitive Bidding for Lab Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11465 Change Payment Structure for Certain Lab Tests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subpart D--Provisions Relating to Parts A and B</b>	0.0							
<b>Total Part 4</b>	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Subtotal, Subtitle D</b>	<b>+0.4</b>	<b>-0.0</b>	<b>-0.3</b>	<b>-0.5</b>	<b>-0.0</b>	<b>-0.6</b>	<b>-0.1</b>	<b>-1.4</b>
<b>Subtitle E--Long-Term Care /B</b>								
	0.0	3.8	3.5	1.8	1.8	1.8	0.8	12.0
<b>Subtitle F--Health Insurance Reform /B /B</b>								
	0.0	0.3	0.3	0.3	0.3	0.3	0.0	1.3

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**President's Proposal Title XI--Health Care, estimated under December 1995 baseline**

8-Dec-95

By fiscal year, in billions of dollars

	1997	1999	2001	2002	Total
--	------	------	------	------	-------

**Subtitle G--Health Insurance for the Temporarily Unemployed**

	1.6	2.2	2.3	2.4	3.1	14.6
--	-----	-----	-----	-----	-----	------

**Subtitle H--Administrative Simplification**

	0.0	0.0	0.0	0.0	0.0	0.0
--	-----	-----	-----	-----	-----	-----

**Total Title XI Health Care**

	-1.3	-0.0	-1.3	-1.7	-3.0	-17.3
--	------	------	------	------	------	-------

**MEMORANDUM: Monthly Part B Premium (By calendar year)**

Estimated premium under proposal	848.50	849.00	853.40	859.50	864.00	870.40
Estimated premium under current law	848.50	850.70	852.20	853.70	855.30	858.00
	45.80	50.70	53.40	59.50	64.60	70.40

**MEMORANDUM: Change in Spending by Medicare, Medicaid, and Other**

Total Medicare	-1.2	-3.2	-6.4	-12.7	-24.4	-36.9
Total Medicaid	-2.3	-3.4	-6.7	-13.3	-27.0	-37.8
Total Other	0.0	5.3	4.1	4.1	4.5	27.1
<b>Total Title XI</b>	<b>-3.5</b>	<b>-1.3</b>	<b>-14.0</b>	<b>-20.7</b>	<b>-28.9</b>	<b>-107.3</b>

620

**FOOTNOTES:**

- 1/ Included in Subtitle B, Medicare Choice.
- 2/ For this discretionary provision, the proposal authorizes \$3.6 billion for 1997 - 1999, \$1.5 billion for 2001 and \$600 million for 2002 - 2006.
- 3/ Proposal would transfer \$62.1 billion to Part B over 7 years.
- 4/ Includes discretionary grant program, but not the expansion of self-employed tax deduction.
- 5/ Most of these are to be made budget neutral; other provisions not sufficiently specified to estimate savings.
- 6/ Probably no significant revenue impacts from repeal of excise tax for non-qualified large group plans etc.
- 7/ Probably no significant revenue impacts from ERISA provisions.
- 8/ Assumes the insurance reforms are identical to S. 102B--additional provisions could have cost/revenue implications.

**NOTES:**

Details may not sum to totals because of rounding.  
 The estimates assume an enactment date of February 7, 1996.  
 The estimates do not incorporate changes in discretionary spending for administration.

**Transfer of Assets and Medicaid Eligibility**

**Question**

Does the Administration support and intend to carry out the provision of the Kennedy-Kassebaum law making it a felony to "knowingly and willfully dispose" of assets in order to become eligible for Medicaid?

**Answer**

The Clinton Administration has pursued a policy of "zero tolerance" for fraud and abuse in our health care system. This is especially true in public programs like Medicare and Medicaid.

In 1993, the Administration toughened Medicaid eligibility rules with respect to individuals who sell or transfer their assets below their market value. Prospective Medicaid beneficiaries are already required to disclose such transfers and are denied Medicaid eligibility for a specified period of time. Those who refuse to disclose such transfers can be penalized.

Provisions of the Health Insurance Accountability and Portability Act of 1996 (the Kennedy-Kassebaum Act) would create a new criminal penalty for those who "knowingly and willfully dispose" of assets to become eligible for Medicaid. The Administration was not involved in drafting this provision.

It appears that this language may be interpreted more broadly than its authors intended and might, therefore, impede the identification and prosecution of fraud and abuse in the Medicaid program. Some in Congress, in fact, are interested in legislative changes in this law. The Department would be supportive of such efforts and stands ready to work with the Congress to make changes in this provision of the law while continuing to stand firm against potential abuse of the Medicaid program.



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 9

Date: 10/21

To:	From:
<u>Sandy Busuek Mx</u>	<u>Christie Provost</u>
Fax: <u>87028</u>	Fax: <u>202-690-8168</u>
Phone: _____	Phone: <u>690-8170</u>

REMARKS: \_\_\_\_\_

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**HEALTH CARE FINANCING ADMINISTRATION**  
 200 Independence Ave., SW  
 Room 341-H, Humphrey Building  
 Washington, DC 20201

## FACT SHEET#1 DRAFT 9/20 a.m.

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

## Prior to welfare reform:

- o Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid.
- o Families which lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for Medicaid for an additional period of time.
- o Various rules of the AFDC program were used to establish Medicaid eligibility under other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.)

Welfare reform eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF).

- o Families which receive cash assistance under TANF are not automatically eligible for Medicaid as they were under AFDC.
- o Families which lose eligibility for cash assistance under TANF because of employment or receipt of support payments are not automatically eligible for extended Medicaid benefits as they were under AFDC.

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

- o A State may lower its income standards but not below the standards which it applied on May 1, 1988.
- o A State may increase its income and resource standards by any increases in the CPI subsequent to July 16, 1996.
- o A State may also choose to apply more liberal income and resource methodologies

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than those in effect on July 16, 1988.

Welfare reform also creates a new Medicaid eligibility group of low income families with children. This group basically consists of families which would have been eligible for AFDC cash assistance and therefore Medicaid under the pre-reform rules. However, it does not require that a complete AFDC eligibility determination be made using all the pre-reform AFDC program rules. Rather it imposes two basic eligibility requirements for this group:

- o The family income and resources must meet the pre-reform AFDC standards as adjusted by the State under the options explained above.
- o The pre-reform AFDC deprivation requirement must be met. (I.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.)

If a family loses Medicaid eligibility under this new group because of employment or receipt of support payments or employment and received Medicaid under this group in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits.

There is a provision which mandates continued Medicaid eligibility for pregnant women and children who qualify for Medicaid under the poverty level related groups and minor children who are not heads of household while allowing States to deny Medicaid benefits to other adults and heads of household who lose TANF benefits because of refusal to work.

## FACT SHEET#2

DRAFT 9/20 a.m.

## LINK BETWEEN MEDICAID AND SSI UNDER WELFARE REFORM

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

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

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

Since, in many States, Medicaid eligibility accrues directly from SSI eligibility, the above changes to SSI will cause a loss of Medicaid eligibility for many children. However, since Medicaid also covers certain poverty-related children irrespective of their SSI status, many of the children who lose SSI will still continue to be covered under Medicaid.

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

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

SSA is required to send notices to all affected recipients no later than January 1, 1997.

- we had a proposal in our bill to get rid of the IFA - too

300,000 get MA thru IFA, many will requalify under medical conditions.

HCFA Actuaries say 50,000 to 60,000 will permanently lose MA

- many of these kids have multiple disabilities, but not one that is severe enough to qualify

-- these kids may fall thru cracks

-- tend to have worse mental, than physical, conditions

## FACT SHEET #3

10/11/96

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF  
THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996Medicaid Eligibility of Legal Immigrants

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

*"Qualified Alien" Defined: A "qualified alien" is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act (INA) including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, an individual who has had his/her deportation withheld, and who has been granted conditional entry. This definition also includes certain battered immigrants.*

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

Immigrants Residing in the U.S.

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

- o For immigrants who are "qualified aliens" receiving Medicaid benefits (were enrolled in the State's Medicaid program) on August 22, 1996, States must continue Medicaid coverage until at least January 1, 1997. After that date, HCFA will assume that States are continuing to cover these individuals, unless the State amends its State Plan to discontinue coverage of these individuals.
- o For immigrants who are "qualified aliens" residing in the United States before August 22, 1996, but were not enrolled on that date, whether eligible or not, States have the option not to provide Medicaid beginning on August 22, 1996. To do so, the State must amend its State Plan.
- o For other immigrants who are not "qualified aliens," Medicaid eligibility was terminated on August 22, 1996 under P.L. 104-193, except for those receiving SSI. For these immigrants, Medicaid eligibility continues until SSA redetermines eligibility (see page 4).

### Excepted Groups of Immigrants

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

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

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

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

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

### Sponsor to "Qualified Alien" Deeming of Income and Resources

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

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

### Emergency Services

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

### SSI/ Medicaid Connection for "Qualified Aliens"

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

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

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

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would automatically continue Medicaid for "qualified aliens" who fit into those groups.
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to provide coverage for non-cash SSI-related groups. HCFA is exploring options to permit States to do this as simply as possible.

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

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

Related Fact Sheets:

[Link Between Medicaid and Temporary Assistance for Needy Families \(TANF\)](#)

[Link Between Medicaid and Coverage of SSI Children under Welfare Reform](#)

[Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996](#)

FACT SHEET#4

DRAFT 9/19 p.m.

**CONTINUATION OF DEMONSTRATION PROVISIONS  
IN SECTION 1115 WELFARE REFORM DEMONSTRATIONS  
UNDER THE PERSONAL RESPONSIBILITY AND WORK  
OPPORTUNITY RECONCILIATION ACT OF 1996**

States with section 1115 welfare reform demonstrations may elect to continue all or some of the individual waivers and costs not otherwise matchable (CNOM) authority they have been granted relating to the Title IV-A cash assistance and Medicaid programs.

Section 415 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) permits States to continue all or some of the AFDC and Medicaid demonstration waivers (hereafter understood to also include CNOMs) granted under section 1115 of the Social Security Act either in effect as of August 22, 1996 or submitted prior to August 22, 1996 and approved on or before July 1, 1997. These waivers may remain in effect until the expiration of the demonstration (excluding any extensions). States also have the option of terminating their waivers prior to expiration of the demonstration, in which case they will be held harmless for their accrued cost neutrality liabilities. While the waivers are in effect, the amendments made by PRWORA will not apply to these demonstrations to the extent that the amendments are inconsistent with the waivers.

Section 1931 of PRWORA establishes a general rule that an individual will be treated as a IV-A recipient for Medicaid purposes if he or she meets the income and resource standards and all other categorical requirements [or should it be "the deprivation requirements"?] for determining AFDC eligibility under the AFDC state plan in effect on July 16, 1996. Section 1931(d) permits States to continue to apply waivers of title IV-A provisions [and CNOMs?] affecting Medicaid eligibility (either in effect as of July 16, 1996 or submitted before August 22, 1996 and approved on or before July 1, 1997) beyond the date the [demonstration] waivers would otherwise expire. Unlike under section 415, these provisions can be extended indefinitely.

The relationship between sections 415 and 1931 is as follows. Section 415 covers a broader range of provisions than does section 1931 (i.e., more than just those provisions related to Medicaid eligibility, and up to as many as all of a State's demonstration waivers, should the State elect to continue their demonstration in toto). However, the waivers selected for continuation by a State under section 415 may be retained only through the previously established expiration date for the demonstration (excluding any extensions). Section 1931, on the other hand, covers a smaller set of waivers (only those AFDC provisions related to Medicaid eligibility), but they can be continued indefinitely.

## FACT SHEET #5

DRAFT 9/20 p.m.

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

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) significantly revised how States determine Medicaid eligibility for needy families and children. The legislation provides a special fund of \$500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to this legislation. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

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

Demonstration to the Secretary

In order to receive the enhanced funding resulting from the increase in the FFP rate, each State must demonstrate to the satisfaction of the Secretary that the costs are attributable to the administrative costs of Medicaid eligibility determinations which are incurred because of the enactment of P.L. 104-193.

National Limitation on Total Funding

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

Time Limitations

The \$500 million is available nationally for expenditures during the time period of Fiscal Years 1997 through 2000. On a State-specific basis, the enhanced funding is available for only 12 quarters. The 12 quarters are prescribed as the first 12 calendar quarters in which a State's TANF program is in effect after August 21, 1996.