

## THE BREAUX-CHAFEE PLAN

The Breaux-Chafee plan continues to seek a middle route between the Republican plan and ours in many respects. However, it also embraces some problematic policies. While the details are still evolving, which will delay CBO scoring, in general:

Policies that move towards the Administration --

- The Medicaid policy is far superior to the Republican plan, and offers an opening for bipartisan compromise.
- The welfare policy moves closer to us in many ways, but with deeper cuts in immigrants benefits.

Policies that remain problematic --

- Breaux-Chafee contains a Medicare premium increase for seniors over 200% of poverty.
- It caps the direct student loan program at 40% of total student loan volume, a policy we successfully opposed in the final 1996 appropriations bill.
- It reduces the CPI by .5% over and above the technical reductions we expect BLS to make in 1997 and 1998, and by .3% thereafter, which saves \$110 billion over seven years.

*In large part because of the larger Medicare, welfare, and CPI savings, Breaux-Chafee apparently does not need to trigger off its tax cut. Without these savings, and without a trigger, the plan would not balance in 2002.*

### *Details on the policies in Breaux-Chafee*

*Discretionary.* The Breaux-Chafee discretionary cuts are smaller than ours over 7 years, but are heavily backloaded and apparently become equally deep in the last year.

*Medicare.* The Medicare savings proposals in Breaux-Chafee, which they describe as saving \$154 billion over 7 years, are quite similar to those in the Administration's \$124 billion package. Note that Breaux-Chafee is using a 1997-2003 timeframe, instead of the 1996-2002 assumed in the Administration's estimate.

The major differences between Breaux-Chafee and the Administration's plan are:

*Part B Premium.* Consistent with Administration policy, Breaux-Chafee maintains the 25% premium for "lower-income seniors." Starting at 200% of poverty, Medicare premium subsidies start to phase out (i.e., couples above \$20,000 will pay a premium equal to 31.5% of Part B program costs, phasing up to 100% for couples at \$150,000).

*MSAs.* Breaux-Chafee would allow MSAs on demonstration basis. No further details are provided.

*Eligibility Age.* It would match Medicare eligibility age to Social Security, phasing up to 66 between 2000 and 2005 and to 67 by 2022.

*Medicaid.* The Breaux-Chafee Medicaid proposal preserves the Federal guarantee of coverage and incorporates many of the state flexibility principles of the Administration's proposal. The proposal also maintains current law mandatory and optional population groups and services. It also retains current law match rates; keeps a federal definition of disability and continues the eligibility expansions enacted in 1990; maintains current nursing home standards with federal enforcement; and maintains the federal right of action.

## Issues with Breaux-Chafee Medicaid policy:

Link between AFDC and Medicaid eligibility. The welfare plan does not guarantee categorical eligibility for all current AFDC recipients. Instead, states would have the option of covering current law AFDC beneficiaries or those eligible under the new welfare program. This option could lead to the loss of Medicaid coverage for some families.

Federal payment to States. Although Breaux-Chafee appears to have a savings mechanism similar to our per-capita cap, it is unclear how the proposal would take into account caseload increases. In addition, it appears that States will be able to retain a base level of federal payments even if they drop coverage for optional services or population groups. This could cause federal funding to be disconnected to the size of the benefit package or number of beneficiaries served.

*Welfare Reform.* Breaux-Chafee is similar to Administration policy on child care, SSI Kids, child nutrition, child protection, and most food stamps and AFDC issues including flexible work requirements, equal protection of benefit recipients, etc.. However, Breaux-Chafee has more savings than the Administration plan, financed with deeper cuts in immigrants benefits and food stamps.

Benefits to Legal Immigrants -- Rather than expanding "deeming" provisions as proposed by the Administration, Breaux-Chafee would ban almost all legal immigrants from receiving SSI with exemptions only for current recipients who are very elderly, disabled, and a few others; virtually all future immigrants would be banned from receiving SSI, including the disabled. In addition, the plan would impose a 5-year ban for most legal immigrants from most federal benefits including Medicaid and AFDC.

Food Stamps -- While Breaux-Chafee does not allow states to turn food stamps into a block grant or cap the program, it does cut deeper than the Administration's plan, primarily by establishing a 4-6 month time limit for benefits for unemployed childless adults. This restriction would affect about a half million persons.

CBO 7-YEAR SCORING OF ALTERNATIVE PLANS  
 ( in billions of dollars)

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President's Budget	President's Budget	Republican Offer (1/6)	Breaux-Chafee Plan
Using April 1996 Baseline	Using December 1995 Baseline		

Savings:				
Discretionary.....	-233	-297	-348	-268
Mandatory:				
Medicare.....	-116	-124	-168	-154
Medicaid .....	-54	-59	-85	-62
Welfare reform.....	-37	-40	-60	-45 to -53
EITC 1/.....	-5	-5	-15	In welfare
Other mandatory.....	<u>-56</u>	<u>-49</u>	<u>-66</u>	<u>-52</u>
Total, mandatory.....	-268	-277	-394	-313 to -321
Tax cuts.....	97	100	207	130
Corporate loopholes and other.....	-53	-62	-26	-25
Extension of expired excise taxes .....	-36	Extension included in December baseline		
CPI adjustment.....	---	---	---	<u>-110</u>
Total, policy proposals.....	-492	-537	-562	-621 to -630
Debt service.....	<u>-38</u>	<u>-56</u>	<u>-59</u>	NA
Total savings.....	-530	-593	-621	NA

1/ Includes revenues.

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## THE IMPACT OF RECENT CBO BASELINE CHANGES

- I. Under the April CBO baseline, the budget deficit outlook has improved significantly. CBO rescoring of the baseline from December 1995 to April 1996 reduced the cumulative deficit by \$114 billion over seven years.

CBO Baseline Deficit, Billions	1996	1997	1998	1999	2000	2001	2002	Total
December 1995	172	182	183	195	204	211	228	N.A.
April 1996	144	165	175	182	191	194	210	N.A.
Change	28	17	8	13	13	17	18	114

The April 1996 CBO baseline deficit assumes the expiration of the air transportation excise taxes and other provisions. If immediate reenactment were assumed, the baseline deficit would be about \$36 billion lower over the seven-year period.

2. However, the large reductions in the baseline deficits provided very little additional deficit reduction in 2002 under actual balanced-budget plans. In fact, when CBO rescored our FY 1997 budget under the April baseline, the 2002 surplus actually declined. Therefore, there is no room for significant additional tax cuts or spending increases in 2002; and any additional spending or tax cuts in the earlier years would have to trigger off before 2002.
- The December 1995 baseline revision reduced the projected deficits under the vetoed Reconciliation bill by much less than the change in the baseline, and only in the early years -- not in 2002, when the balanced-budget constraint binds.
  - CBO has not rescored the Republicans' vetoed Reconciliation bill under their new April 1996 baseline. However, the April 1996 baseline revision reduced the projected deficits under the President's FY 1997 Budget very little, and worsened the projected surplus in 2002. This result strongly suggests that rescoring of the Republicans' latest offer, or any other balanced-budget plan, would not provide any significant room in 2002.

THE PRESIDENT'S FY 1997 BUDGET								
CBO-Scored Deficit, in Billions	1996	1997	1998	1999	2000	2001	2002	Total
December 1995 Baseline	158	164	150	126	109	62	-8	N.A.
April 1996 Update	146	155	152	123	105	54	-3	N.A.
Difference	12	9	-2	3	4	8	-5	29

- These baseline improvements have little effect on 2002 deficits for two basic reasons:

First, most improvement in the CBO baseline comes in the early years rather than the outyears -- in contrast to the OMB baseline improvement, which grows over time.

Second, much of the improvement in the CBO baseline comes in areas -- discretionary, Medicare, Medicaid -- where spending is essentially capped by the balanced-budget policies. Reducing baseline spending in these areas does not reduce the projected deficit; it reduces only the projected budget savings.

For example, the Reconciliation bill capped Medicaid spending in 2002 at \$128 billion. The baseline was \$178 billion; therefore scored savings were \$50 billion. Subsequent events pushed the baseline down to \$173 billion. But that did not reduce the expected deficit at all, because expected outlays were still \$128 billion. Instead, it reduced the scored savings from \$50 billion to \$45 billion.

## SENATE CENTRIST COALITION 7-YEAR BALANCED BUDGET PLAN INTRODUCTION

For the past several months, a bipartisan group of 22 Senators has worked to craft a seven-year balanced budget agreement that is fair to all Americans. We have made the difficult choices and compromises necessary to reach an agreement because we are concerned about the effect a continuing deficit will have on the quality of life for each and every American.

If we act, we can foster economic growth and prosperity. If we fail to act, we undermine the future of our children and grandchildren. This is an historic opportunity and we should not let it pass.

Balancing the budget will spur economic growth, and help families make ends meet by lowering interest rates on home mortgages, car loans, and education loans.

Balancing the budget will also brighten our children's future. Last year's report of the Bipartisan Commission on Entitlement and Tax Reform illustrates the magnitude of the problem facing future generations. Left unchecked, by the year 2012, projected outlays for entitlements and interest on the national debt will consume all tax revenues collected by the federal government, leaving nothing for national defense, roads, or education. We cannot stand by and let this happen.

We formed this Centrist Coalition because we believe a balanced budget is possible only if Democrats and Republicans work together. We offer this proposal as a way to bridge the gap between our two parties. We hope our effort will spur the President and our colleagues in the House and Senate to work together to enact a balanced budget this year.

Robert F. Bennett  
Christopher S. Bond  
John B. Breaux  
Hank Brown  
Richard H. Bryan  
John H. Chafee  
William S. Cohen  
Kent Conrad

Dianne Feinstein  
Bob Graham  
Slade Gorton  
James M. Jeffords  
J. Bennett Johnston  
Nancy Landon  
Kassebaum  
J. Robert Kerrey

Herb Kohl  
Joseph I. Lieberman  
Sam Nunn  
Charles S. Robb  
Alan K. Simpson  
Arlen Specter  
Olympia J. Snowe

**SENATE CENTRIST COALITION  
7-YEAR BALANCED BUDGET PLAN  
EXECUTIVE SUMMARY**

**MEDICARE** (estimated savings: \$154 billion)

**Expands choices for Medicare beneficiaries.**

Beneficiaries can remain in the traditional fee-for-service Medicare program or choose from a range of private managed care plans, based upon individual need. Options include point-of-service plans, provider sponsored organizations and medical savings accounts (on a demonstration basis).

**Promotes the growth of managed care.**

By creating a new payment system for managed care -- which blends national and local payment rates -- the plan encourages growth in the availability and accessibility of managed care. Indirect Medical Education payments would be redirected to teaching hospitals; currently, they are paid to managed care plans.

**Ensures the solvency of the Medicare Trust Fund.**

By slowing the rate of growth in payments to hospitals, physicians and other service providers, the plan extends the solvency of the Medicare Trust Fund.

**Higher income seniors should pay more.**

Through affluence testing, the plan reduces the Medicare Part B premium subsidy to higher income seniors, and asks them to pay a greater share of the program's cost.

**MEDICAID** (estimated savings: \$62 billion)

**Incorporates a number of NGA's recommendations.**

The proposal incorporates many of the principles of the NGA proposal regarding enhanced state flexibility, while also maintaining important safeguards for the federal treasury and retaining the guarantee of coverage for beneficiaries.

**Sharing the risks and rewarding efficiency.**

Funding is based upon the number of people covered in each state, ensuring federal funding during economic downturns. States will be able to redirect the savings they achieve toward expanding Medicaid coverage to the working poor.

**Guaranteed coverage for the most vulnerable populations.**

The plan maintains a national guarantee of coverage for low-income pregnant women, children, the elderly and the disabled (using the tightened definition of disability included in welfare reform legislation).

**Increased flexibility for the states.**

States can design the health care delivery systems which best suit their needs without obtaining waivers from the federal government. Under this plan, states can determine provider rates (the Boren amendment is repealed), create managed care programs, and develop home and community based care options for seniors to help keep them out of nursing homes.

**WELFARE** (estimated savings: \$45-\$53 billion)**Includes many of NGA's recommendations.**

The plan, which includes several prominent features of the NGA proposal, is based upon the welfare reform bill that passed the Senate by a vote of 87-12 in September 1995.

**Tough new work requirements.**

States must meet a 50 percent work participation requirement by the year 2002.

**Time limited benefits.**

Cash assistance is limited for beneficiaries to a maximum of five years.

**A block grant providing maximum state flexibility.**

States will be given tremendous flexibility to design welfare programs, in accordance with their own circumstances, that promote work and protect children.

**More child care funding to enable parents to work.**

The plan provides the higher level of child care funding (\$14.8 billion) recommended by the NGA to enable parents to get off welfare and to help states meet the strict work participation requirements contained in the plan.

**Extra funds for states to weather recessionary periods.**

The plan includes a \$2 billion contingency fund to help states through economic downturns.

**Important safety nets maintained.**

The plan preserves the food stamp and foster care programs as uncapped entitlements. States must provide vouchers to meet the basic subsistence needs of children if they impose time limits shorter than five years (states set amount of voucher).

**Encourages states to maintain their investment in the system.**

States must maintain their own spending at 80 percent to get the full block grant, and 100 percent to get contingency and supplemental child care assistance funds; contingency and child care funds must be matched.

**Reforms Supplemental Security Income programs.**

The plan disqualifies drug addicts and alcoholics from receiving SSI benefits, and tightens eligibility criteria for the childrens' SSI disability program.

**Retargets Earned Income Credit**

The Earned Income Credit is retargeted to truly needy by reducing eligibility for those with other economic resources. The plan also strengthens the administration of the Earned Income Credit by implementing procedures to curb fraud.

**ECONOMIC GROWTH INCENTIVES** (estimated cost: \$130 billion)**A three-pronged tax relief program for working families.**

The plan establishes a new \$250 per child credit (\$500 per child if the parent contributes that amount to an IRA in the child's name); expands the number of taxpayers eligible for deductible IRAs, creates a new "backloaded" IRA, and allows penalty free withdrawals for first time homebuyers, catastrophic medical expenses, college costs, and prolonged unemployment; and provides for a new "above the line" deduction for higher education expenses.

**Encourages economic growth.**

A capital gains tax reduction based on the Balanced Budget Act formulation (effective date of 1/1/96): 50 percent reduction for individuals; 31 percent maximum rate for corporations; expanded tax break for investments in small business stock; and capital loss of principal residence. The proposal also provides for AMT relief (conformance of regular and alternative minimum tax depreciation lives).

**Important small business tax assistance.**

An exclusion from estate tax on the first \$1 million of value in a family-owned business, and 50 percent on the next \$1.5 million. Increases the self-employed health insurance deduction to 50 percent.

**Extension of expiring provisions.**

The plan provides for a revenue neutral extension of expiring provisions.

**LOOPHOLE CLOSERS** (estimated savings: \$25 billion)**Closes unjustifiable tax loopholes.**

The cost of the economic growth incentives is partially offset by the elimination of many tax loopholes, and through other proposed changes in the tax code.

**CPI ADJUSTMENT** (estimated savings: \$110 billion)**A more accurate measure of increases in the cost of living.**

The plan adjusts the CPI to better reflect real increases in the cost of living by reducing it by half a percentage point in years 1997-98, and by three-tenths of a percentage point thereafter. The proposed adjustment is well below the range of overstatement identified by economists.

**DISCRETIONARY SPENDING** (estimated savings: \$268 billion)**Achievable discretionary spending reductions.**

Unlike most of the other budget plans, this proposal provides for discretionary spending reductions which can actually be achieved. The plan proposes a level of savings which is only \$10 billion more than a "hard freeze" (zero growth for inflation), ensuring adequate funds for a strong defense and for critical investments in education and the environment.

**OTHER MANDATORY SPENDING** (estimated savings: \$52 billion)**Balanced reductions acceptable to both parties.**

The plan includes changes that were proposed in both Republican and Democratic balanced budget measures in the areas of banking, commerce, civil service, transportation and veterans programs.

**Additional mandatory savings.**

The plan adopts other changes, including a cap on direct lending at 40 percent of total loan volume, extending railroad safety fees, and permitting Veterans' hospitals to bill private insurers for the care of beneficiaries.

**SENATE CENTRIST COALITION  
7-YEAR BALANCED BUDGET PLAN  
DETAILED SUMMARY**

**MEDICARE (est. savings \$154b.)**

The plan proposes a variety of reforms to the Medicare program designed to promote efficiency in the delivery of services and strengthen the financial status of the Trust Fund. The proposal retains the traditional, fee for service Medicare program, but also encourages the formation of private managed care options for seniors and the disabled, allowing point of service plans, provider sponsored organizations, and medical savings accounts (on a demonstration basis).

The plan's provider payment savings and the expanded availability of managed care delivery of services will lower the cost of the Medicare program over the next seven years thereby extending the solvency of the Medicare Trust Fund.

**Program Reforms**

Increase choice of private health plans. Under the proposal, preferred provider organizations (PPOs), provider sponsored organizations (PSOs), Medical Savings Accounts (as a demonstration project), and other types of plans that meet Medicare's standards are made available to Medicare beneficiaries.

Annual enrollment. The plan allows beneficiaries to switch health plans each year during an annual "open season" or within 90 days of initial enrollment.

Standards. The Secretary of HHS, in consultation with outside groups, will develop standards which will apply to all plans. These standards will involve benefits, coverage, payment, quality, consumer protection, assumption of financial risk, etc., which will apply to all plans; PSOs will be able to apply for a limited waiver of the requirement that plans be licensed under state law.

Additional benefits. Under the proposal, health plans would be permitted to offer their participants additional benefits or rebates in the form of a reduced Medicare Part B premium. Plans would be prohibited from charging additional premiums for services covered by Medicare Parts A&B.

Payments to private health plans. Payments to managed care plans will be de-linked from traditional fee-for-service payments and will be computed using both locally-based and nationally-based rates. Future payments will grow by a predetermined percentage and a floor will be established in order to attract plans to the lowest payment areas.

Commission on the Effect of the Baby Boom Generation. The plan proposes the creation of a commission to make recommendations regarding the long-term solvency of the Medicare program.

Conform Medicare with Social Security. The eligibility age for Medicare is increased to 67 at the same rate as the current Social Security eligibility age is scheduled to increase.

#### Part A Program Savings (Hospitals)

Hospital Market Basket Update Reduction. For hospitals, the proposal sets the annual update for inpatient hospital services at the market basket minus one and one-half percentage points for fiscal years 1997 through 2003.

Capital Payment Reduction. For hospitals, the proposal reduces the inpatient capital payment rate by fifteen percent for fiscal years 1997 through 2003.

Reduce The Indirect Medical Education Reimbursement Rate. The proposal phases-in a reduction to the additional payment adjustment to teaching hospitals for indirect medical education from 7.7 percent to 6.0 percent.

Reduce DSH Payment. The plan reduces the extra payments made to certain hospitals that serve a disproportionate share of low income patients by 10 percent less than current-law estimates.

Skilled Nursing Facility Payment Reform. The proposal adopts a Prospective Payment System (PPS) for Skilled Nursing Facilities by November 1997. In moving to the new methodology, a temporary freeze on payment increases is imposed and then an interim system is implemented until the full PPS system is implemented.

#### Part B Program Savings (Physicians)

Physician Payment Reform. The proposal adjusts the Medicare fee system used to pay physicians. A single conversion factor would be phased-in for all physicians instead of the current three conversion factors. Surgeons would be phased-in over a two year period. The conversion factor for 1996 would be \$35.42 and the annual growth rate would be subject to upper and lower growth bounds of plus 3 percent and minus 7 percent.

Reduce Hospital Outpatient Formula. The proposal adjusts the current Medicare formula for hospital outpatient departments to eliminate overpayments due to a payment formula flaw.

Reduce Oxygen Payment. The proposal would decrease the monthly payment for home oxygen services and eliminate the annual cost update for this service through 2003.

Freeze Durable Medical Equipment Reimbursement. The proposal eliminates the CPI-U updates for payments of all categories of Durable Medical Equipment for fiscal years 1997 through 2003.

Reduce Laboratory Reimbursement. The proposal lowers expenditures on laboratory tests by reducing the national cap for each service to 72 percent of the national median fee during the base year for that service.

Ambulatory Surgical Center Rate Change. The proposal lowers the annual payment rate adjustment by minus three percent for fiscal years 1997 and 1998 and then reduces the rate by minus two percent for remaining fiscal years through 2003.

#### Part A & B Program Savings

Medicare Secondary Payer Extensions. The proposal would make permanent the law that places Medicare as the secondary payer for disabled beneficiaries who have employer-provided health insurance. It also extends to twenty-four months the period of time employer health insurance is the primary payer for end stage renal disease (ESRD) beneficiaries.

Home Health Payment Reform. The proposal reforms the payment methodology used to pay home health services by the beginning of fiscal year 1999. While a prospective payment system is developed, current payments are frozen and an interim payment system implemented.

Fraud & Abuse Changes. The proposal includes a number of provisions designed to improve the ability to combat Medicare fraud and abuse by providers and beneficiaries

Medicare Part B Premium Reform. The plan retains the pre-1996 financing structure for the Part B program by requiring most participants to pay for 31.5% of the program's costs. Premiums for lower income seniors are lowered to 25% of the program's costs. In addition, the proposal eliminates the taxpayer subsidy of Medicare Part B premiums for high income individuals.

## MEDICAID (est. savings \$62b.)

The proposal incorporates many of the principles of the NGA proposal regarding enhanced state flexibility, while also maintaining important safeguards for the federal treasury and retaining the guarantee of coverage for beneficiaries.

Payments to States. States are guaranteed a base amount of funds that may be accessed regardless of the number of individuals enrolled in the State plan. Each state would have the ability to designate a base year amount from among their actual Medicaid spending for FY 1993, 1994, or 1995. Approximately one-third of disproportionate share hospital payments would be included in the base year amount, one-third would be used for deficit reduction, and one-third would be used for a federal disproportionate share hospital payment program.

In addition, states will receive growth rates which reflect both an inflation factor and estimated caseload increases. If the estimate for caseload in any given year was too low, states would receive additional payments per beneficiary from an "umbrella fund" to make up the difference. Conversely, if the caseload was overestimated, the estimate for the following year would be adjusted downward. Regardless of caseload, a state's allocation never fall below the base year allocation for that state. The plan retains the current law match rates and restrictions on provider taxes and voluntary contributions.

Eligibility. The proposal maintains current law mandatory and optional populations with the following modifications: states would cover those individuals eligible for SSI under a more strict definition of disabled (tightened by the welfare reform changes included in this proposal) as well as SSI-related groups; states would have the option of covering current-law AFDC beneficiaries or those eligible under a revised AFDC program (includes one-year transitional coverage); and, states are permitted to use savings in their base year amount to expand health care coverage to individuals with incomes below 100% of the federal poverty level without obtaining a federal waiver.

Benefits. The plan maintains current law mandatory and optional benefits except that Federally Qualified Health Center (FQHC) services would be optional rather than mandatory. The proposal also gives the Secretary of HHS the authority to redefine early periodic screening and diagnosis treatment (EPSDT) services.

Provider payments. The proposal repeals the so-called Boren amendment as well as the reasonable-cost reimbursement requirements for FQHCs and rural health clinics, thus allowing states full flexibility in setting provider rates.

Quality. States would be allowed to set provider standards. States would no longer be required to obtain a waiver to enroll patients in managed care plans, provided the plans met the state's standards developed for private plans.

Nursing Home Standards. The proposal maintains current nursing home standards with existing enforcement. Streamlines certain requirements.

Enforcement. Individuals and providers are required to go through a state-run administrative hearing process prior to filing suit in federal court.

Set Asides. The plan establishes a federal fund for certain states that have high percentages of undocumented aliens, as well as a fund for FQHCs and rural health clinics.

Program Structure. The reforms are made to the existing Medicaid statute.

**WELFARE (est. savings \$45b. - 53b.)**

Block Grant. The proposal transforms existing welfare programs into a block grant to states to increase program flexibility and encourage state and local innovation in assisting low-income families in becoming self-sufficient. This structure provides incentives to states to continue their partnership with the federal government by encouraging states to maintain 80 percent of their current spending on major welfare programs. While the plan provides maximum flexibility, it requires states to operate their programs in a way that treats recipients in a fair and equitable manner.

Contingency Fund. To protect states facing difficult economic times, the plan calls for the creation of a \$2 billion federal contingency fund.

Child Care. The plan provides \$14.8 billion in mandatory federal funds for child care and ensures that those child care facilities meet minimum health and safety standards so that children are well-cared for while their parents go to work.

Maintenance of Effort. To encourage states not to substitute these new federal funds for current state spending, a 100 percent maintenance of effort and a state match are required in order to access additional federal money for child care and contingency funds.

Work Requirement and Time Limit. The plan requires states to meet tough new work requirements -- 50 percent by 2002 -- and limits a beneficiary's cash assistance to five years, so that AFDC becomes a temporary helping hand to those in need, rather than a permanent way of life.

Retention of Certain Safety Nets. The proposal retains important protections for welfare's most vulnerable beneficiaries, the children. It allows states to waive penalties for single parents with children under school age who cannot work because they do not have child care, gives states the option to require those parents to work only 20 hours a week, and requires states with a time limit shorter than five years to provide assistance to children in the form of vouchers.

Out-of-Wedlock Births. The plan encourages a reduction in out-of-wedlock births by allowing states to deny benefits to additional children born to a family already on welfare and rewarding states that reduce the number of out-of-wedlock births.

Curbing SSI Abuse. The proposal repeals the Individualized Functional Assessment (IFA) used to determine a child's eligibility for Supplemental Security Income (SSI) and replaces it with a tightened definition of childhood disability. It maintains cash assistance for those children who remain eligible for SSI under this new criteria. It also eliminates SSI eligibility for addicts and alcoholics.

Foster Care and Adoption Assistance. The federal entitlement for foster care and adoption assistance (and their respective pre-placement and administrative costs) is maintained under the proposal. States are required to continue to meet federal standards in their child welfare and foster care programs.

Food Stamp and Child Nutrition Programs. The proposal streamlines the food stamp and child nutrition programs, while retaining this critical safety net as a federal entitlement. The work requirement for single, childless recipients in the food stamp program is toughened.

Promoting Self-Sufficiency for Immigrants. The plan establishes a five-year ban on most federal "needs based" benefits for future immigrants, with exceptions for certain categories of individuals (such as veterans, refugees and asylees) and certain programs (such as child nutrition, foster care and emergency health care under Medicaid). The plan also places a ban on SSI for all legal immigrants, but exempts current recipients who are at least 75 years of age or disabled; veterans and their dependents; battered individuals; those who have worked 40 quarters; and for a five-year period refugees, deportees and asylees. Finally, future deeming requirements are expanded to last 40 quarters, but do not continue past naturalization.

Retargets Earned Income Credit. The Earned Income Credit is retargeted to the truly needy by reducing eligibility for those with other economic resources. The plan also strengthens the administration of the Earned Income Credit by implementing procedures to curb fraud.

## TAXES (\$130b.tax cut; \$25b.loophole closers)

Child Credit. The proposal provides a \$250 per child tax credit for every child under the age of 17. The credit is increased to as much as \$500 if that amount is contributed to an Individual Retirement Account in the child's name.

Education Incentives. The plan provides two separate education incentives. The first is an above-the-line deduction of up to \$2,500 for interest expenses paid on education loans. The second incentive is an above-the-line deduction for qualified education expenses paid for the education or training for the taxpayer, the taxpayer's spouse, or the taxpayer's dependents. Both deductions will be phased out for taxpayers with incomes above a certain threshold. The phaseout thresholds and the dollar amounts for the deductions are subject to revenue considerations.

Capital Gains: Individuals. The proposal allows individuals to deduct 50 percent of their net capital gain in computing taxable income. It restores the rule in effect prior to the Tax Reform Act of 1986 that required two dollars of the long-term capital loss of an individual to offset one dollar of ordinary income. The \$3,000 limitation on the deduction of capital losses against ordinary income would continue to apply. Under the plan, a loss on the sale of a principal residence is deductible as a capital loss. These changes apply to sales and exchanges after December 31, 1995.

Capital Gains: Corporations. The plan caps the maximum tax rate on corporate capital gains at 31 percent. This change applies to sales and exchanges after December 31, 1995.

Capital Gains: Small Business Stock. The maximum rate of tax on gain from the sale of small business stock by a taxpayer other than a corporation is 14 percent under the proposal. The plan also repeals the minimum tax preference for gain from the sale of small business stock. Corporate investments in qualified small business stock would be taxed at a maximum rate of 21 percent. The plan increases the size of an eligible corporation from gross assets of \$50 million to gross assets of \$100 million, and repeals the limitation on the amount of gain an individual can exclude with respect to the stock of any corporation. The proposal modifies the working capital expenditure rule from two years to five years. Finally, an individual may roll over the gain from the sale or exchange of small business stock if the proceeds of the sale are used to purchase other qualifying small business stock within 60 days. The increase in the size of corporations whose stock is eligible for the exclusion applies to stock issued after the date of the enactment of this proposal. All other changes apply to stock issued after August 10, 1993.

Alternative Minimum Tax Relief. The plan conforms the Alternative Minimum Tax depreciation lives to the depreciation lives used for regular tax purposes for property placed in service after 1996.

**CONSUMER PRICE INDEX (est. savings \$110b.)**

The plan includes an adjustment to the Consumer Price Index to correct biases in its computation that lead to it being overstated. The proposal reduces the CPI for purposes of computing cost of living adjustments and indexing the tax code by one-half of a percentage point in 1997 and 1998. The adjustment is reduced to three-tenths of a percentage point in 1999 and all years thereafter.

**DISCRETIONARY SPENDING (est. savings \$268b.)**

The plan holds discretionary spending to an amount that is slightly below the fiscal year 1995 level for each of the next seven years. This is \$81 billion less than the cuts proposed as part of the Balanced Budget Act and \$29 billion less than the cuts proposed by the Administration.

**OTHER MANDATORY SPENDING (est. savings \$52 b.)**

Housing. The proposal reforms the Federal Housing Administration's home mortgage insurance program to help homeowners avoid foreclosure and decrease losses to the federal government. It also limits rental adjustments paid to owners of Section 8 housing projects.

Communication and Spectrum. The plan directs the Federal Communications Corporation to auction 120 megahertz of spectrum over a 7-year period.

Energy & Natural Resources. The proposal call for the privatization of the US Enrichment Corporation and the nation's helium reserves. It extends the requirement that the Nuclear Regulatory Commission collect 100% of its annual budget through nuclear plant fees. The proposal allows for the sale of the strategic petroleum reserve oil (SPRO) at the faulty Weeks Island location and leases the excess SPRO capacity. Under the plan the Alaska Power Market Administration, various Department of Energy assets, Department of Interior (DOI) aircraft (except those for combating forest fires), Governor's Island, New York, and the air rights over train tracks at Union Station would be sold. The plan raises the annual Hetch Hetchy rental payment paid by City of San Francisco and authorizes central Utah prepayment of debt.

Civil Service & Related. The plan increases retirement contributions from both agencies and employees through the year 2002, delays civilian and military retiree COLAs from January 1 to April 1 through the year 2002, and reforms the judicial and congressional retirement. Finally, the plan denies eligibility for unemployment insurance to service members who voluntarily leave the military.

Transportation. The proposal extends expiring FEMA emergency planning and preparedness fees for nuclear power plants, vessel tonnage fees for vessels entering the U.S. from a foreign port, and Rail Safety User Fees that cover part of the cost to the federal government of certain safety inspections.

Veterans. The plan extends seven expiring provisions of current law and repeals the "Gardener" decision thereby restoring the Veterans Administration's policy of limiting liability to those cases in which an adverse outcome was the result of an accident or VA negligence. Pharmacy co-payments are increased from \$2 to \$4, but not for the treatment of a service-connected disability or for veterans with incomes below \$13,190. Also, the increase applies only to the first 5 prescriptions that a veteran purchases per month. The proposal authorizes a veteran's health insurance plan to be billed when a VA facility treats a service-connected disability.

Student Loans. The proposal caps the direct lending program at 40 percent of total loan volume. It imposes a range of lender and guarantor savings. The proposal does not include fees on institutions, the elimination of the grace period, or any other provisions negatively impacting parents or students.

Debt Collection. The plan authorizes the Internal Revenue Service to levy federal payments (i.e. RR retirement, workman's compensation, federal retirement, Social Security and federal wages) to collect delinquent taxes.

Park Service Receipts & Sale of DoD Stockpile. The proposal raises fees at National Parks. It directs the Defense Department to sell materials in its stockpile that are in excess of defense needs (i.e. aluminum and cobalt) -- but not controversial materials such as titanium.

Long-Term Federal Retirement Program Reforms. The plan increases the normal civil service retirement eligibility to age 60 with 30 years of service, age 62 with 25 years of service, and age 65 with 5 years of service. Military retirement eligibility for active duty personnel is increased to age 50 with 20 years of service, with a discounted benefit payable to a person retiring before age 50. No changes are proposed for the retirement eligibility of reserve servicepersons. These changes would not apply to current or previously employed federal workers or anyone who is now serving or who has previously served in the military. Although these changes will not produce budget savings in the coming seven years, they do provide significant savings over the long-term.

Individual Retirement Accounts. The proposal expands the number of families eligible for current deductible IRAs by increasing the income thresholds. In addition, the annual contribution for a married couple is increased to the lesser of \$4,000 or the combined compensation of both spouses. Penalty-free withdrawals are allowed for first-time homebuyers, catastrophic medical expenses, higher education costs and prolonged unemployment. The plan creates a new type of IRA which can receive after-tax contributions of up to \$2,000. Distributions from this new IRA would be tax-free if made from contributions held in the account for at least five years.

Estate Tax Relief. The plan provides estate tax relief for family-owned businesses by excluding the first one million dollars in value of a family-owned business from the estate tax and lowering the rate on the next one and one-half million dollars of value by 50 percent. To preserve open space, the plan excludes 40 percent of the value of land subject to a qualified conservation easement.

Other Provisions. The proposal contains a revenue neutral package extending the expired tax provisions. The plan also calls for increasing the self-employed health insurance deduction to 50%.

#### **Loophole Closings and Other Reforms.**

The plan includes a package of loophole closers and other tax changes designed to reduce the deficit by \$25 billion over seven years. Changes include, for example, phasing out the interest deduction for corporate-owned life insurance, eliminating the interest exclusion for certain nonfinancial businesses, and reforming the tax treatment of foreign trusts. In addition, the Oil Spill Liability tax and the federal unemployment surtax are extended as part of the plan.

## MediGrant II

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1. **Base:** Set in legislation (sort of states' choice of 1993, 1994, 1995, but not exactly)

2. **"Needs-Based Amount"**

Product of:

- a. Number of poor people in a state and
- b. State-adjusted national MediGrant spending per poor person

Adjusted for:

State's casemix index (ranges from 0.9 to 1.15)  
Medicare hospital wage index times 0.85 plus 0.15

3. **Floors and Ceilings**

The Needs-Based Amount is compared to the Base to yield a growth rate.

That growth rate cannot be :

Greater than ceilings

125% of the national rate for most states

150% of the national rate for 10 states with the lowest federal funding per poor person (e.g., FL, CA)

Less than the floors

3% for most states

90% of the national rate for states with certain rates

Almost all states are at their floors and ceilings for the 1996 to 2002 period. No state gets a needs-based amount for full period.

4. **Scalar:** To ensure that the Federal budget target is hit, all states are multiplied by a scalar or ratio. This occurs within the floor and ceiling growth rates.

### MediGrant II State Growth Rates

<b>Special Growth Rate Ceiling: 9.3% in 2002 (150% of national rate)</b>	
California	Nevada
Florida	New Mexico
Idaho	Oklahoma
Mississippi	
<b>General Growth Rate Ceiling: 7.7% in 2002 (125% of national rate)</b>	
Alabama	Kentucky
Alaska	Louisiana
Arizona	South Carolina
Arkansas	Texas *
Colorado	Utah
Delaware	Virginia *
Georgia	Wyoming
<b>Special Growth Rate Floor: 5.6% in 2002 (90% of national rate)</b>	
Illinois *	North Dakota
Indiana	Ohio
Iowa	Oregon
Kansas	Pennsylvania
Maryland	South Dakota
Michigan	Tennessee
Missouri	West Virginia
Montana	Wisconsin
North Carolina	
<b>General Growth Rate Floor: 3.0% in 2002</b>	
Connecticut	Nebraska
District of Columbia	New Hampshire
Hawaii	New Jersey
Maine	New York
Massachusetts	Rhode Island
Minnesota	Washington

Source: US General Accounting Office.

- \* States which are eligible for the special ceiling but do not receive it, probably because of the scalar. Vermont begins with the general floor growth rate but gets a higher rate due to the "small state minimum". New Hampshire and Louisiana get no growth between 1997 and 2000.

**Table 5**  
**Comparison of 1996 State Allotments with 1997 Needs Based Amount and Allotments**  
**Conference Agreement**

	1996 Allotment (millions)	1997 Aggregate Expenditure Need (federal share) <sup>1</sup>			ACTUAL 1997 Allotment (millions)	Allowed Growth Rate	
		WITHOUT Floors, Ceilings or Scalars		1996-1997 % Change		1997	1998 <sup>2</sup>
		(millions)					
Total	96,246	107,715	11.9%	103,084			
Alabama	1,518	2,633	73.5%	1,654	9.0%	5.3%	
Alaska	205	203	-1.0%	223	9.0%	4.0%	
Arizona	1,371	1,532	11.7%	1,484	9.0%	4.2%	
Arkansas	1,011	1,471	45.5%	1,102	9.0%	7.0%	
California	6,947	14,033	58.9%	8,752	9.0%	5.3%	
Colorado	757	1,005	32.7%	826	9.0%	5.3%	
Connecticut	1,483	681	-54.8%	1,514	3.5%	3.0%	
Delaware	212	159	-25.2%	220	3.5%	3.0%	
District of Columbia	501	313	-37.5%	519	3.5%	3.0%	
Florida	3,716	5,615	51.1%	4,050	9.0%	5.3%	
Georgia	2,428	3,531	45.5%	2,645	9.0%	7.0%	
Hawaii	323	385	+19.2%	352	9.0%	7.0%	
Idaho	278	440	58.2%	303	9.0%	5.3%	
Illinois	3,467	4,198	21.1%	3,779	9.0%	5.3%	
Indiana	1,852	1,940	-0.6%	2,128	9.0%	4.0%	
Iowa	835	852	2.0%	810	9.0%	4.0%	
Kansas	714	704	-1.4%	778	9.0%	4.0%	
Kentucky	1,578	2,232	41.5%	1,720	9.0%	7.0%	
Louisiana	2,622	3,386	29.1%	2,622	9.0%	7.0%	
Maine	894	496	-28.5%	718	3.5%	3.0%	
Maryland	1,370	1,503	9.8%	1,493	9.0%	4.0%	
Massachusetts	2,870	2,005	-30.2%	2,971	3.5%	3.0%	
Michigan	3,465	3,845	11.0%	3,777	9.0%	4.0%	
Minnesota	1,794	1,353	-24.6%	1,857	3.5%	3.0%	
Mississippi	1,262	2,106	68.9%	1,375	9.0%	5.3%	
Missouri	1,848	2,073	12.1%	2,016	9.0%	4.0%	
Montana	312	398	27.5%	340	9.0%	7.0%	
Nebaska	464	442	-4.7%	496	6.8%	3.0%	
Nevada	258	497	82.8%	281	9.0%	5.3%	
New Hampshire	360	250	-30.5%	360	3.5%	3.0%	
New Jersey	2,855	2,448	-14.2%	2,955	3.5%	3.0%	
New Mexico	635	1,134	78.7%	692	9.0%	5.3%	
New York	12,902	8,577	-33.5%	13,353	3.5%	3.0%	
North Carolina	2,588	3,003	18.0%	2,821	9.0%	7.0%	
North Dakota	241	257	6.6%	283	9.0%	4.0%	
Ohio	4,034	3,885	-3.7%	4,356	8.0%	4.0%	
Oklahoma	911	1,431	57.0%	893	9.0%	5.3%	
Oregon	1,089	1,042	-4.3%	1,189	7.4%	4.0%	
Pennsylvania	4,454	4,352	-2.3%	4,855	9.0%	4.0%	
Rhode Island	546	381	-33.9%	685	3.5%	3.0%	
South Carolina	1,621	2,296	41.6%	1,767	9.0%	7.0%	
South Dakota	263	296	12.5%	285	9.0%	4.0%	
Tennessee	2,520	2,891	14.7%	2,747	9.0%	8.2%	
Texas	8,352	8,488	33.5%	6,824	9.0%	7.0%	
Utah	484	607	25.3%	528	9.0%	7.0%	
Vermont	248	176	-29.2%	257	3.5%	3.0%	
Virginia	1,145	1,942	69.8%	1,248	9.0%	5.3%	
Washington	1,763	1,420	-19.5%	1,825	3.5%	3.0%	
West Virginia	1,157	1,091	-5.7%	1,223	5.7%	3.0%	
Wisconsin	1,710	1,643	-3.9%	1,842	7.8%	4.0%	
Wyoming	133	112	-15.4%	138	3.5%	3.0%	

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<sup>1</sup> This is the amount that each state would receive if the allotments were based strictly on the poverty population, average spending per poor person, health care costs, casemix, and the current FMAP. The floor and ceiling growth rates, in addition to the scalar, are used to bring the total 1997 allotment down to the legislated level of \$103.0 billion dollars.

<sup>2</sup> The floor growth for 1998 is 3.0%. This drops to 2.0% for 1999 and thereafter.

\*States that are affected by application of the scalar.

Source: Urban Institute Medical Expenditure Growth Model, December 1995.

May 23, 1996

**THE MEDICAID RESTRUCTURING ACT OF 1996:  
WHEN IS A GUARANTEE NOT A GUARANTEE?**

by Cindy Mann

The first goal stated in the Governor's Medicaid resolution of February 6, 1996 is that "the basic health care needs of the nation's most vulnerable populations must be guaranteed." The new Republican proposal, touted as following the governors' resolution, restates that goal in its first section.

But the new Republican proposal fails to live up to this central principle. While the bill does direct states to provide some coverage to younger children, pregnant women, and some disabled and elderly people, as called for in the governors' resolution, various other provisions in the bill negate any semblance of a real guarantee of coverage even for these groups. *If this bill were to become law, there would be no federally-defined group of people who would be guaranteed affordable health care coverage.*

By repealing the federal Medicaid law and using an earlier version of the Republican Medicaid proposal as the basis for this bill, it eliminates many provisions in current law that were not specifically addressed by the governors' resolution. In addition, the bill adds provisions not agreed to by the governors that bear directly on the governors' principle of guaranteeing coverage. Some of these omissions and additions are major, while others are less significant, but in combination they make the so-called guarantees in the bill largely cosmetic. The result is something far different from the balance between federal guarantees and state flexibility the governors stated they were seeking to achieve through their resolution. This paper identifies some of the provisions in the new bill that undermine the guarantee to coverage envisioned by the governors' resolution. Specifically;

- The bill undermines the coverage guarantee for low-income children and pregnant women because states could set all income and asset rules.
- The bill allows states to impose additional eligibility rules, such as residency requirements, that could deny or delay coverage even to protected groups of beneficiaries.

- The bill further undermines the guarantee of coverage by allowing relatively large health care costs to be imposed on people with low incomes.
- The bill allows states to restrict benefits sharply even to those people who are guaranteed coverage.
- No one would have a legally enforceable right to coverage.

One question often asked is whether states can be expected to use their new flexibility to restrict coverage and benefits to the extent the bill would permit. While no one really knows the answer to that question, it is important to consider the question in light of the bill's financing provisions.

The bill offers states new opportunities and incentives to withdraw large amounts of *state* Medicaid funding. The state cuts could be as large as \$178 billion over six years, making the total — state and federal cuts — 3.5 times as large as the proposed \$72 billion in federal Medicaid cuts. The level of total cuts, moreover, could be even deeper than that because the bill would restore currently outlawed financing gimmicks, such as special provider taxes and intergovernmental transfers, that many states used in the past to leverage federal funds without putting up any real state funds.

The ability of states to withdraw large amounts of state dollars and use illusory financing schemes, combined with the lack of any real guarantee of coverage, make it that likely that if the bill is enacted, the first principle of the governors' resolution — that the nation's most vulnerable populations be protected — will be little more than a hollow promise.

### **Guarantees for Low-income Children and Pregnant Women Are Undermined Because States Would Set All Income and Asset Rules**

The governors agreed that federal law should assure that young children and pregnant women with incomes below specified levels would be covered by Medicaid in all states.<sup>1</sup> However, because the bill eliminates all federal rules relating to how income and assets would be measured and grants states unfettered discretion to set their own rules in these areas, the federally prescribed income eligibility levels become virtually meaningless.

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<sup>1</sup> Under the governors' resolution pregnant women and children up to age six are to be covered if their income is below 133 percent of the poverty level. Children ages six through 12 are to be covered if their income is below 100 percent of the poverty level.

- **States would decide what income would be counted.** States could consider gross rather than net income in determining eligibility for Medicaid. They could choose to disallow any of the current deductions (such as those for work-related expenses, including child care) intended to assure that only income available to pay for medical care is considered when Medicaid eligibility is determined. In addition, states could count non-cash benefits when calculating financial eligibility.

*Receipt of housing assistance, transportation vouchers or child care subsidies might disqualify children or pregnant women from Medicaid even if their cash income were well below the poverty level.*

- **States would set assets levels and decide what assets would be counted.** Asset rules would be left entirely to the states.

*A child whose parent loses her job and her only source of income could be denied Medicaid if the family owns its own home.*

*A car needed for work could make a pregnant woman ineligible for coverage, regardless of the level of her income or whether her car had any significant value.*

- **States would decide whose income and assets would be counted.** In determining eligibility for Medicaid, a state could decide to count the income of anyone — or everyone — residing together, regardless of whether those persons actually support or have any legal obligation to support the Medicaid applicant.

*An infant whose family income is below the poverty level could be denied Medicaid if his or her grandmother moved in to help the family with child care.*

*Children could be denied coverage based on the income of unrelated boarders.*

Moreover, states could count income of nonsupporting family members who do not reside with the Medicaid applicant.

*A poor child could be denied Medicaid based on the income of an absent father, even if the father did not contribute anything towards the child's support.*

## **States Could Establish Additional Eligibility and Enrollment Rules That Deny or Delay Coverage Even to Protected Beneficiaries**

Even though the governors agreed that certain groups of people must be covered, the bill allows states to establish eligibility standards and enrollment procedures that could deny or delay care to these protected categories of people.

- **States could impose any limits on eligibility, including those relating to age, income and resources, residency, disability status, immigration status, and employment status.**

*A chronically ill child with no health care coverage could be denied Medicaid based on a state rule limiting coverage to people who have lived in the state for a specified period of time, such as one or two years.*

*A state could limit Medicaid coverage to children whose parents are employed a certain number of hours per month, as Pennsylvania has just done with respect to its general assistance medical program.*

- **States could establish their own enrollment system.** All federal rules governing enrollment, such as those requiring simplified applications for children and pregnant women and establishing limits on how long states may take to determine if an applicant is eligible, would be repealed. States could delay application determinations, convert to a quarterly enrollment system or take other actions that would slow the rate of new enrollments, lower costs, and deny or delay access to care.

*A state could limit Medicaid enrollments by allowing workers 60 or 90 days to decide eligibility or by qualifying people only at the beginning of each calendar quarter. Under a quarterly enrollment system, access to medical services for a person who applies in late January would be delayed until April, the beginning of the next full calendar quarter.*

## **The Income Protections Agreed to by the Governors Are Undermined Because Unaffordable Health Care Costs Could Be Imposed on People with Very Low Incomes**

Under current law, pregnant women and children cannot be charged copayments, and other Medicaid beneficiaries are protected from having to pay more than "nominal" copayments. In addition, Medicaid patients cannot be billed by providers, and services cannot be denied to patients who cannot afford the copayment.

However, under the bill, these “affordability” protections are substantially modified or repealed, undermining the governors’ principle that coverage should be assumed for certain low-income groups.

- **Virtually all federal rules preventing states from imposing unaffordable cost-sharing requirements are eliminated.** Only limited protections for pregnant women and children would remain.

*Poor children and pregnant women could be required to pay a 10 percent copayment for hospital care.*

*Elderly or disabled people could face large deductibles for diagnostic laboratory tests or medications before Medicaid coverage would begin.*

The bill also would eliminate the current law prohibiting providers from denying services if the required copayment cannot be paid at the time of service. In addition, the bill would permit states to condition cost-sharing on participation in state-mandated programs that “promote personal responsibility.” Higher copayments could be imposed on people who do not participate in such programs.

*A new mother with little or no income could be required to pay a 20 percent copayment for health care services if she refused to attend abstinence counseling, and she could be denied those health care services if she did not have the means to pay.*

- **Providers could bill Medicaid patients.** Under current law, providers must accept Medicaid payment in full and cannot charge patients for any part of the cost of the services. The bill drops this protection against “balance billing.” As a result, providers could bill patients — even beneficiaries who are guaranteed coverage — for the difference between customary charges and the Medicaid payment.

*If the normal hospital charge for an outpatient surgical procedure is \$1,000 but the Medicaid payment to the hospital is \$800, the hospital could bill the Medicaid patient for \$200.*

In many states, the gap between Medicaid rates and customary charges is already large. The elimination of federal provider rate standards and the reductions in federal and state Medicaid funding will likely result in even lower provider rates. Without the protection against balance billing, low-

income beneficiaries may be liable for a growing share of the cost of services.

- **Federal rules regarding private insurance buy-ins would be eliminated.** Under current law, persons with access to private insurance must enroll in the plan if the state determines enrollment to be cost-effective. Medicaid, however, must pay premiums, deductibles, and other cost-sharing requirements imposed by the private plan. Thus, under current law, if a low-income parent enrolled in her employer's health plan and the plan called for a \$250 deductible, Medicaid would pay the deductible and the private plan would cover other costs. The bill drops these cost-sharing protections. It permits states to deny benefits to individuals where benefits are available under a private plan, without regard to how much the individual must pay for the private plan.

*If a low-wage worker was offered private health insurance that required a \$250 deductible, the employee could be denied Medicaid even if she could not access care under the plan because she could not afford the deductible.*

### **Coverage Guarantees Agreed to by the Governors Are Further Eroded by Provisions That Would Allow States to Restrict Benefits Sharply Even for Guaranteed Beneficiaries**

While the governors agreed to let states determine the amount, scope and duration of the benefits provided to eligible persons, the bill adds several provisions that could lead to sharp restrictions in benefits even for beneficiaries who are supposed to be guaranteed coverage. States would be under no requirement to have objective standards for determining benefit packages.

- **States could deny or limit benefits for people who need costly medical care.** Federal rules that require that benefit packages be comparable across groups of Medicaid recipients, as well as rules that prohibit states from discriminating among beneficiaries based on diagnosis, illness or condition, would be substantially modified or eliminated. A state could not deny coverage based on a "pre-existing" condition. However, it could deny or limit coverage for various types of medical treatments for people suffering from certain major illnesses.

*A state could limit Medicaid coverage for chemotherapy for cancer patients, or it could refuse to cover high cost medications for patients with HIV.*

- **The bill undercuts the “set aside” for disabled people.** The governors agreed to let states determine who was eligible as a “disabled” person but to require states to spend a certain portion of their Medicaid funds on disabled people. While the requirement that states spend a certain portion of their Medicaid funds on the disabled is in the bill, it adds a provision not agreed to by the governors. The new provision allows states to use federal Medicaid payments to fund state mental health facilities; under current law, states *cannot* use Medicaid payments for facilities that treat persons ages 21 - 64. If a state funded its state psychiatric facilities through Medicaid, the cost could consume much, if not most, of the state’s expenditure requirement for the disabled. States thus could use federal Medicaid funds to replace some of the state funds now used for those facilities while restricting coverage or cutting Medicaid services sharply for the non-institutionalized disabled individuals.
- **States could allow counties or cities to determine benefits and to deny payment for needed services that are not available locally.** States could turn their Medicaid program into local block grants, as Governor Pataki has already proposed to do. Benefits could be set by counties or other local jurisdictions since rules requiring a statewide benefit package are eliminated.

*A county could deny coverage to persons who recently moved into the county and it could deny county residents payment for services unavailable in that county and obtained outside the county.*

Again, it appears that these restrictions could apply to all groups of beneficiaries including those guaranteed coverage.

- **States could avoid their responsibility to Qualified Medicare Beneficiaries.** Under current law, Medicaid pays the *Medicare* premiums and copayments that low-income Medicare beneficiaries incur. The governors’ resolution would continue this protection. However, under the new bill, states could deny or limit payment for these costs if the rates the state pays to medical providers under Medicaid were lower than the rates Medicare pays for the same services. Poor elderly and disabled Medicare beneficiaries would remain liable for these uncovered costs.

## **There Would Be No Legally Enforceable Assurance of Coverage**

- **Federal rules governing administrative hearings would be eliminated.** Federal law assures that applicants and beneficiaries have access to impartial administrative hearings, including impartial decision makers, a fair process and timely decisions. Under the bill, states would develop their own systems which may differ sharply from current federal standards.

*A pregnant woman contesting whether she was entitled to coverage for a laboratory test might be limited to a grievance procedure administered by the managed care plan, even though the plan would have a financial interest in the outcome of the grievance.*

- **No person could enforce their claim for coverage in federal court.** Access to federal court would be denied to all persons. Moreover, access to state court would be limited to disputes over whether a particular benefit was covered under a state plan. It appears that individuals would not be able to sue in state or federal court if they were determined ineligible for any coverage under the plan.

*A disabled woman who believes she falls within the state's definition of "disabled" would have no ability to go to court if she was denied coverage.*

## **Conclusion**

These are just some of the ways in which the new proposal fails to live up to the stated principle that vulnerable populations will be guaranteed health care coverage.

Letter also sent to Chairman Archer  
and Chairman Bliley

May 10, 1996

The Honorable William Roth, Jr.  
Chairman  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Roth:

The undersigned organizations representing hospitals and health systems have reviewed the Fiscal Year 1997 (FY 97) House and Senate Budget Committee proposal, particularly with respect to the Medicare and Medicaid programs.

While it appears that the overall Medicare budget reductions of \$167 billion are roughly the same as those in the last Republican offer in January, the Budget Committees have significantly changed the allocation of reductions within the program. While it is difficult to assess the overall impact of the budget resolution in the absence of greater detail, now larger Medicare Part A reductions mean hospitals are likely to experience actual reductions in payment rates under the committees' proposal.

The budget resolution now includes lower budget reductions in Part B of Medicare, while the reductions in Part A have increased by approximately \$25 billion since the January offer. While the FY 97 budget resolution offers a milder overall approach to deficit reduction compared to last year's resolution, its impact on hospitals appears worse. To achieve reductions of this magnitude, Congress may need to adopt policies resulting in payment rates per beneficiary that would be frozen or actually reduced.

We also have serious concerns about the Budget Committees' Medicaid reductions. We would like to take this opportunity to reiterate our support for maintaining the entitlement nature of the Medicaid program to ensure that those who have coverage today will continue to have coverage tomorrow. Furthermore, we support maintaining current law provider assessment restrictions and Boren amendment payment safeguards. While the overall reductions are somewhat lower than the January offer, if combined with corresponding state reductions through lower state matching requirements or new provider assessments, these reductions could be quite significant for providers.

Hospitals and health systems support the need to adopt a reasonable deficit reduction package, and believe that changes in Medicare are needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare and Medicaid. However, we are gravely concerned about the level of reductions proposed by the Budget Committees in these programs.

**Chairman Roth**  
**May 10, 1996**  
**Page 2**

**We strongly urge you to reconsider both the overall level of Medicare and Medicaid reductions included in the budget resolution and, in your capacity as chairman of the authorizing committee, adjust the allocation between Parts A and B proposed by the Budget Committees.**

**American Association of Eye and Ear Hospitals**  
**American Hospital Association**  
**American Osteopathic Healthcare Association**  
**Association of American Medical Colleges**  
**Catholic Health Association**  
**Federation of American Health Systems**  
**InterHealth**  
**National Association of Children's Hospitals**  
**National Association of Public Hospitals and Health Systems**  
**Premier**

*John D. Deardourff*  
**Guarantees  
For the  
Children**

For 18 months numerous members of Congress have been pushing legislation that would all but eliminate crucial federal safety net programs for poor children and turn them into block grants to the states. More recently, they were joined by the Republican-dominated National Governors' Association. Programs such as Medicaid, foster care, Aid to Families with Dependent Children and child nutrition would be stripped of most of the rules that now ensure at least minimal help to hungry, poor, sick, abused or neglected children, regardless of where they happen to live. In place of these guarantees, states would be given reduced federal funds and broad new flexibility—in some cases nearly total flexibility—to operate the programs as they see fit.

Enactment of these proposals in their present form would almost certainly mean grave, irreparable harm to millions of America's most defenseless children. Having just participated in an extensive 18-month study of how state capitols work and how to protect children in the state legislative process, I have personally concluded that some basic national guarantees are essential. Without them, children will be the certain losers when state governments divide up a shrinking pot of federal funds.

This is not to say that states and local governments should not have considerably more flexibility in running these programs. They should. And I am not suggesting that most governors and state legislators don't care about poor children or families in their states. Most do care. But I also know that politics is politics, and when the horse-trading starts in state capitols, poor children are often left far behind.

To take just two examples, 36 states have underfunded child-care help for poor working families so badly that they have substantial waiting lists of children needing such help. And no state currently comes anywhere close to providing enough money to fund Head Start programs for each child who meets the eligibility requirements.

It is a cliché by now that children don't vote or make campaign contributions. But that cliché rests on the powerful truth that children in fact do not have any direct access to the levers of political power. And their political powerlessness is exacerbated by the fiscal incentives, built into many of these block grant plans, to slash benefits for children. In the National Governors' Association Medicaid plan, for example, children are singled out among various populations for a funding cap that will force many states to toss more and more children out of the Medicaid program. More than 4 million children—most of them from poor working families—could lose their guaranteed Medicaid health care coverage.

Gary Stangler, director of the Missouri Department of Social Services, has predicted that children and pregnant women will bear the brunt of funding cuts in the absence of some basic national guarantees. "That's where we'd have to go," he says, explaining that the greater political clout of the disabled and elderly would make it politically impossible for his state to cut eligibility or benefits for those large groups.

The multi-year study of how children fare in state capitols in which I participated was undertaken by the State Legislative Leaders Foundation. That study had its origin in trying to figure out why state budget cuts in the 1991 recession had their most damaging effect on children and families. As part of the study, my colleagues and I conducted lengthy personal interviews with 177 state legislative leaders, from both parties, in all 50 states. We also interviewed 167 state-based child advocacy organizations in every part of the country.

We learned that while there are dedicated people working hard for children in many state capitols, in state after state, these children's advocates are outgunned by richer and more powerful interests, whether homebuilders, truckers, nursing home operators, trial lawyers, veterans or the elderly. Children's advocates typically have far less staff, money, visibility—and effectiveness. In most states they have little or no access to the top legislative decision-makers.

A legislative leader from a large mid-western state put it to me bluntly: "Hell, funeral home directors have more clout in our state than child advocates." The speaker of the house in a large eastern state was even more explicit, "If we have \$20 million and the choice is between spending it for senior citizens or poor kids, it's no contest. The seniors get the money every time."

The reality is that in all but a handful of the largest states, state legislatures operate part-time, with very limited staff help. Lobbyists play a huge role in what goes on, and that role is growing with the advent of term limits. In the absence of federal safety net guarantees, the powerful special interests that can afford full-time lobbyists and who provide money and manpower to political campaigns will, inevitably get far more than vulnerable children when public resources are allocated.

Nobody who really knows the politics of most state capitols can seriously doubt what block grants would mean: a massive hemorrhage of protections and funds from children's and families' health care, child care, nutrition, income help and protective services.

This is a tragedy that is close to inevitable unless the governors and Congress rethink these block grants and find constructive ways to give states greater flexibility without sacrificing basic guarantees for our most vulnerable families and children.

*The writer is a Republican political consultant.*

*Revised May 24, 1996*

**FEDERAL CAPS AND STATE MATCHING REQUIREMENTS  
UNDER THE NEW REPUBLICAN MEDICAID PROPOSAL**

by Richard Kogan

This paper addresses one aspect of the new Republican Medicaid proposal — the combined effect of capping federal Medicaid payments and reducing state “matching” requirements. It finds that total Medicaid funding could fall below CBO projections of Medicaid funding levels under current law by as much as \$250 billion over six years, with at least 70 percent of this potential reduction reflecting cuts in *state* Medicaid funding.

Over 10 years, total Medicaid funding could fall as much as \$690 billion below projected levels, with \$425 billion reflecting reductions in state funding.

*Current Matching Requirements*

Under current law, Medicaid is funded jointly by the federal and state governments. The federal government pays each state a fixed percentage of its total Medicaid costs, and the state pays the rest. The federal percentage is called the Federal Medical Assistance Percentage, or FMAP.

The FMAPs are based on state per-capita income; the poorer a state, the higher the federal share of Medicaid costs and the lower the state share. State shares of Medicaid costs range from 21 percent in the poorest state (Mississippi) to 50 percent in the twelve states with the highest per-capita income. On average, states pay 43 percent of Medicaid costs.

Currently, if Medicaid costs rise in a state for any reason — for example, if more people enroll in Medicaid or health care providers raise the fees they charge — the federal government pays its share (at least 50 percent) of the additional costs. Similarly, if states reduce Medicaid expenditures, the federal government receives at least 50 percent of the resulting savings.

*The New Republican Proposal*

The new Republican Medicaid bill would change current law in three fundamental ways.

- The proposal would set a ceiling or “cap” on federal Medicaid payments for each state. Once federal payments reached the ceiling, the federal

government would cease providing funds, and a state would bear in full any additional costs incurred. Since the federal cap would be set below what federal Medicaid expenditures would be under current law, the amount of matching funds a state would have to put up to secure its maximum allotment of federal funding would be *less* than the amount of matching funds the state would be expected to contribute under current law. As a consequence, states could reduce anticipated state contributions for Medicaid without such action affecting the amount of federal funds they would receive.

- In addition, the bill would reduce state matching percentages for 37 states. The 25 states that currently pay more than 40 percent of Medicaid costs would now have to pay no more than 40 percent of such costs. Twelve states that currently pay less than 40 percent of Medicaid costs also would have their matching percentages reduced.

A state that currently has a 50 percent matching rate — and thus must provide \$1 in state funds for each federal Medicaid dollar it receives — would now have a 40 percent rate and be required to provide just 67 cents in state funds for each \$1 in federal funds received. To put this another way, if a state has a 40 percent matching requirement, it would need to provide only \$2 in state funds for every \$3 in federal funds it received. Under a 50 percent matching requirement, the state must put up \$3 in state funds for each \$3 in federal funds received.

A state whose matching percentage is reduced from 50 percent to 40 percent thus could reduce its state contribution by *one-third* without such action having any effect on the level of federal funding it secures.

- Finally, the bill would make legal the sham financing schemes that some states used in past years to secure federal Medicaid funds without actually providing state matching funds. These schemes were outlawed by federal legislation enacted during the Bush Administration.

These dubious financing measures include schemes under which a state could, for example, collect \$100 million from hospitals through a “provider tax,” return the \$100 million to the hospitals as Medicaid “disproportionate share hospital” payments, and use the \$100 million in payments to hospitals to secure \$60 million in federal matching funds and satisfy \$40 million of the state’s matching requirement. Making such financing schemes legal again would enable states to *appear* to meet state matching requirements without really spending state money on Medicaid benefits.

### *How Much Might Total Medicaid Funding Be Reduced?*

The new bill is designed to achieve \$72 billion in federal Medicaid savings over the next six years. On this basis, it is possible to calculate the amount of federal, state, and total reductions in Medicaid funding that could occur under the bill. If each state contributed the amount needed to draw down its full federal payment, but no more than that, the results would be as follows:

- Over the next six years, states would be able to cut their own Medicaid funding \$178 billion. Under this scenario, the total federal and state six-year cut would be \$250 billion. The cut would grow each year, reaching 24 percent in 2002. States would be able to reduce state funding more than twice as much as federal funding would be cut.
- It also is possible to examine the effect of the bill over 10 years. The Congressional Budget Office has published projections of Medicaid spending over the next 10 years, and the new bill includes a formula for determining federal Medicaid payments in years after 2002.

Over the 10 years from fiscal year 1997 through fiscal year 2006, federal Medicaid funding would be reduced \$265 billion below projected levels. In addition, states would be able to reduce state matching contributions by \$426 billion without that reduction affecting the level of federal Medicaid funding they would receive. Total federal and state reductions thus could reach \$691 billion over 10 years. The potential reduction in overall Medicaid funding would reach 32 percent in 2006, relative to current expenditure projections. (See Tables 1 and 2; also see box on page 6 for a discussion of Senator William Roth's comments on this analysis.)

**Table 1**

<b>Potential Effect of Reducing State Matching Requirement</b> (Reductions from CBO's baseline, in billions of dollars)		
	<b>6 Years</b> <b><u>1997-2002</u></b>	<b>10 Years</b> <b><u>1997-2006</u></b>
Federal Reduction	-72	-265
State Reduction	(-178)	(-426)
• because of federal cuts	-56	-203
• because of reduced matching requirement	-122	-223
<b>Total Reduction</b>	<b>-250</b>	<b>-691</b>

***Using Sham Financing Schemes to Produce State Matching Funds***

In one sense, Table 1 presents a worst-case scenario, since it assumes no states contribute unmatched dollars to Medicaid. On the other hand, reductions in Medicaid resources could be even deeper than the table shows if some states use sham financing schemes to meet a portion of their matching requirements. The new Republican plan would repeal all legal bars to the use of such financing schemes.

In the past, some states used creative financing schemes to make payments that they could call "Medicaid contributions" but that really were not. For example, a state might impose a special "tax" on a health care providers and then rebate to that provider the amount collected from it. The provider and the state would be in the same financial position as if this back-and-forth transfer had never occurred, and no additional medical services would be provided as a result of the transfer. But the state could call the rebate a "Medicaid expenditure" and claim federal matching funds for it. (See box on next page.) Congress largely banned such sham transactions in the early 1990s. The Republican proposal would make them legal again.

**Table 2**

<b>Depth of Reductions in Republican Medicaid Bill</b>		
	<b>Percentage Reduction 1997-2006</b>	<b>Percentage Reduction in 2006</b>
<b>Federal</b>	-16%	-26%
<b>State</b>	-34%	-41%
<b>Total</b>	-24%	-32%

### **Examples of How Special Medicaid Financing Methods Can Allow States to Draw down Federal Dollars Without Spending State Funds**

The following example illustrates how some sham financing schemes worked in the past.

Assume a state imposes a provider tax that is paid by hospitals and that raises \$40 million dollars. The state then pays back to the hospitals that are subject to the tax \$50 million in disproportionate share hospital ("DSH") payments. (These payments are supposed to provide additional funds to hospitals that serve a disproportionately high number of Medicaid and low-income uninsured patients.) If the state's federal Medicaid match rate is 50 percent, it can claim \$25 million in federal Medicaid funds based on the \$50 million in DSH payments made to the hospitals.

The result: the hospitals gain \$10 million (\$50 million in DSH payments less the \$40 million in provider taxes); the state gains \$15 million (\$25 million in federal matching funds plus \$40 million in provider taxes minus \$50 million in DSH payments); and the federal government pays \$25 million without any net state funds having actually been expended.

Michigan's practices are instructive. Michigan is not the only or most egregious example of a state that has used such financing methods. It is selected for illustrative purposes because this example was documented by GAO and is straightforward.

In fiscal year 1993, Michigan raised \$452 million through hospital donations and then paid the hospitals \$458 million in disproportionate share (DSH) payments. Based on these payments, Michigan claimed \$256 million in federal matching funds. The net effect of these transactions is as follows: the hospitals gained \$6 million (\$458 million in DSH funds less \$452 million in provider donations); the state gained \$250 million (\$256 million in federal matching funds less \$6 million in net payments to the hospitals); and the federal government paid \$256 million in federal matching funds without any net state funds having been expended.

When provider donations were limited by Congress through legislation enacted in 1991 that became effective on January 1, 1993, this loophole was closed. Michigan responded by relying on intergovernmental transfers and changing its criteria for deciding which hospitals would qualify for DSH payments, a determination that prior law left almost entirely to state discretion. In October 1993, Michigan paid \$489 million to the one hospital that met its new DSH definition — the state-owned University of Michigan hospital. The state claimed \$276 million in federal matching funds for this payment, but the public hospital returned the full \$489 million payment to the state through an intergovernmental transfer the very same day the payment was made. Through this one transaction, Michigan realized a net gain of \$276 million in federal Medicaid payments, again without expending any state funds. This practice also is now limited through provisions enacted in 1993 that took effect in July 1994.

Source: GAO, *States Use Illusory Approaches to Shift Program Costs to Federal Government*, August 1994.

## Comments on the Center's Analysis by Chairman William Roth

In commenting on an earlier version of this paper, Senator William Roth, Chairman of the Senate Finance Committee, stated on May 24:

"First, the facts: ... the states will increase their own spending on Medicaid by at least 35% over the next six years ... total Medicaid spending (federal and state) will increase by nearly 40%, with an annual average increase of at least 6%. Under our legislation, total Medicaid spending will exceed \$1.3 trillion between 1996 and 2002. ... [The governors] can expand health insurance coverage for more low income working families even while slowing the rate of growth..."

The Center and Chairman Roth *agree* that total Medicaid spending will "exceed \$1.3 trillion between 1996 and 2002." (The Center's estimate, if all states spend only the amount needed to match their federal grants, is \$1.333 over that seven-year period.) This means that Chairman Roth's \$1.3 trillion estimate is *consistent* with the Center's calculations that total Medicaid spending could fall below CBO's baseline projection by \$250 billion over six years and \$691 billion over ten years. Chairman Roth's dollar estimate verifies, rather than contradicts, the Center's calculations.

However, Chairman Roth's calculations are internally inconsistent in another respect. Specifically, \$1.3 trillion in spending implies a total growth rate of 33 percent, not the 40 percent Chairman Roth uses, and an average annual growth rate of 4.9 percent, not 6 percent. (Moreover, if CBO's 1996 estimate of total Medicaid spending — \$168 billion — were increased by exactly 6 percent per year, total Medicaid spending over the seven-year period 1996-2002 would equal \$1.410 trillion, not the \$1.3 trillion that both the Chairman and the Center use.) In other words, Chairman Roth's growth rates contradict his estimate of total spending and imply about \$100 billion *less* in Medicaid reductions than either he or the Center actually estimate.

What is the meaning of these spending estimates? CBO estimates the number of Medicaid beneficiaries will grow at 2.6 percent per year and that general inflation will also be 2.6 percent per year; hence, Medicaid costs could be expected to rise by 5.3 percent per year *just to provide existing health services for expected Medicaid beneficiaries*. This means a growth rate of 4.9 percent per year — as under the proposed bill — would force cutbacks. It would not cover an expansion of Medicaid to low-income working families, of which Chairman Roth spoke. Nor would it cover the increased costs of medical care that results from improvements in medical technology.

For decades, improvements in medical technology, techniques, and drugs have greatly improved the quality of medical care and the life span and health of Americans, but at a real increase in costs. CBO assumes these trends will continue.

To put the matter most simply, under the new Republican bill, total Medicaid spending per beneficiary, after adjusting for general inflation, would be *lower* in 2002 than it is in 1996. This belies the picture of ever-expanding benefits implied by Chairman Roth's comments.

It also should be noted that reductions in cost from efficiencies in the delivery of medical services — such as increased use of managed care — while real, are not expected to be large enough to offset the Medicaid funding reductions under the bill. As a result, reductions in Medicaid coverage and benefits would be a likely result. The Urban Institute estimated last year that between four and nine million beneficiaries could lose coverage, based on a package of Medicaid reductions only one-fifth larger than the reductions that could occur under the new bill.

John D. Deardourff

# Guarantees For the Children

For 18 months numerous members of Congress have been pushing legislation that would all but eliminate crucial federal safety net programs for poor children and turn them into block grants to the states. More recently, they were joined by the Republican-dominated National Governors' Association. Programs such as Medicaid, foster care, Aid to Families with Dependent Children and child nutrition would be stripped of most of the rules that now ensure at least minimal help to hungry, poor, sick, abused or neglected children, regardless of where they happen to live. In place of these guarantees, states would be given reduced federal funds and broad new flexibility—in some cases nearly total flexibility—to operate the programs as they see fit.

Enactment of these proposals in their present form would almost certainly mean grave, irreparable harm to millions of America's most defenseless children. Having just participated in an extensive 18-month study of how state capitols work and how to protect children in the state legislative process, I have personally concluded that some basic national guarantees are essential. Without them, children will be the certain losers when state governments divide up a shrinking pot of federal funds.

This is not to say that states and local governments should not have considerably more flexibility in running these programs. They should. And I am not suggesting that most governors and state legislators don't care about poor children or families in their states. Most do care. But I also know that politics is politics, and when the horse-trading starts in state capitols, poor children are often left far behind.

have underfunded child-care help for poor working families so badly that they have substantial waiting lists of children needing such help. And no state currently comes anywhere close to providing enough money to fund Head Start programs for each child who meets the eligibility requirements.

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states to toss more and more children out of the Medicaid program. More than 4 million children—most of them from poor working families—could lose their guaranteed Medicaid health care coverage.

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The multi-year study of how children fare in state capitols in which I participated was undertaken by the State Legislative Leaders Foundation. That study had its origin in trying to figure out why state budget cuts in the 1991 recession had their most damaging effect on children and families. As part of the study, my colleagues and I conducted lengthy personal interviews with 177 state legislative leaders, from both parties, in all 50 states. We also interviewed 167 state-based child advocacy organizations in every part of the country.

cated people working hard for children in many state capitols, in state after state these children's advocates are outgunned by richer and more powerful interests, whether homebuilders, truckers, nursing home operators, trial lawyers, veterans or the elderly. Children's advocates typically have far less staff, money, visibility—and effectiveness. In most states they have little or no access to the top legislative decision-makers.

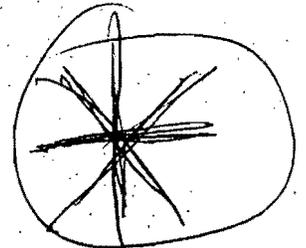
A legislative leader from a large mid-western state put it to me bluntly: "Hell, funeral home directors have more clout in our state than child advocates." The speaker of the house in a large eastern state was even more explicit, "If we have \$20 million and the choice is between spending it for senior citizens or poor kids, it's no contest. The seniors get the money every time."

The reality is that in all but a handful of the largest states, state legislatures operate part-time, with very limited staff help. Lobbyists play a huge role in what goes on, and that role is growing with the advent of term limits. In the absence of federal safety net guarantees, the powerful special interests that can afford full-time lobbyists and who provide money and manpower to political campaigns will inevitably get far more than vulnerable children when public resources are allocated.

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This is a tragedy that is close to inevitable unless the governors and Congress rethink these block grants and find constructive ways to give states greater flexibility without sacrificing basic guarantees for our most vulnerable families and children.

The writer is a Republican political consultant.



THE WASHINGTON POST

SUNDAY, JUNE 9, 1996

# Congress of the United States

Washington, DC 20515

June 13, 1996

The Honorable Newt Gingrich  
Speaker of the House  
U.S. House of Representatives  
The Capitol  
Washington, DC 20515

The Honorable Trent Lott  
Senate Majority Leader  
United States Senate  
The Capitol  
Washington, DC 20510

Dear Speaker Gingrich and Majority Leader Lott:

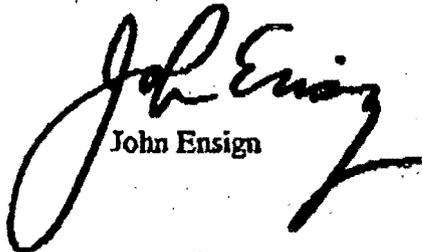
As the House begins to move forward in our promise to balance the federal budget and contain the escalating costs of entitlement programs, we strongly believe it is in the best interest of the American people to send the Welfare Reform bill to the President separate from any other legislation, including Medicaid reform.

Republicans and Democrats, governors and legislators have overwhelmingly agreed on the immediate need to pass welfare reform into law so that people can begin to lift themselves out of a cycle of perpetual dependency and into the workforce. This reform is critical to saving the children being raised in the welfare state and to bringing relief to hard-working Americans whose tax dollars fund this dependency.

Welfare Reform is just too important to risk defeat due to its connection with other legislation that may not be as overwhelmingly supported. For those who do not support real Welfare Reform, there should be nowhere to run to and nowhere to hide.

We stand ready to work with you to ensure that the President is given the chance to sign or veto a separate Welfare Reform bill.

Sincerely,

  
John Ensign

  
Dave Camp

American Hospital Association



FOR YOUR INFORMATION

FROM  
RICK POLLACK

Liberty Place  
Washington Office  
325 Seventh Street, N.W.  
Suite 700  
Washington, DC 20004-2802  
202-638-1100

## **MEDIA ADVISORY**

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Carol Schadelbauer 202/626-2342

June 12, 1996

### **24 HEALTH CARE GROUPS RAISE CAUTIONS ON MEDICAID**

**Twenty-four health care groups today urged the House Commerce Committee and the Senate Finance Committee to remember the vital role Medicaid plays for "35 million of our most vulnerable citizens."**

In a letter to members of the two committees, the organizations reaffirm their support for "reforms to the Medicaid program that preserve its original mission to provide medical assistance to needy, low-income individuals and families." Budget savings "should not come at the expense of eliminating our longstanding national commitment to a federal health care entitlement for all categories of vulnerable Americans covered under the Medicaid program," the letter continues.

A copy of the letter is attached.

Also attached is a separate letter sent today to the House Commerce Committee by eight hospital groups supporting a Medicaid amendment to be offered by Rep. Frank Pallone (D-NJ). The amendment seeks to continue guaranteed access to Medicaid services by "ensuring that providers are given adequate resources to meet requirements imposed by federal and state governments."

**American Academy of Pediatrics**  
**American Association of Eye and Ear Hospitals**  
**American College of Physicians**  
**American College of Emergency Physicians**  
**American Health Care Association**  
**American Hospital Association**  
**American Nurses Association**  
**American Occupational Therapy Association**  
**American Osteopathic Healthcare Association**  
**American Pediatric Surgical Association**  
**American Pharmaceutical Association**  
**American Physical Therapy Association**  
**American Rehabilitation Association**  
**Association of American Medical Colleges**  
**Catholic Health Association**  
**Federation of American Health Systems**  
**Health Industry Purchasing Association**  
**InterHealth**  
**National Association of Public Hospitals and Health Systems**  
**National Association of Children's Hospitals**  
**National Association of Counties**  
**Premier, Inc.**  
**VHA Inc.**  
**Volunteer Trustees of Not-For-Profit Hospitals**

June 12, 1996

The Honorable Thomas J. Bliley Jr.  
U.S. House of Representatives  
2241 Rayburn House Office Building  
Washington DC 20515

Dear Chairman Bliley:

As the House Commerce Committee and the Senate Finance Committee consider legislation to restructure the Medicaid program, we want to call to mind the critical role Medicaid plays in caring for more than 35 million of our most vulnerable citizens, including the elderly, people with disabilities, pregnant women, and children.

The Honorable Thomas J. Bliley Jr.

June 12, 1996

Page 2

As health care organizations representing hospitals, outpatient facilities, physicians, nurses, pharmacists, rehabilitation specialists, occupational therapists, pharmaceutical group purchasing organizations, and county supported facilities and providers, we support reforms to the Medicaid program that preserve its original mission to provide medical assistance to needy, low-income individuals and families.

Federal budget savings should not come at the expense of eliminating our longstanding national commitment to a federal health care entitlement for all categories of vulnerable Americans covered under the Medicaid program. As health care organizations, we have many varied concerns with the Medicaid Restructuring Act of 1996, H.R. 3507/S. 1795. But we wish to highlight three key principles that serve as the basis of our opposition to HR. 3507 and S. 1795:

**Preservation of the Medicaid Entitlement.** The federally enforced entitlement to a set of meaningful benefits must be maintained.

**Continued State Financial Responsibility for Medicaid.** The states' long-standing financial partnership in funding the Medicaid program must be maintained. States should not be allowed to lower their maximum state financial contribution. In addition, states should not be permitted to shift their financing responsibility to other payers such as providers through providers taxes or local municipalities through intergovernmental transfers.

**Assure a Financial Environment in which Providers can Continue to Serve Medicaid Patients.** Current Medicaid law provider payment safeguards that assure access to quality services through adequate payment must be maintained. H.R. 3507 and S. 1795 not only repeal these protections, but limit a provider's due process rights by prohibiting private rights of action in both federal and state court.

We are committed to efforts to restore the nation's fiscal strength and we acknowledge that states should be granted the appropriate flexibility to enable them to better administer the Medicaid program. But as health care leaders, we urge you to approach this task with care and compassion. A viable Medicaid program is important to communities and the country because it is available to help our most vulnerable citizens in their time of need.

Sincerely,  
The Above Listed Organizations

June 12, 1996

The Honorable Thomas J. Bliley Jr.  
U.S. House of Representatives  
2241 Rayburn House Office Building  
Washington DC 20515

Dear Chairman Bliley:

On behalf of the undersigned health care provider organizations, we are writing to ask you to support an amendment during mark-up of the Commerce Committee's proposed Medicaid reconciliation legislation. The amendment, which will be offered by Congressman Frank Pallone (D-NJ), seeks to continue guaranteed access to services for Medicaid recipients by ensuring that providers are given adequate resources to meet requirements imposed by federal and state government.

The Pallone amendment proposes the establishment of a Medicaid rate setting process which allows for public review and comment on the proposed rates paid to providers. It also requires independent review of these rates for actuarial soundness. And finally, the amendment would permit rates -- whose adequacy is disputed as being insufficient to meet federal and state requirements -- to be resolved through the judicial process.

The Pallone amendment is fair -- it calls for public participation. The Pallone amendment is prudent -- it calls for independent review. The Pallone amendment is equitable -- it allows for judicial review of a contested payment standard which ensures access to health care services for underserved populations.

Please support the Pallone Amendment and vote for an open, fair, and equitable process.

Sincerely,

American Association of Eye and Ear Hospitals  
American Health Care Association  
American Hospital Association  
Association of American Medical Colleges  
InterHealth  
National Association of Public Hospitals and Health Systems  
Premier, Inc.  
VHA Inc.



# CENTER ON BUDGET AND POLICY PRIORITIES

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Revised June 11, 1996

## **"Umbrella Payments" Under The Medicaid Restructuring Act of 1996**

by Richard Kogan

The new Republican Medicaid proposal, the Medicaid Restructuring Act of 1996, would replace the current Medicaid program with federal block grant payments to states. States also could receive "umbrella payments" to protect them from "unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters."<sup>1</sup>

The idea behind "umbrella payments," as conceived by the governors last winter, is that if a state's Medicaid caseload exceeded expectations for any reason, umbrella payments would cover the federal government's share of the extra Medicaid costs. When the National Governors Association approved a Medicaid outline that included an umbrella payment mechanism in February, governors said it would assure that "federal dollars would follow beneficiaries."

The Medicaid Restructuring Act, however, falls far short of this goal. The umbrella mechanism in the bill is *not* what the governors recommended in February. Under the bill's umbrella provisions, state access to the umbrella fund would be largely unrelated to greater-than-expected caseloads. As a result, the distribution of umbrella payments among states would be highly inequitable, and many states would be denied umbrella payments in all but the most extreme cases.

In addition, the umbrella payments would cover *only the first-year cost* of extra caseload, not the continuing cost in years after that. As a result, even states that *did* have access to umbrella payments would generally be indemnified for only a small fraction of the cost of serving a greater-than-expected caseload. States would be left holding the bag for most of the costs that would result if their Medicaid caseloads climbed, which is precisely the result the governors sought to avoid.

Finally, there would be virtually no adjustments in block grant payments to compensate for the inadequacy of the umbrella mechanism.

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<sup>1</sup> The quote comes from the bill's Statement of Goals, Section 2002(b)(4).

## I. Access to Umbrella Payments Largely Unrelated to Extra Caseload

The bill's proponents describe its umbrella payment mechanism as protecting states against unanticipated caseload growth. Such descriptions, however, are not accurate. One key reason that the bill's umbrella mechanism does not provide such protection is that access to the umbrella fund would be largely unrelated to whether a state's caseload rose beyond projected levels. Instead, those states whose average Medicaid costs per beneficiary are currently high would have easy access to the umbrella fund, while states that now have low average costs per beneficiary would have little or no access to the fund.

In theory, a state would receive umbrella payments to cover the federal costs of extra caseload. Extra caseload is defined in the bill as reflecting the degree to which a state's actual caseload exceeds its anticipated caseload for a given fiscal year. That sounds like how an umbrella mechanism ought to work.

But there is a catch. The legislation has a very peculiar definition of "anticipated caseload." A state's "anticipated caseload" for a year is defined as (1) its actual caseload in the prior year, increased by (2) the growth rate between the prior year and the current year in the amount of federal block-grant funds the state receives, adjusted for inflation. This means the rate of growth in each state's federal block-grant funding level is the pivotal factor that determines whether the state has access to umbrella payments.

For example, under the legislation, Georgia's block grant funding would grow five percent between 2001 and 2002. If inflation in 2002 is three percent, as the Congressional Budget Office forecasts, the *adjusted* growth rate for Georgia's block grant funding level is two percent. To determine whether Georgia would qualify for umbrella payments, Georgia's actual caseload level in 2001 would be increased by two percent, since that is Georgia's adjusted block-grant growth rate. This yields an "anticipated" caseload for the state in 2002 that equals its caseload in 2001 plus two percent. If Georgia's *actual* caseload in 2002 proved greater than this "anticipated" caseload, Georgia would receive an amount from the federal government as an umbrella payment for each extra beneficiary.

This formula for determining whether a state can receive umbrella funds produces strange effects. Under the bill, the block-grant funding levels for states that now have high average Medicaid costs per beneficiary would generally grow slowly from year to year. By contrast, the block grant funding levels for states with below-average Medicaid costs per beneficiary would grow at a faster rate. This feature of the bill is designed to narrow modestly the cost differences between high-cost and low-cost states. This feature may also reflect recognition of the fact that some low-cost states

have already instituted certain efficiencies to control Medicaid cost growth that some high-cost states have yet to implement on a large scale. These high-cost states thus can reap future savings to slow the rate at which their Medicaid costs grow, while low-cost states that already have these savings in their "base" do not have similar opportunities to slow the rate at which their Medicaid costs climb.

Varying block grant growth rates in this manner, so that low-cost states are allowed to grow somewhat faster than high-cost states, seems reasonable enough. But the umbrella mechanism would undercut this feature of the bill and also render the distribution of umbrella funds among states highly inequitable. Under the bill's umbrella mechanism, states whose block-grant funding levels would grow slowly from year to year — that is, the high-cost states — would have ready access to the umbrella fund even if their caseloads grew very little. At the same time, states whose block-grant funding levels would grow more rapidly — i.e., states with low costs per beneficiary — would have little ability to get umbrella payments unless their caseloads grew unusually swiftly. Here is why this would occur.

- Suppose the block-grant funding level for a state with low average costs per beneficiary is scheduled to rise seven percent per year. If inflation remains at three percent per year as CBO forecasts, the state's *adjusted* block grant growth rate would be four percent. The state would get umbrella payments only if — and only to the extent that — its caseload rose more than four percent per year.

Low-cost states such as California, Texas, Florida, and Virginia would be in this situation. According to Urban Institute forecasts, Medicaid caseload is projected to grow noticeably more slowly than that in each of these states.<sup>2</sup> For these states and others in the same position, caseloads would have to grow considerably faster than projected before the states could receive a dollar in umbrella payments.

- By contrast, the block grant funding level for some high-cost states would, after the first few years, increase less than three percent per year. If the inflation rate is three percent as forecast, the adjusted block-grant growth rate for these states would be *zero* (since the rate of inflation would exceed the rate of growth in the block-grant funding level for these states).<sup>3</sup> As a

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<sup>2</sup> Forecast developed by David Liska and John Holahan of the Urban Institute.

<sup>3</sup> The adjusted growth rate — the block-grant growth rate adjusted for inflation, which serves as the "umbrella threshold" — is not allowed to be smaller than zero. For high-cost states whose block-grant funding level grows more slowly than inflation, the umbrella threshold is zero by definition. For these

(continued...)

result, these states would get umbrella payments for *any* increase in caseload. States such as Massachusetts, Connecticut, New York, and New Jersey would be in this situation by 1998.

In summary, some states would receive umbrella payments for caseload growth that is already projected to occur, while other states would not receive umbrella payments even if caseload growth noticeably exceeded current projections.<sup>4</sup> This is inconsistent with the principles the governors adopted in February.

## II. The Umbrella Covers Only the First-Year Costs of Unanticipated Caseload

Even if the problem just described did not exist — and states received umbrella payments whenever their caseloads grew faster than some objective forecast of anticipated caseload growth — states still would not receive umbrella payments sufficient to cover the costs of higher-than-anticipated caseloads. The reason is that the bill's umbrella mechanism contains a second fundamental flaw — the umbrella payments would cover the cost of extra caseload *only in the first year*. Yet extra caseload usually lasts for a number of years, if not permanently.

This flaw stems from the fact that the amount of umbrella payments a state will receive depends on the state's annual caseload *growth rate*, rather than on its actual caseload *level*. A simple example illustrates the point.

- Suppose a recession sets in during 1997. A state's Medicaid caseload might consequently be four percent higher than would otherwise be the case in 1997, in 1998, and in 1999 (if not longer). Medicaid participation responds to changes in the unemployment rate, and recessions generally

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<sup>3</sup> (...continued)

states, the "anticipated caseload" for any year simply equals the state's actual caseload in the prior year.

<sup>4</sup> Extra caseload, and the attendant umbrella payments, would be calculated separately for each of eight groups of Medicaid beneficiaries: pregnant women, children, disabled persons, disabled-but-working persons, the elderly, two different sets of "qualified Medicare beneficiaries" (QMBs), and everyone else (basically AFDC adults). Dividing beneficiaries among groups creates data integrity problems but has two policy advantages. First, by making separate calculations for each group, umbrella payments can be pegged at appropriate levels — a state will receive higher umbrella payments on behalf of extra disabled beneficiaries (who tend to be quite expensive) than on behalf of extra child beneficiaries (who tend to be inexpensive). Second, because extra caseload in one group offsets caseload shortfalls in another group, the umbrella mechanism responds to unanticipated changes in case *mix* as well as in total caseload (although *net* umbrella payments cannot be negative). Unfortunately, for the reasons described in this paper, the umbrella fund responds inequitably and inadequately to unanticipated caseload growth.

cause higher unemployment for a number of years after the economy stops contracting.

- In 1997, the state's caseload growth rate would be higher than anticipated. Consequently, umbrella payments would cover the federal share of the extra Medicaid costs.
- But look ahead to 1998. The state's caseload *level* in 1998 would be four percent above caseload projections for that year because of the long-lasting effect of the recession. But the state's caseload *growth rate* from 1997 to 1998 would *not* be higher than anticipated. The extra growth would have occurred in 1997; in 1998, the caseload *level* would reflect the higher-than-anticipated level it reached the previous year, but the caseload would not still be growing at a faster-than-anticipated *rate*. Because the caseload growth rate in 1998 would not be higher than anticipated, however, the state would get no umbrella payments in 1998. The umbrella payment the state received in 1997 would end after 1997, even through the extra caseload added in 1997 would still be present. The same phenomenon would recur in 1999.

In short, the umbrella payments cover only the first year of extra caseload in a state even if the extra caseload lasts for many years.

A second example illustrates the extent to which umbrella payments could fall short of need. The table on the next page shows what would happen if the caseload in a particular state started at 100,000 and grew faster than expected by one percentage point per year for each of the six years from 1997 through 2002. In this example, the state's adjusted block-grant funding rate — which serves as the state's threshold for receiving umbrella funding — grows two percent per year (see line A in the table), but the state's actual caseload level grows three percent per year (as shown in line B).<sup>5</sup>

By 2002, the state's actual caseload would be 6,800 higher than what the block grant and the umbrella fund would cover (see line C). The umbrella payments however, would not cover 6,800 extra beneficiaries in 2002; these payments would cover only 1,200 additional beneficiaries (see line E).

The umbrella payments thus would be insufficient. They would cover only a fraction of the amount by which the state's actual caseload exceeded the caseload level

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<sup>5</sup> In this case, we are assuming that two percent per year is in fact a reasonable, objective forecast of expected caseload growth, and that the actual growth rate of three percent per year represents one percent per year of unanticipated caseload growth.

<b>The Umbrella Does Not Provide Full Protection</b> (Hypothetical example: caseload in thousands)							
<b>Caseload</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>
A) Caseload growth assumed in the state's block grant funding level (2% per year in this example)	100.0	102.0	104.0	106.1	108.2	110.4	112.6
B) Actual Caseload growth of 3% per year	100.0	103.0	106.1	109.3	112.6	115.9	119.3
C) Caseload for which umbrella funding is needed (B minus A)		1.0	2.0	3.2	4.3	5.5	6.8
D) Caseload level above which umbrella payments actually are provided (prior year's actual caseload + 2%)		102.0	105.1	108.2	111.5	114.8	118.2
E) Actual Umbrella payments (B minus D)		1.0	1.0	1.1	1.1	1.1	1.2

\*Figures may not add due to rounding.

assumed in the state's block grant. Put differently, extra caseload that lasts more than one year does *not* trigger umbrella funding for a state for any year after the first year. In still other words, if extra caseload is permanent, it will have a cumulative effect, with each year's extra caseload added to the prior years' extra caseload. But the umbrella mechanism does not cover that cumulative effect.

It should also be noted that the size of a state's basic block grant will *not* adjust in subsequent years to compensate for the temporary nature of the umbrella mechanism. See Appendix A.

This flaw in the design of the umbrella fund has significant policy implications. To cite one, it would make the option of phasing in Medicaid coverage for poor children aged 13 through 18 unattractive to states. Under current law, states are required to raise the age at which poor children are eligible for Medicaid one year at a time, until by 2002 all poor children through age 18 are eligible. The Medicaid Restructuring Act repeals this requirement, permitting states to choose whether to make such children eligible. If it had been designed properly, states could use the

umbrella mechanism cover the costs of insuring these poor children. In practice, this approach would not work. As just explained, the umbrella mechanism would provide temporary funding for what, in this case, would be a permanent caseload increase.

By 2002, states electing to phase in Medicaid coverage for these children would have enrolled six additional age groups of children: first 13-year-olds, then 14-year-olds, etc. But in any given year, these states would receive umbrella payments on behalf of only *one* additional age group, the group being newly enrolled. In 2002, such states would receive umbrella payments on behalf of their newly enrolled 18-year-olds. But they would not receive umbrella payments on behalf of poor children aged 13 through 17 because those caseload increases would have occurred in prior years.

### **Other Problems with the Umbrella Fund**

The design of the umbrella fund in the new legislation also is flawed in other respects.

- **States would receive inadequate payments for Qualified Medicare Beneficiaries ("QMBs").** Under current law, *Medicaid* pays the cost of *Medicare* premiums, copayments, and deductibles incurred by Medicare beneficiaries who are poor or near-poor. The Medicaid Restructuring Act repeals this requirement, making continuation of this coverage a state option. If a state attempted to continue providing QMB benefits consistent with current law, however, it would not receive adequate umbrella payments if the number of QMBs exceeded the anticipated level. Under the bill, the amount of umbrella payments provided for extra QMBs would be based solely on the cost of Medicare premiums for these individuals. Medicare copayments and deductibles would be ignored. Yet premiums contribute *less than 30 percent* of total QMB costs, according to the Congressional Budget Office.
- **People with disabilities might not be covered by the umbrella fund.** Under the governors' proposal, states would have been allowed to develop their own definitions of disability, and the umbrella fund would have protected states if the number of disabled enrollees exceeded expectations. The Medicaid Restructuring Act stipulates that states can choose either to use the SSI definition of disability or to develop their own disability definition. But a state using its own disability definition would be ineligible for umbrella payments on behalf of disabled people.

This restriction might encourage more states to use the SSI definition of disability. But in states that nevertheless chose to develop their own

definition, disabled individuals would be placed at a disadvantage. If the number of such beneficiaries exceeded the anticipated level, these states would not receive federal umbrella payments on their behalf.

## **Conclusion**

The umbrella payments would be of use to states with low average costs per beneficiary only if caseload growth or inflation exceeded current forecasts by large amounts. In addition, for *all* states — including high-cost states — any umbrella payments would cover only the first year of added costs, ignoring the continuation of such costs in subsequent years.

The umbrella funding mechanism in the Medicaid Restructuring Act is quite different from what the governors recommended. It does relatively little to protect states from increased costs over time that result from unanticipated growth in their Medicaid beneficiary populations.

## Appendix A

### Would the Block Grant Adjust to Cover Unexpected Caseload?

During hearings on the Medicaid Restructuring Act, Rep. Bilirakis contended that the basic block grant to each state would automatically adjust to cover the federal cost of unanticipated caseload after the first year, thus curing that defect in the umbrella mechanism. His contention is incorrect.

As noted in this analysis, if 10,000 "unanticipated" beneficiaries enroll in a state's Medicaid program in 1997, the state will receive umbrella payments on their behalf in 1997 but will have to pay the full costs of those 10,000 enrollees in 1998, 1999, and so on — unless they or 10,000 other enrollees unexpectedly drop out.

This aspect of the umbrella mechanism would not be a problem if federal block grant funding would automatically adjust to cover unanticipated caseload growth in the years *after* the growth first occurs. Automatic adjustments to the block grant *can* occur, because the number of a state's "residents in poverty" is part of the formula that determines the size of the state's block grant. But the likelihood that automatic adjustments to the state's block grant will cover the costs of unanticipated caseload is almost entirely an illusion for three reasons.

- First, the adjustment to the block grant is based on the number of residents in poverty, not on the number of enrollees. The two can be unrelated. For example, a state that chooses to phase in Medicaid coverage of poor children ages 13 through 18 will have increasing Medicaid enrollment, but may not have any increase in the number of residents in poverty. Another example is if employers drop coverage for their employees.
- Second, for 43 states and the District of Columbia, the formula for the block grant is either higher than the statutory "ceiling" on block-grant growth rates or lower than the statutory "floor." As a result, block grants for those states will grow at the rate of the ceiling or floor *regardless of any changes in the number of residents in poverty*. In short, for these 43 states the block grant won't change even if need does.
- Finally, for the remaining seven states, adjustments in the size of the block grant will usually be undercut by the bill's requirement that the total, national cost of all block grants must not exceed an *inflexible cap*. Suppose that a national recession increased the number of residents in poverty in all states by four percent. For the seven states with adjustable block grants, the formula would initially produce a higher block grant; but then

the block grant for each of the seven states would be cut across the board to prevent a breach in the national cap. In this case, the automatic adjustment would be completely offset by the across-the-board cut, so there would be no increase in the size of the block grants these states would receive.

Thus, a state could have its block grant adjusted upward *only* if a) it was one of the seven states not governed by the statutory floors or ceilings, and b) an increase in the number of residents in poverty in that state was offset by a decrease in the number of residents in poverty in one of the other seven states. And even in this very rare case, the adjustment might be inadequate: first, the adjustments are based on a three-year average of the number of residents in poverty, so they will not fully compensate for increases in poverty until several years have gone by. In addition, any such adjustment would be only partial if the state with more residents in poverty hit one of the statutory ceilings or the state with fewer residents in poverty hit one of the statutory floors.

In summary, for all states, block grant funding does not follow enrollees; it follows a formula. For all but seven states — representing 89 percent of Medicaid costs — that formula is immutable. For the remaining seven states, the formula will generally not respond at all to changes in poverty; if it does respond, the response will be late and probably inadequate.

As a result, states will receive umbrella payments to cover only the first year of unanticipated caseload increases, and only some states will receive those payments. There will not be compensating adjustments in block grant funding. This is not what the governors called for last February.

## Appendix B

### Adjusting for Inflation: A Solid Concept

To calculate a state's umbrella threshold — the growth rate above which umbrella payments are made — the state's block-grant growth rate is adjusted for inflation, as measured by *actual* percentage changes in the Consumer Price Index (CPI). Suppose a state's block-grant growth rate were five percent in 1998. If inflation were three percent, as CBO forecasts, the state would receive umbrella payments to the extent its caseload growth exceeded two percent. If inflation turns out to be four percent rather than three percent, the state would be protected. In this case, the state would receive umbrella payments to the extent its caseload growth exceeded one percent, rather than two percent. Higher inflation would mean a lower "umbrella threshold," which in turn would mean higher umbrella payments. Stated another way, higher-than-expected inflation means higher umbrella payments.

Using the umbrella mechanism to protect against higher inflation is desirable; it affords needed protection to states if CBO's inflation forecast proves to have been too low. Inflation protection of this type does not put the federal Treasury at risk; both CBO and OMB analyses show that higher inflation generally causes higher spending and higher revenues in almost equal amounts and hardly affects the deficit as a result.

At the same time, however, the umbrella mechanism fails to provide adequate protection against the permanent, cumulative costs of higher-than-expected inflation.<sup>6</sup> As a result, the protection it affords in this area is inadequate. And, as explained in Part I of this paper, states will not have equal access to umbrella payments to begin with. For example, states with low block-grant growth rates (generally the high-cost states) will have no protection against extra inflation because their umbrella threshold is already at the statutory minimum of zero.

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<sup>6</sup> The design flaw discussed in Part II of this paper vitiates the inflation protection the umbrella formula is supposed to provide if inflation is higher than forecast. As explained, umbrella payments would increase if the actual inflation rate exceeds inflation forecasts. But the umbrella payments would not take into account the cumulative effect of inflation. If inflation were one percent higher than anticipated for four years in a row, by the fourth year prices would exceed the initial forecast for that year by approximately four percent. Yet a state would receive an umbrella payment for that year covering one percent extra costs due to higher-than-anticipated inflation, not four percent. The preceding three years of extra inflation, which would permanently increase the cost of medical care, would be reflected neither in the state's umbrella payment nor in its block grant allocation.

June 25, 1996

TO: Distribution  
FROM: Chris Jennings

The attached was released today from the Republican Governors' Association. As you know, it will insist that Welfare Reform be linked to Medicaid -- no big surprise, but thought you might want to have this fyi.

Charlie Solen



REPUBLICAN GOVERNORS ASSOCIATION  
*NOW AMERICA'S MAJORITY*

June 25, 1996

The Honorable Trent Lott  
Senate Majority Leader  
S-230 U.S. Capitol  
Washington, D.C. 20510

The Honorable Newt Gingrich  
Speaker of the House  
H-232 U.S. Capitol  
Washington, D.C. 20515

Dear Mr. Leader and Mr. Speaker:

In February, the nation's governors unanimously agreed on a strategy to reform the federal cash welfare and Medicaid programs. This bipartisan reform plan is currently making its way through Congress.

We believe strongly that welfare cannot be reformed without addressing critical concerns regarding Medicaid. We are concerned, however, that legislation might move forward without provisions to fix an overly complicated Medicaid system that is failing the very families it is supposed to help.

There is no question that these two issues are inextricably linked and cannot be separated. In fact, continued rigidity in one program diminishes the value of flexibility in the other. Medicaid and cash welfare are mutually dependent, and failure to reform both will mean the failure to reform either. Neither the states nor the people we represent can afford to fail. Too many families are depending on us.

Think of these issues in another way. If you went to the doctor complaining of chest pains and a broken leg, you would expect the doctor to treat both problems. However, if the Congress only addresses welfare and not Medicaid, it would be like setting the broken leg and ignoring the heart problem.

For example, many families become dependent on welfare mainly because they need the health care coverage provided by Medicaid. At the same time, a barrier to leaving the welfare rolls is the prospect of losing Medicaid coverage. Under the current system, states are severely limited in their ability to address this Catch-22 that perpetuates dependence.

The Honorable Trent Lott  
The Honorable Newt Gingrich  
June 25, 1996  
Page 2

Reforming the Medicaid system means removing burdensome federal rules and giving more flexibility to the states to solve this problem and to design innovative ways to deliver services that reach more people. As a result, the states, the federal government and clients will be able to share the cost of providing Medicaid coverage to more working families. In addition, states will be able to run the program more efficiently and to choose the types of coverage that help people who need help the most.

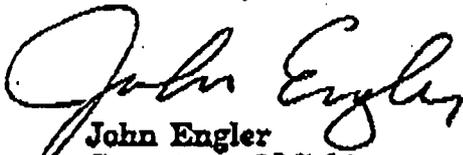
We believe that removing Medicaid from the reform package will lend credence to invalid criticisms of our plan. Contrary to the defenders of the status quo, the truth is that the Medicaid Restructuring Act protects vulnerable Americans by:

- guaranteeing eligibility for low income pregnant women, children, elderly and the disabled;
- providing a generous comprehensive medical benefit package;
- limiting premium and cost-sharing charges;
- retaining current law nursing home standards and recipient protections; and,
- increasing Medicaid spending substantially -- an increase of 35.5% over the next six years.

By wide margins, the American people support reforming the welfare system by requiring work and personal responsibility. If we don't include Medicaid in our reform plan now, public pressure to address this issue will fade, and an historic opportunity will be lost.

The bottom line is this: If our goal is independence for more strong, healthy families, Congress must reform both welfare and Medicaid.

Sincerely,

  
John Engler  
Governor of Michigan  
Chairman

  
Steve Merrill  
Governor of New Hampshire  
Vice Chairman

cc: Senator Roth  
Congressman Bliley  
Congressman Archer  
Congressman Shaw

JE/jn/lr.dc



DATE: 6-26-96

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**200 INDEPENDENCE AVE., SW**  
**WASHINGTON, D.C. 20201**

PHONE: (202) 690-7627 FAX: (202) 690-7380

**OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION**  
**ROOM 416-G HUMPHREY BUILDING**

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**REMARKS:**

*Chris Jennings - 456-5542*  
*Nancy Ann Min - 395-7289*  
*Bridgett Taylor - 225-5288*

*Part II*

*(None to follow)*

CHAIRMAN'S MODIFICATIONS TO S.1795

DIVISION B--RESTRUCTURING MEDICAID

<u>Page</u>	<u>Explanation of Change</u>
1044	Add provision which requires the Secretary, in consultation with the States, to establish, monitor and enforce minimum health, safety and welfare standards for ICFs/MR, including assurances that individuals receiving care in ICFs/MR are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel.
1044	Add current law restrictions on State or local officers or employees relating to conflict of interest (Section 1902 (a) (4) (C)).
1044	Add a provision requiring States to implement an ongoing program to measure, evaluate and improve quality of care in their Medicaid programs including independent external review of managed care organizations.
1046	Strike language in (12) and add: (12) (A) Acute inpatient mental health services, including services furnished in a State-operated mental hospital in the case of an adult. (12) (B) Inpatient mental health services, including services furnished in a State-operated mental hospital and residential or other 24-hour therapeutically planned structured services in the case of a child.
1046	Strike language in (13) and add: (13) Outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home services for children, and partial hospitalization.

CHAIRMAN'S MODIFICATIONS TO S.1795

DIVISION B--RESTRUCTURING MEDICAID

<u>Page</u>	<u>Explanation of Change</u>
1051	Clarify that the definition of EPSDT services has the meaning given the term early and periodic screening, diagnostic and treatment services under section 1905(r) of Title XIX as in effect on June 1, 1996.
1061	Strike language in the definition of covered entities related to furnishing drugs at a cost no greater than the acquisition cost plus a dispensing fee.

CHAIRMAN'S MODIFICATIONS TO S.1795

DIVISION B--RESTRUCTURING MEDICAID

<u>Page</u>	<u>Explanation of Change</u>
1104	<p>Add a provision establishing a National Commission on Medicaid to report to Congress on the impact of Medicaid reform and make recommendations.</p>
Insert as appropriate.	<p>Add a provision regarding minimum standards for Medicaid managed care plans, including:</p> <ul style="list-style-type: none"><li>-- If Medicaid beneficiaries are required to enroll in a managed care plan, they must be given the choice between at least 2 such plans or between a managed care plan and a primary case management provider.</li><li>-- Special needs children, the homeless, and migrant agricultural workers may not be required to enroll in a managed care plan.</li><li>-- Managed care plans must make medically necessary services available 24 hours a day, seven days a week.</li><li>-- Managed care plans must contract with a reasonable number of primary care and specialty care providers to meet the health care needs of their Medicaid enrollees.</li><li>-- States must require health plans to make adequate provision against the risk of insolvency.</li><li>-- States must prohibit managed care health plans from: discriminating in enrollment based on health status or need for care; fraudulent enrollment and the use of false and misleading marketing information; and from affiliating with any providers barred from Federal government contracting.</li><li>-- States must require that managed care plans provide specified financial information to the state and agree to allow audit and inspection of books and records needed for verification.</li><li>-- States may not automatically enroll individuals who do not choose a plan into health plans that are out of compliance</li></ul>

CHAIRMAN'S MODIFICATIONS TO S.1795

DIVISION B--RESTRUCTURING MEDICAID

<u>Page</u>	<u>Explanation of Change</u>
	with standards. -- States must establish sanctions (including intermediate sanctions and civil money penalties) for use in enforcing compliance with the minimum standards, and correcting failure to provide medically necessary services that are required under a contract with the state.
xx	Add report language to clarify that the Governor may appoint the state's Drug Use Review Committee to serve as the committee which develops any drug formulary which might be used by the state's Medicaid program.
xx	Add report language to clarify that a state Veterans Home may require veterans receiving Aid and Attendance and Unusual Medical Expenses to contribute all but a per diem to the cost of their care.
xx	Add report language to clarify that the definition of medical assistance includes services of certain Christian Science facilities and organizations.
xx	Add report language to encourage states to assure access to pregnant women and children to appropriate levels of basic, specialty and subspecialty care.

**DRAFT**

CHAIRMAN'S MODIFICATIONS TO S. 1795

TECHNICAL AMENDMENTS

DIVISION A--REFORMING NONMEDICAL WELFARE PROGRAMS

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
I	17	In line 11, insert, "the Secretary has found". Adds language clarifying that the Secretary has the authority to determine whether the State Plan contains all the required elements
I	23	Clarifies language so that only states that had an Emergency Assistance request approved in 1994 or 1995 qualify for additional money in their block grant
I	37	Drops several lines of text to clarify that the performance bonus is based on all the purposes of title I and not just employment
I	55	Adds the terms "average monthly" before "number of families" in Subparagraph (3) to clarify that the calculation for pro rata reduction of participation rates is based on the average monthly number of IV-A recipients
I	65	Drops the phrase "Except to the extent necessary to enable the State to comply with section 457" to correct a drafting error from H.R. 4 that erroneously changed the child support assignment rules; the effect of the change is to ensure that families retain the right to all arrearages that accrue after the family leaves welfare
I	81	Inserts language to clarify that the good cause exemption applies to applicants who have cause not to cooperate with child support officials
I	83	Strike lines 17, 18 and insert "state expenditures that consist of funds transferred from state program not described in subclause (I) or from local programs that are not funded by the states"

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
I	89	Rename as more precise header, "Required Replacement of Grant Fund Reductions Caused by Penalties"
I	99	Drops the requirement that States report information on the number of welfare recipients who leave welfare for work; this requirement is no longer necessary because the bill does not allow States to count welfare recipients who leave welfare for work toward fulfilling participation standards
I		Adds the year "2001" to authorize payments to Indian tribes that formerly received JOBS funds, covering the length of the TANF block grant (1996-2001)
I	114, 115	Change "1995" to "1996" to clarify that waivers may be continued
I	117	Add language on reductions on FTEs at the Department of Health and Human Services into this section
I	119	Adds State option to contract with charitable, religious or private organizations to provide services to definitions section
I	125	Adds transition language so States would not be entitled to both money from current funding under Title IV-A and the new State entitlement program under Title VIII of the Committee provision
I		Moves language that appeared in the wrong order because of a printing error
I	136	Drops the word "agency" to clarify that States have the option of deciding whether the agency administering TANF, child support, or title XV can make good cause determinations
I	136	Changes "cooperate" to "cooperation" to make the sentence grammatically correct
I	165	Language required by CBO to ensure that states can not obtain child care funds from two sources simultaneously

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
II	182	Corrects language so that the effective date of application for benefits is uniformly applied for individuals qualifying at age 65 (per Social Security Administration).
II	188	Restores a one-time appropriation in H.R.4 of \$0.3 billion to the Social Security Administration to conduct redeterminations and continuing disability reviews required under this bill.
III	231	Replaces "and" with "or" to clarify that recipients need meet either the good cause exception or other exceptions (but not both) that are recognized by states
III	241	Adds the phrase "except for amounts collected pursuant to Section 464" in Subparagraph (v) at the request of CBO to clarify the distribution rules for purposes of scoring
III	243	Drops the parenthetical material from the subparagraph on "Federal Share" which was left over from previous drafts; the material was necessary when all the current Title IV-E programs were placed in a new Title IV-B; dropping the new Title and restoring IV-E as under current law obviated the need for this material; also clarifies that "assistance" refers to foster care maintenance payments under Title IV-E
III	244	Given the changes in Medicaid that are contemplated as part of the welfare reform bill, this change in the subparagraph on "Federal Medical Assistance Percentage" establishes the Medicaid match rate on September 30, 1996 for each State as the rate that will be the Federal medical assistance percentage (FMAP) for purposes of this section

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
III	244	Four changes are made to the provision on gap payments (gap payments are payments States can make to welfare recipients from child support collections up to the amount of the difference between the State standard of need and the State payment standard for AFDC): 1. the provision is made a State option; 2. language is added to clarify that the gap payment is paid to the family in addition to the welfare payment otherwise payable to the family; 3. the word "paid" is substituted for the word "distributed" to be consistent with Title IV-A terminology; and 4. the relationship between gap payments and the hold harmless language in subparagraph (d) and the termination of the \$50 passthrough is clarified
III	245	Changes the effective date of the new distribution rules from "July 1, 1996" to "October 1, 1996" in Subparagraph (c) to give States more time to implement the rules
III	258	Strikes language that would eliminate the city of New Orleans from the one-year extension provided to Louisiana from the requirement of single-source distribution of child support payments
III	299	Removes a stray ")" that appeared in the text
III	303	Changes the reference from "(a) (1)" to "(a) (1) (A)" in Subparagraph (F) on income withholding; this change has the effect of limiting the mandate on States to provide expedited procedures for wage withholding only to non-AFDC cases that elect to participate in the child support program

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
III	325	Changes "1997" to "1998" under the effective date for "Incentive Adjustments"; this change eliminates a drafting oversight that had States receiving Federal reimbursement during fiscal year 1998 both under the current incentive system as well as the new incentive system that will begin in fiscal year 1999
III	376	Inserts the word "to" to make the sentence grammatically correct
III	380	At the request of the Department of State, we changed the term "child support" to "support" throughout this section on international agreements; however, we inadvertently missed one occurrence of the term
III	468	Eliminates the reference to part E under "For Failure to Maintain Effort" which was inadvertently left over from a previous draft
IV	397	Changes the Medicaid reference from title XXI (the Medicaid title in the Balanced Budget version of H.R. 4) to title XV (the Medicaid title in this bill)
IV	411	Corrects a drafting error that resulted in a reference to just part B of title IV instead of to both part B and part E
XI	760	Changes the wording of the provision to clarify that in States in which the Governor previously had exclusive control over Federal block grant funds, State legislatures now would share control through the appropriations process. However, States would continue to spend Federal funds in accord with Federal law
XI	768	Adds the provision that nothing in Federal law prevents States from testing welfare recipients for use of controlled substances

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
XI	774	Clarifies the correct levels of funding for SSBG as follows:  1996:                   \$2,381,000,000 1997:                   \$2,380,000,000 1998-2002:             \$2,240,000,000

**DIVISION B--RESTRUCTURING MEDICAID**

- 778 Line 19, insert ", using the methodology provided for determining eligibility for payment of supplemental security income benefits under title XVI" after "who".
- 778 Line 21, strike "the payment of supplemental security income benefits under Title XVI" and insert "payment of such benefits".
- 778 Line 24, insert ", using the methodology provided for determining eligibility for payment of supplemental security income benefits under title XVI" after "who".
- 779 Line 1, strike "the payment of supplemental security income benefits under title XVI" and insert "payment of such benefits".
- 779 Line 11, insert ", " after income and delete "and"; after resource, insert ", and eligibility".
- 783 Lines 18, 20 and 25, insert ", " after income and delete "and"; after resource, insert ", and eligibility".
- 784 Line 14, insert ", " after income and delete "and"; after resource, insert ", and eligibility".
- 785 Lines 5, 7, and 9, insert ", " after income and delete "and"; after resource, insert ", and eligibility".

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
	785	Line 12, strike "March" and insert "May".
	787	Line 3, indent the heading.
	789	Line 4, insert a closing parenthesis after "(5)".
	791	Line 17, strike "under" and insert "over".
	797	Strike line 7 and all that follows through "and" on line 9 as unnecessary.
	832	After line 15, insert the following: "The administrative procedure under subparagraph (A) shall include impartial decision makers and a fair process and timely decisions".
	832	Line 4, insert "AND JUDICIAL" after "ADMINISTRATIVE".
	850	Line 24, strike "for a fiscal year" and insert "for fiscal year 1997 is 126.98 percent and for a subsequent fiscal year".
	859	Lines 4 and 10, strike "(D)" and "(E)" and insert "(E)" and "(F)", respectively.

Title	Page	Explanation of Change
	859	After line 3, insert the following new subparagraph (and redesignate the succeeding subparagraphs accordingly):  "(D) FLOORS AND CEILINGS ON PROGRAM NEED. - (i) IN GENERAL. - In no case shall the value of the program need for a State for a fiscal year be less than 90 percent, or be more than 115 percent, of the program need based on national averages (determined under clause (ii)) for that State for the fiscal year. (ii) PROGRAM NEED BASED ON NATIONAL AVERAGES. - For purposes of clause (i), the 'program need based on national average' for a fiscal year is equal to the sum of the product (for each of the population groups) of the following 3 factors (for that group, year, and State or District): (I) WEIGHTING FACTOR FOR GROUP. - The weighting factor for the group (described in subparagraph (C) (1)). (II) TOTAL NUMBER OF NEEDY IN STATE. - For all groups, the average annual number of residents in poverty in each State or District (as defined in subparagraph (C) (ii) (I)). (III) NATIONAL PROPORTION OF NEEDY IN GROUP. - The proportion, of all individuals who received medical assistance under this title in all of the States and the District in all such groups, that were individuals in such group.
	861	Line 9, strike "(2) (A)" and insert "(2) (C) (ii) (I)".
	871	Line 2, delete "the percentage by which" and insert "the number of percentage points by which".
	933	Lines 12 and 20, strike "1507" and insert "1508".
	1089	Line 21, insert after drug ", including a biological product or insulin,".

<u>Title</u>	<u>Page</u>	<u>Explanation of Change</u>
	1093	Line 16, strike "subparagraph (C) or (D) of paragraph (2)" and insert "paragraph (2) (D)".
	1100	Conform new Title XV to Secretary's waiver authority in Section 1115 of the Social Security Act.
	1100	TRANSFER OF CERTIFYING AUTHORITY FOR CHRISTIAN SCIENCE FACILITIES--Amend sections 1902(a) and 1908(e) (1) of Title XIX of the Social Security Act by striking "The First Church of Christ, Scientist, Boston, Massachusetts," and inserting "The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc."