

MEMORANDUM

January 30, 1997

TO: Erskine Bowles
Bruce Reed
Marcia Hale

FROM: Chris Jennings

RE: Medicaid and the governors

Attached are two documents in preparation for your upcoming discussions on Medicaid with the governors. The first document responds to the governors' concerns about the per capita cap as reported in today's article in the *New York Times*. The second document provides brief background on the Medicaid per capita cap and talking points to incorporate into your remarks to the governors when referencing Medicaid.

I hope this information is helpful. Please call me if you have any questions.

cc: Elena Kagan
Sylvia Matthews
Vicki Radd
Jason Goldberg

Talking Points/Q&A to Respond to Governors' Opposition to the President's Medicaid Proposal

Q: The Governors are joining advocates and providers in strongly opposing your per capita cap and significant savings in the Medicaid program. Aren't you concerned that support for your proposal seems to be waning?

A: There is no news here. Both sides are taking consistent and expected positions going into an important discussion about balancing the budget.

The Governors are once again taking the position that they would like maximum flexibility in administering their programs and would prefer not to have Federal budget constraints on the program if we are going to maintain the Medicaid's guarantee of coverage. This is not new.

The President, for the third year in a row, is proposing significant flexibility provisions for the States. In return, he is also proposing that the Federal Treasury be protected against excessive cost increases in the future. Again, this is not new.

The only thing that has changed is that the President's budget recognizes that growth in the Medicaid program has declined and as such will include much more modest savings than previous balanced budget initiatives.

We look forward to working with the Governors to craft appropriate and much overdue flexibility provisions to enable us to not only constrain costs but hopefully to expand health insurance coverage.

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TALKING POINTS FOR DGA/NGA

I. Background

During the upcoming FY1998 budget debate (and the upcoming NGA conference), the Governors will return to their traditional role of advocating for significant flexibility in administering the Medicaid program combined with an aversion to any Federal fiscal constraints over the program. They have a longstanding policy of opposition to any cap (such as a per capita cap) on programmatic expenditures in combination with the retention of a Federal entitlement. They believe that such an approach leaves them holding the bag for guaranteed benefits and coverage. (The Democratic Governors now take the position that they only supported a per capita cap when it was the only realistic alternative to a block grant).

While some Governors will support the concept of additional savings from disproportionate share spending (DSH), their support generally dwindles when they conclude that such proposals would have significant impact on their state. Moreover, they strongly believe that the Medicaid program has made a significant contribution to deficit reduction that mitigates any need for any major savings to be taken from Medicaid in the upcoming budget debate.

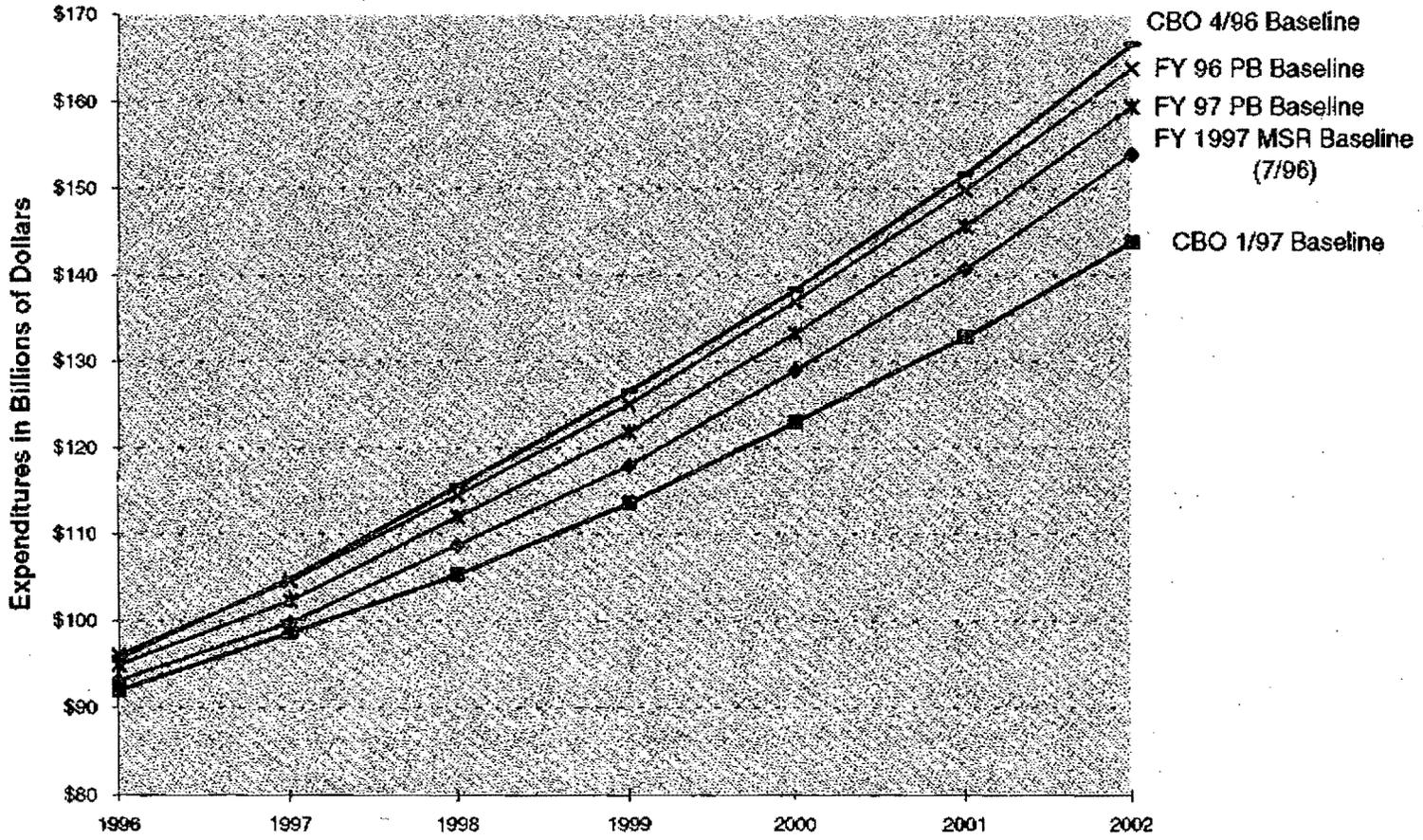
II. Suggested Talking Points

- I fully recognize that you all have been extremely successful in constraining growth in your Medicaid programs. I hope you believe that the Federal government has become more your partner rather than your adversary in helping you get control over your programs.
- I have watched many states expand coverage, reduce infant mortality coverage, and make their programs much more efficient. These are achievements for which we can all be proud.
- We must make sure that our successes are maintained and enhanced in the years to come. While you all know that my upcoming balanced budget proposal will include provisions (a per capita cap and reductions in disproportionate share payments) to ensure that the Federal Treasury is not exposed to excessive increases in growth rates in future years.
- However, I want you to know that my budget will reflect the significant achievements you have made in this area. As such, savings from the Medicaid program will be modest.

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- I know more than most, that our goal in achieving constraints in Medicaid cannot be realized without providing you much greater flexibility to administer your programs.
- This means that we must work together with the Congress to pass initiatives which would:
 - repeal the Boren Amendment,
 - repeal the cost-based reimbursement requirements for health centers,
 - eliminate the burdensome Federal waiver process for implementing managed care options, and
 - allow home and community care initiatives without a Federal waiver.
- And finally, as we work together to moderate the growth of the Medicaid program, I also want to work with you to expand coverage, particularly to children. Today, we have three million children who are eligible, but are not receiving, Medicaid. I want to work collaboratively to expand coverage not only to this population but to also children above poverty and Americans who are in-between jobs.
- None of these endeavors can be successful without your help. I look forward to building on our mutual successes and learning from your individual successes as we take steps together to improve the health care system for all Americans.

The Decline of the 1996-2002 Medicaid Baseline



CBO 1/97 Baseline, -80.1 billion off the CBO 4/96 baseline, FY 1998-02

The Medicaid Per Capita Cap Policy

Issue

The per capita cap promotes cost consciousness and fiscal accountability in Medicaid while protecting the entitlement to health coverage for vulnerable people.

Key Facts

A "per capita cap policy" limits the growth in per capita costs for the aged, disabled, children and adults in each State. Under a per capita cap, the Medicaid entitlement is maintained and States continue to receive federal matching dollars, up to a capped level, for their Medicaid spending. Thus, States facing economic downturns, for example, are not penalized for adding people to their Medicaid rolls. This ensures that Medicaid beneficiaries will not lose coverage, while ensuring fiscal responsibility in the states.

A per capita cap policy thus limits federal spending without risking the loss of health coverage. It sets, for each State, a federal spending "cap" per beneficiary, which adapts automatically to the size and type of each State's Medicaid beneficiary population. It provides a mechanism that protects the federal budget if States fail to control their own per capita Medicaid spending.

Under the plan, a federal spending "cap" would apply in each State. The cap in each State would be the product of three components: (1) total State and federal spending per beneficiary (annualized) in the base year; (2) an index for the years between the base year and the current year; and (3) the number of beneficiaries (annualized) in the current year. To accommodate the variation across States in the composition of the Medicaid population, as well as changes in the mix of Medicaid beneficiaries over time, the cap in a State would equal per capita spending in each of the four subgroups, the aged, individuals with disabilities, non-disabled adults, and non-disabled children, weighted by the number of beneficiaries in each of these groups. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum federal spending per state. Because the cap would be enforced at the aggregate statewide level, that is, the sum of the subgroup caps, States would be able to use any savings from one group to offset the costs of another.

Under the President's plan last year, the cap limited per beneficiary spending growth to a specified index. If a State's actual spending exceeded the cap, the federal government would match only up to the cap, using the current federal matching assistance percentage (FMAP) for the State.

Administration history:

The Administration proposed a per capita cap for Medicaid in late 1995 and early 1996.

Medicaid State Flexibility

Issue

States and the Federal government have long sought to preserve flexibility for States to implement their Medicaid programs within a framework of providing a standardized set of benefits to specified eligibility groups. However, over time, as the program has undergone incremental eligibility expansions and as the structure of the US health care system has changed, States have found that program administrative and other requirements have become rigid and burdensome. The Administration's goals are to increase state flexibility while preserving its commitment to quality care and services for Medicaid beneficiaries.

Key Facts

Governors have been eager to increase the flexibility of their States in administering Medicaid. The President's plan last year would have substantially increased flexibility for the States in managing their Medicaid programs. The Administration's goal this year is to expand state flexibility so that innovation can continue at the state and local levels. Some of the key proposals included in the President's plan last year are listed below.

Provider Payments: The President's plan included provisions to repeal the Boren Amendment and to repeal the requirement that States pay for private insurance when it is cost-effective.

Delivery Systems: The President's plan included provisions to change managed care (1915(b)) waivers to State Medicaid plan amendments, to repeal the requirement that 25 percent of every managed care plan's enrollees be non-Medicaid, and to allow States to provide home and community-based services at State option, without federal (1915c) waivers.

Administration: The President's plan would have repealed federally-mandated administrative requirements in the personnel area (e.g., merit personnel standards, training of sub-professional staff) and would have re-engineered the Medicaid Management Information System (MMIS) requirements.

Eligibility: The President's plan would have enabled states to expand or simplify eligibility for individuals up to 150 percent of the federal poverty level through a simplified and expedited procedure.

Administration history:

These items were part of the President's plan in 1995-1996.

Medicaid Trends

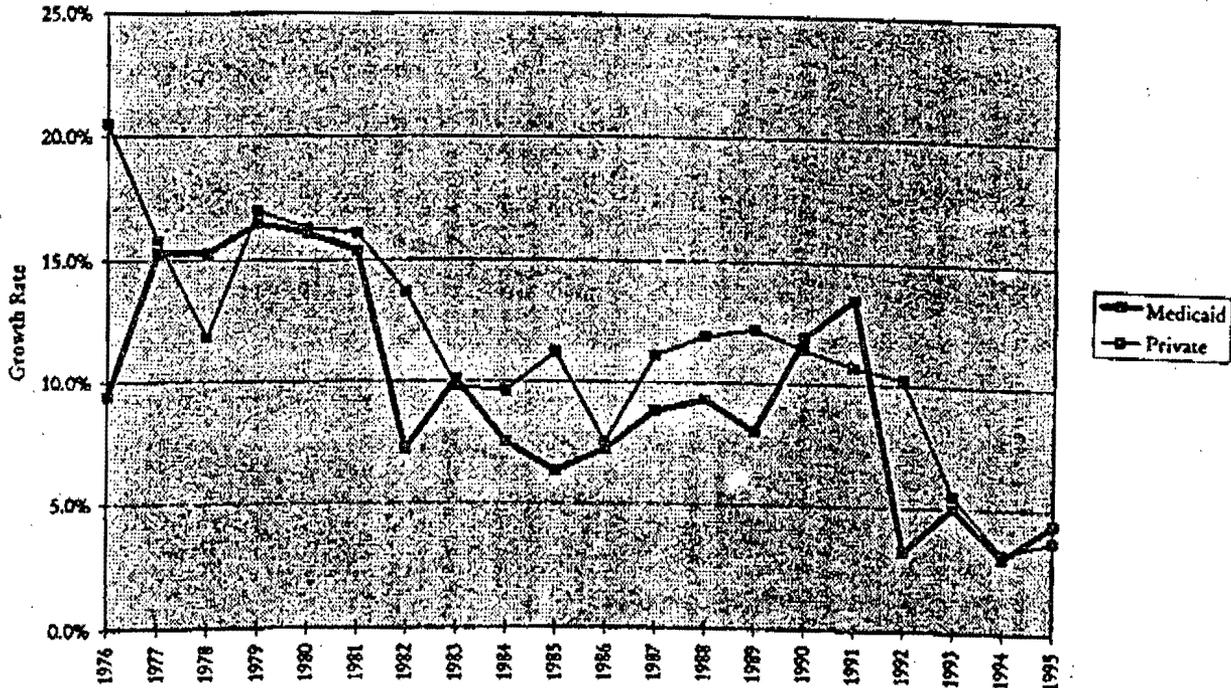
Issue

What are the trends in Medicaid spending, including comparison to private sector spending growth rates, Medicaid coverage, and the movement to managed care?

Key Facts

As shown in the chart below, Medicaid spending growth rates generally have followed growth in private health insurance costs. Per capita growth rates have fallen over the last several years. Projections for the future show a continuation in low growth rates due to increased controls on cost and utilization.

Annual Percent Increase in Medicaid Expenditures per Enrollee vs. Private Health Insurance



Managed care: Enrollment in Medicaid managed care organizations has increased significantly in recent years to 11.6 million people in mid-1995, which is about 30 percent of the beneficiary population. Managed care as of the end of 1996 is available to Medicaid beneficiaries in almost all states, although enrollments are concentrated in large states or those with extensive managed care plans. The vast majority of Medicaid beneficiaries in managed care are pregnant women and families with children. Few states offer managed care to the elderly or disabled Medicaid beneficiaries.

Recipients and Coverage: The number of Medicaid recipients rose from 23.1 million in 1987 to 36.3 million in 1995. Of the 36.3 million, 28 percent are aged, blind, or disabled; 47 percent are children under 21 years of age; 21 percent are adults; and about 4 percent are other or unknown.