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President Clinton Announces New Family-Friendly Workplace Proposals

- ✓ **Expanded Family & Medical Leave**
- ✓ **Employee-Choice Flex-Time**

June 24, 1996

Nashville Family Reunion Conference Hosted By Vice President Al Gore

PRESIDENT CLINTON ANNOUNCES NEW FAMILY-FRIENDLY WORKPLACE PROPOSALS:

- **EXPANDED FAMILY & MEDICAL LEAVE**
- **EMPLOYEE-CHOICE FLEX-TIME**

NEW EXPANSION OF FAMILY AND MEDICAL LEAVE: *President Clinton's new proposal would deepen and expand Family Leave by allowing a worker to take unpaid hours off -- with a maximum of 24 hours a year -- for child education, older relatives' health needs, and routine family medical purposes.*

Current Family and Medical Leave Law. The FMLA helps families only with a medical crisis or special limited care-giving needs, such as a birth or adoption. But working families often have to care for children or parents in circumstances for which they cannot use Family and Medical Leave.

New Family And Medical Leave Procedures. FMLA expansion would be limited to 24 hours a year for the following specific purposes:

- **SCHOOL ACTIVITIES.** Participating in school activities directly related to the educational advancement of your child, such as parent-teacher conferences or interviewing for a new school;
- **ROUTINE FAMILY MEDICAL PURPOSES.** Accompanying your child to routine dental or medical appointments, such as annual checkups or vaccinations;
- **OLDER RELATIVES' HEALTH NEEDS.** Accompanying an elderly relative to routine medical appointments or other professional services related to the care of the elderly relative, such as interviewing nursing homes or group homes.

NEW EMPLOYEE-CHOICE FLEX-TIME: *President Clinton's new proposal would offer American workers more choice and flexibility in finding ways both to earn the wages they need to support their families and still find the time they need to be with them. The President's proposal would:*

- **EMPLOYEE CHOICE.** Allows employees to agree with their employers to work overtime in exchange for paid time-off -- flex-time -- with a limit of up to 80 hours. An hour of overtime could thus be used for 1-and-1/2-hours of overtime pay or 1-and-1/2 hours of flex-time.
- **FLEX-TIME FOR ANY PURPOSE WITH 2 WEEKS NOTICE.** Workers could use their earned flex-time for any reason -- as long as they give their employers 2 weeks notice.
- **EMPLOYEES CAN ALWAYS CHOOSE PAY OVER FLEX-TIME.** Workers would maintain the right to choose overtime pay, and even if they choose flex-time, they could still cash out any portion of their flex-time pay with two weeks notice.
- **FLEX-TIME FOR FAMILY LEAVE.** Employees can use their accumulated family flex-time for family leave purposes at any time.

OPPOSE ATTEMPTS TO REDUCE WORKER CHOICE: *In announcing these new family-workplace proposals, President Clinton made clear that he would oppose any bill that allows for coercion and uses phrases like "comp-time" as a cover for giving workers less choice in the workplace.*

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BACKGROUND MATERIALS

EXPANDING THE FAMILY AND MEDICAL LEAVE ACT – TO HELP FAMILIES BALANCE WORK AND FAMILY RESPONSIBILITIES

June 24, 1996

"Family and medical leave is a matter of pure common sense and a matter of common decency. It will provide Americans what they need most: peace of mind. Never again will parents have to fear losing their jobs because of their families."

-- President Clinton at the signing of the Family and Medical Leave Act, February 5, 1993

PRESIDENT CLINTON DELIVERED ON HIS PROMISE TO PROVIDE FAMILY LEAVE: In his first month in office, President Clinton delivered on his promise and signed the Family and Medical Leave Act of 1993 into law. The law allows workers at businesses with 50 or more employees to take up to 12 weeks of unpaid, job-protected leave to care for a newborn or adopted child, to attend to their own serious health needs, or to care for a seriously ill parent, child or spouse.

NEW BIPARTISAN REPORT SHOWS THE LAW IS WORKING: The recent report on the impact of the law by the bipartisan Commission on Leave -- chaired by Senators Dodd and Craig -- shows that the law is working:

- **67 million Americans -- over half of workers -- are guaranteed they can take leave** from their job to care for a sick relative or a newborn child without fear of losing their job or their health insurance.
- **More than 12 million eligible workers have taken leave since its enactment.**
- **40% of all workers think they will need to take leave for a covered reason** at some time in the next 5 years. The leading reason is to care for a seriously ill parent.
- **Despite opponents' claims, compliance is easy and costs low for most employers:**
  - 9 in 10 employers find the law "very" or "somewhat" easy to administer
  - Compliance entails either little or no costs for 89%-99% of businesses
  - Smaller covered worksites found it easier to comply than the larger sites.
- **Some businesses have reported reduced employee turnover, enhanced productivity** and improved morale which they attribute to the Act.

NOW IT IS TIME TO EXPAND THE LAW TO BETTER HELP WORKERS CARE FOR THEIR CHILDREN AND PARENTS. While the law is a major step forward, it does not cover many situations facing working families. Today, President Clinton proposed expanding the law to cover more family obligations to better help working families care for their children and elderly relatives without sacrificing their work obligations. Under the proposed expansion, workers could take up to 24 hours of leave each year to meet additional specified family obligations, including routine doctors appointments and parent-teacher conferences. Leave could be taken for the following purposes:

- **Participating in school activities** directly related to the educational advancement of your child, such as parent-teacher conferences or interviewing for a new school;

- **Accompanying your child to routine dental or medical appointments,** such as annual checkups or vaccinations;

- **Accompanying an elderly relative to routine medical appointments or other professional services** related to their care, such as interviewing nursing homes or group homes.

PRESIDENT CLINTON'S NEW EMPLOYEE-CHOICE FLEX-TIME PROPOSAL

TODAY, PRESIDENT CLINTON ANNOUNCES A NEW EMPLOYEE-CHOICE FLEX-TIME PROPOSAL. President Clinton's employee-choice flex-time proposal would help to make workplaces more family friendly by ensuring worker flexibility while guarding against abuses by coercive or unstable businesses -- with explicit protections against coercion. President Clinton's proposal would allow more Americans to have the time they need to fulfill their responsibilities as both workers and as parents or grown children of elderly relatives.

- **Workers could agree with their employers to receive extra paid time-off -- "flex-time" -- instead of working overtime for cash pay.** Consistent with existing law, workers would get time-and-a-half in flex-time -- extra paid time-off -- for each hour of overtime. There would be a limit of 80 hours that a worker could accumulate in flex-time. And all additional overtime work -- beyond the limit -- would have to be paid in cash.

- **Employees can choose to use their flex-time for family and medical leave purposes whenever they need it.** At any time, workers can use their flex-time for family and medical leave purposes -- to care for a new born or adopted child, to attend to their own serious health needs, or to care for a seriously ill child, parent, spouse.

- **Workers maintain ultimate control of when to use flex-time, as long as they provide two weeks notice to their employers.** Employees can use flex-time for any purpose as long as the worker gives at least two weeks of notice to his or her employer, or with less notice if the employer's operations are not unduly disrupted. Private-sector employees may elect to cash out their flex-time for cash due as long as two weeks of notice is given to their employer.

- **To protect against abuses by coercive or unstable businesses, the employee-choice flex-time proposal includes explicit protections against coercion.**

  - **Employees and employers would have a written flex-time agreement.** President Clinton's employee-choice flex-time proposal would also require employees and employers to agree in writing that the worker will receive flex-time -- instead of cash pay -- before the worker performed any overtime work.

  - **Private-sector workers can get cash for their accumulated flex-time within two weeks of notice.** With two or more weeks of notice, a worker in the private sector can cash out their flex-time for cash due.

  - **Protecting workers from businesses that go bankrupt.** To ensure workers receive their accumulated flex-time when their employers seek bankruptcy protections, unpaid flex-time would receive special protection -- the same as given to other wages -- in bankruptcy proceedings. For employees in thinly capitalized businesses, additional protections will be included.

- **Additional protections to ensure that worker protections:**

  - President Clinton's employee-choice flex-time proposal would not allow unused flex-time to deprive a worker of unemployment compensation that he or she has earned.

  - To ensure protections against coercion, part-time, seasonal, and temporary workers would exempted from this proposal. The Secretary of Labor would also be able to make recommendations to exclude low-wage workers who are vulnerable to coercion or certain occupations and industries that show a pattern of abuse.

- **Ability to collect from violators of overtime laws are improved.** President Clinton's employee-choice flex-time proposal improves the Labor Department's ability to collect fines due from violators of overtime laws, including double damages for certain egregious violations. This proposal also imposes civil money penalties for violations of flex-time and for willful or repeated recordkeeping violations.

PRESIDENT CLINTON WILL STRONGLY OPPOSE ANY BILL THAT REDUCES WORKER CHOICE IN THE WORKPLACE. President Clinton will strongly oppose any bill that allows employers to coerce their employees fails to protect true worker choice and fails to guarantee that workers will receive the compensation they are due.

COMPARISON OF PRESIDENT CLINTON'S EMPLOYEE-CHOICE FLEX-TIME PROPOSAL AND REPRESENTATIVE BALLENGER'S COMP-TIME PROPOSAL

	PRESIDENT CLINTON'S EMPLOYEE-CHOICE FLEX-TIME PROPOSAL	REPRESENTATIVE BALLENGER'S COMP-TIME PROPOSAL
WRITTEN AGREEMENT	• To provide true employee choice, employees and employers must agree in writing that compensation will be provided as flex-time rather than as overtime wages.	• No written agreement is necessary -- only an understanding.
FLEX-TIME FOR FAMILY AND MEDICAL LEAVE PURPOSES	• Employees may use flex-time for family and medical leave whenever they need it.	• No comparable provision.
USE OF FLEX-TIME	• Employees maintain ultimate control of when to use flex-time, as long as they provide two weeks notice to their employers. Workers can use flex-time for any other purpose as long as they provide two or more weeks of notice. They receive flex-time with less notice, but only if the employer is not unduly disrupted.	• Employers maintain ultimate control of when to grant their workers flex-time. Regardless of the amount of notice the worker provides, employers can deny use of comp-time if the firm claims they would be "unduly disrupted."
PAYOUT OF FLEX-TIME	• Private-sector employees may elect to cash out their flex-time for cash due with at least two weeks of notice to their employer.	• Rather than ensuring payout within two weeks as the President's proposal, private-sector employers would have up to 30 days to payout the cash due for accumulated flex-time.
FLEX-TIME BANK	• Private-sector workers can accumulate flex-time for overtime worked (at a rate of time and a half) in a "Flex-time Bank." There would be a limit of 80 hours that a worker could accumulate in flex-time. All additional overtime work must be compensated in cash.	• Employees can accumulate up to 240 hours of comp-time.

Bankruptcy Protection	• To ensure workers receive their flex-time when firms enter into bankruptcy, unpaid flex-time would receive special protection -- the same as given to wages -- in bankruptcy proceedings. For employees in thinly capitalized businesses, additional protections will be included.	• No comparable provisions.
Enforcement Provisions	• Improves remedies against violators, including double damages for overtime that an employee would have earned, but was not permitted to work because the worker wanted to earn pay rather than flex-time. Civil money penalties for violations of flex-time and for willful or repeated recordkeeping violations.	• Double damages only for willful violations of anti-coercion provisions. Civil money penalties only for willful violations.
Treatment of Flex-time As Wages and Hours Worked	• Unused flex-time cannot be used to deprive a worker of unemployment compensation that he or she has earned. Flex-time pay-outs are treated as wages for health and pension benefit plans. Flex-time used is also treated as hours worked for overtime accrual purposes.	• No comparable provisions on unemployment compensation or benefit plans. Comp-time used is not treated as hours worked.
Exemptions for Vulnerable Sectors	• To ensure protections against coercion, part-time, seasonal, and temporary workers would exempted from this proposal. The Secretary of Labor would also be able to make recommendations to exclude low-wage workers who are vulnerable to coercion or certain occupations and industries that show a pattern of abuse.	• No comparable provisions.
Sunset	• Flex-time provision expires in four years. Bipartisan Commission will study and report to the Secretary of Labor and Congress prior to sunset.	• No comparable provision.

HOW THE PRESIDENT'S FAMILY-FRIENDLY PROPOSALS WOULD AFFECT TYPICAL FAMILIES

NOTE: These hypothetical examples illustrate how the President's proposal compares with current law and the Ballenger bill to create "comp-time." All of these examples assume the adoption of some proposal allowing the accumulation of flex-time or "comp-time" in lieu of time-and-one-half pay for overtime.

1. **Expanded Family And Medical Leave For Child Education Purposes.** Jane Smith works for XYZ Inc. She has a conference scheduled with her daughter's teacher for three weeks from today and needs four hours of time off to travel to and from the school and meet with the teacher. Jane is willing to take unpaid leave.

   ✓ Under the President's proposal, Jane can take unpaid leave to attend the parent-teacher conference.

   ☒ Under current law, Jane is not assured she can take unpaid leave to attend the parent-teacher conference.

   ☒ Under the Ballenger bill, Jane is not assured she can take unpaid leave to attend the parent-teacher conference.

2. **Expanded Family And Medical Leave For Caring For Older Relative.** While Jane Smith is tending to her daughter's educational needs, Jane's husband John needs to help move his grandfather from one nursing home to another. John will need 4 hours time-off in order to do this. Because he is very involved with his family, John has not worked any overtime this year and does not have any accumulated flex-time. Thus, he would like to use unpaid family and medical leave to take his son to the doctor.

   ✓ Under the President's proposal, John can take unpaid family and medical leave to move his grandfather from one nursing home to another.

   ☒ Under current law, John cannot use family and medical leave to help move his grandfather from one nursing home to another.

   ☒ Under the Ballenger bill, John cannot use family and medical leave to help move his grandfather from one nursing home to another.

3. **Employer-Imposed "Comp-Time."** Bill Johnson and his family live on a very tight budget. The time-and-one-half pay Bill receives for the 10 hours of overtime he works each month provides just enough money to pay the mortgage on his family's house. In his latest paycheck, Bill's employer inexplicably did not include any pay for his overtime work. When Bill complains, his boss explains that this is the new "comp-time" program and from now on Bill will get extra time off in return for his overtime. Bill fears he will not be able to make ends meet. He doesn't remember agreeing to accept "comp-time."

✓ Under the President's proposal, Bill and his employer would have to had agreed in writing prior to the overtime that he would accept flex-time instead of time-and-one-half pay. Otherwise, Bill must be paid his time-and-one-half in cash.

✓ Under current law, Bill would have to be paid time-and-one-half in cash for the overtime he worked.

☒ Under the Ballenger bill, the employer could say that he had a verbal agreement with Bill to give him "comp-time." That makes it Bill's word against his employer's word.

4. **Flex-Time For Planned Family Needs.** Ann's husband Bill has a heart condition and will require heart surgery within the next few weeks. Ann wants to spend time with Bill after the surgery to help care for him. Her family's growing financial worries make it vital that Ann be able to use her accumulated flex-time to be with her husband without losing a day's pay. Ann and Bill scheduled the surgery three weeks in advance and Ann gave her employer two-weeks notice. Two days before the surgery, Ann's employer ZYX Co. decides to change their production schedule. In their view, Ann's absence will "unduly disrupt" the workplace operations.

✓ Under the President's proposal, Ann can use her accumulated flextime to be with her husband without losing pay -- as long as she gives two-weeks notice.

☒ Under current law, Ann is assured only of unpaid family and medical leave time.

☒ Under the Ballenger bill, Ann cannot use her accumulated "comp time" if it will "unduly disrupt" her employer's operations. ZYX Co. can force her to take unpaid leave to be with her husband in the hospital.

5. **Protection of Unemployment Benefits.** Al Jones is a construction worker who got laid off from Builders Inc. after it finished its latest project. He worked enough overtime to accumulate 80 hours of accrued flex-time. Now, he wants to collect the unemployment benefits he usually gets when his employer lays him off. This time, however, Builders Inc. challenged Al's eligibility for unemployment insurance on the grounds that he is still "working" because he is getting paid for his accumulated flextime.

✓ Under the President's proposal, Al is explicitly protected from this type of challenge. If he's otherwise eligible, Al should get his unemployment insurance.

☒ Under the Ballenger bill, Al is not explicitly protected from this challenge to his unemployment insurance eligibility.

Kassebaum–Kennedy Insurance Reform

Talking Points:

- The President is very encouraged by the Senate's 100 to 0 vote on the Kassebaum–Kennedy bill. Such an action shows that Republicans and Democrats can work together to address some of the many shortcomings of our health care system.

- He hopes the Senate and the House can work out their differences expeditiously and avoid loading up this legislation with controversial provisions that have not attracted broad–based, bipartisan support.

- The Senate–House conference for Kassebaum–Kennedy insurance reform bill must deal with three particularly problematic "poison pill" provisions. Each of these three provisions did not receive broad, bipartisan support and were only retained in the House–passed version. They are the establishment of Medical Savings Accounts (MSAs), the deregulation of Multiple Employer Welfare Arrangements (MEWAs), and the intrusion of flawed, Federal micromanagement over state regulation of medical malpractice.

- Other concerns include provisions that actually reduce our ability to enforce Medicare fraud and abuse violations and undermine consumer protections for Medicare supplemental (Medigap) policies that duplicate Medicare coverage. The President has directed Administration staff to provide technical assistance to the Hill to work through these and other issues.

- So, despite the 100 to 0 vote, there is still a good deal of work that needs to get done to ensure that an acceptable bill gets to the President's desk for his signature. Failure to do so will be a tragedy for the American public and the vast majority of the nation who supports the Kassebaum–Kennedy legislation. The President is confident, though, that the Congress and the Administration will find a way to produce a bill we can all support and that can get signed into law in short order.

May 20, 1996

QUESTIONS AND ANSWERS RE KASSEBAUM/KENNEDY

(MSAs and Mental Health Parity)

1. Would the President really risk the enactment of the Kassebaum–Kennedy bill over the issue of Medical Savings Accounts (MSAs)? Would he really veto the whole bill just because the MSA provision was included?

Yes. The President would veto the MSA provision now being advocated by the Republicans. It is costly ($1.7 billion), regressive (according to Congress' own Joint Tax Committee, less than 2 percent of recipients would have incomes of $30,000 or less), flawed tax policy that has great potential to undermine the insurance market through adverse risk selection. By any definition, it is a poison pill that the President won't swallow.

The real question is why are the Republicans willing to risk the enactment of a bill that just received unanimous approval in the Senate? Why are they even contemplating adding this controversial provision to a conference report after a bipartisan 52–46 vote that explicitly rejected this provision?

We have all learned that health care must be done on a bipartisan basis. Not one Democrat voted for the MSA amendment. In fact, in the vote for final Senate passage of the Kassebaum–Kennedy bill, every single Senator (100 to 0) voted for this legislation WITHOUT the MSA provision. It certainly is disappointing that some Republicans are now obviously more interested in playing politics than in getting a bill singed into law.

2. The President seemed to be hinting that he would accept a Medical Savings Account demonstration the other day. Is this true? What did he mean?

He was saying that it makes no sense to spend precious taxpayer dollars to support the implementation of a nationally–based, open–ended, untested MSA proposal. The President wants a bill that has broad, bipartisan support. If there is an acceptable alternative to the House–passed MSA provision, he has not seen it. If the Republicans are going to insist on having any remnant of an MSA, it is their responsibility to develop one for the President and the Democrats to review. The ball is in their court.

Does that mean he would support some version of a Medical Savings Account?

Not unless it addressed the numerous flaws of the House–passed proposal. And again, the President has not yet seen any version of an MSA that he could support.

3. Does the President support the Domenici/Wellstone mental health–parity amendment?

Yes he does. We have always supported moving towards parity for mental health benefits. In addition, this amendment received the type of broad bipartisan support that is obviously necessary for any health reform to be enacted. 65 Senators, including well over half of the Republicans (29), voted for this legislation.

What about your previously stated position in support of a clean, non–controversial amendment approach?

We wanted to help ensure that only broadly–supported initiatives would be included in the final bill presented to the President. Clearly, the vote on the mental health parity amendment proved that its provisions have broad and deep support by Members of Congress of all ideologies. Certainly, any amendment that receives the support of Senator Wellstone, Senator Dole, and Senator Helms meets the broad–based definition. Moreover, all 100 Senators voted to support the final bill with this provision in it. **Having said this, we want to work with the private sector to address legitimate cost and administrative concerns.**

4. Aren't you concerned about the CBO projection that 800,000 will lose their health insurance coverage as a result of the mental health parity provision?

We do not believe that this amendment will have any significant affect on coverage. The amendment does NOT require any insurer or health plan to provide mental health benefits. It only requires that, if they are provided, they are equivalent to coverage for other medical conditions.

Everyone who supports this amendment has worked hard to increase coverage for the 40 million Americans without health insurance coverage. I can assure you that they are not interested in doing anything that will further jeopardize coverage in this nation.

Does this mean you are calling into question CBO's credibility?

We have no desire to cast dispersions on CBO. As an independent body, CBO makes its own judgements. Having said this, no one would dispute that estimates of coverage loss are, by nature, very controversial and extremely complex. Assigning large numbers of coverage loss to a provision that has no requirement to cover any benefit does seem somewhat questionable.

KASSEBAUM-KENNEDY HEALTH REFORM LEGISLATION

Background:

On April 23rd, the Senate passed (by a 100 to 0 vote) an amended version of the Kassebaum-Kennedy insurance reform bill. The previous week, every Democratic Senator joined with five Republican Senators to support an amendment (in a 52-46 vote) to strike Medical Savings Accounts (MSAs) from a Dole Amendment to the legislation. (The Republicans that supported the amendment were Senators' Bond, Gorton, Chafee, Kassebaum, and Hatfield). This was played by the media and the Democrats as a stinging defeat for Senator Dole.

As of May 15th, the conferees for the Senate-House conference had not been selected because Senator Kennedy has continued to object to the Members Senator Dole planned to appoint to the Committee. In an almost unprecedented move, the Majority Leader attempted to stack the conference with Members friendly to the House MSA provision. (He was not at all subtle in picking Members who normally would not be on the conference and bypassing those who would have.)

Kassebaum-Kennedy Insurance Reforms

The underlying Kassebaum-Kennedy insurance reform provisions address some of the major problems in today's insurance market. According to the General Accounting Office, it would benefit as many as 25 million Americans. Like the President's balanced budget proposal, this legislation provides for:

- **Guaranteed Access.** Insurers would be required to offer health plan coverage to all groups, regardless of the health status of any member of the group. In addition, employees could not be denied group coverage based on their health status.

- **Guaranteed Renewal.** Insurers would be required to renew coverage to groups and individuals as long as the premiums are paid and employers could not have their coverage terminated if their workers incur large medical costs.

- **Limits on Imposition of Pre-existing Condition Exclusions.** Insurers could not impose pre-existing conditions for people who have switched jobs and have maintained coverage for longer than 12 months. (They could not impose a pre-existing condition for longer than 12 months for those who have not had continuous coverage.)

- **Increased Access to Individual Policies.** Individuals with previous coverage would have access to the individual health insurance market (if certain conditions are met.)

- **Promotion of Purchasing Cooperatives.** States would be given assistance to help certify and encourage the development of purchasing cooperatives to help small businesses gain leverage in buying more affordable and accessible health insurance.

Senate Amendments to Kassebaum–Kennedy

The Senate defeat of the MSA amendment covered up some significant additions to the underlying insurance reform bill. They included:

(1) Expansion of the self–employed tax deduction to 80 percent over 10 years (the President's balanced budget has a phase–in to 50 percent, as does the House–passed version of Kassebaum–Kennedy);

(2) Clarification that tax treatment of private long–term care policies should be the same as traditional health insurance (the President's balanced budget does not have this provision, but the President advocated for a similar provision in the Health Security Act; the House–passed bill has a similar provision);

(3) Strengthening of Medicare fraud and abuse prevention/enforcement (the President's balanced budget has a similar provision, as does the House–passed insurance reform bill –– although it is flawed as it, in some cases, weakens enforcement); and

(4) the Prohibition of health plans from imposing limits or caps on mental health services if similar limitations are not imposed on coverage for other conditions (the President's balanced budget does not allow plans to discriminate by disease category, but does allow plans to have differential coverage limits; the House–passed insurance reform bill has neither the President's nor the Senate–passed provisions.) This last item was sponsored by Senator Domenici and Senator Wellstone and won by a surprisingly large 65–33 margin.

Outstanding Issues Going Into Conference: The House–passed bill has at least 5 major provisions that are extremely problematic. They were well aware that we had grave concerns about them, but they went ahead and included (1) Medical Savings Accounts, (2) Caps on punitive and non–economic medical malpractice awards, (3) **the deregulation of state oversight over MEWAs –– Multiple Employer Welfare Arrangements** –– that the Governors, the Insurance Commissioners, the consumer groups, the insurers and many providers believe will severely undermine the insurance market by providing for an under–regulated environment in which healthy employees/employers can be selected away from unhealthy populations, (4) the elimination of the prohibition against insurers selling Medigap policies that duplicate benefits that beneficiaries already receive through their Medicare coverage, and (5) the weakening of certain Medicare fraud and abuse enforcement provisions.

The Senate–passed bill does not include the first four provisions and improved on the problematic fraud and abuse provisions. We believe that we can and should work out some of the minor concerns we have with the Senate provisions (mostly relating to the long–term care tax clarifications and the fraud and abuse provisions). However, the real fight will be on the House–passed provisions. The business community might help us fight the House–passed controversial provisions. However, they will also be focusing their guns on the Domenici/Wellstone mental health parity provision. (They believe it is huge, new Federal mandate.)

Possible Medical Savings Account Compromise

Summary: Implement a staged, phase-in of Medical Savings Accounts (MSAs), which is preceded with a 3-year demonstration designed to study the potential benefits and problems with MSAs. This study would provide recommendations about the feasibility and advisability of expanding them nationwide. The results of the study, conducted by an independent recognized expert body would be provided to the Congress for its consideration. A fast-track procedure for affirmatively extending MSAs to large employers would require an up or down vote within 90 days of the receipt of the report. If the Congress passes this legislation, an automatic extension to small business occurs unless the Congress rejects it in a fast-track vote. In the third stage, an automatic extension to the individual market occurs unless the Congress rejects it on a similar fast-track vote. At each stage of Congressional consideration of further extension of MSAs, the nationally recognized authority would supplement their first report with recommendations related to the expansion to other markets.

Proposal

Demo: A 3-year demonstration project (similar to Empowerment Zones) would be conducted on the feasibility and advisability of implementing MSAs through the tax code The tax provisions for the MSA demonstration project would be similar to those in the House-passed health insurance reform bill (except that the favorable tax treatment for MSAs would expire at the end of the study period and certain safeguards would be built into the design of the MSA to minimize adverse effects on health markets, the tax system, and to assure that the high deductible policy provides meaningful health coverage).

State and local governments would compete for 4 separate slots for the MSA demonstration project. At least one slot would be reserved for a rural area. Applications by two or more States would be permitted to create a regional demonstration project. Selections would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Treasury, based on the overall strength of the application. Evaluation of submitted applications would be based on the strength of the experimental design and its ability to measure the effects of MSAs.

In the third year of the demonstration project, an evaluation would be completed by an independent, recognized expert body. The report of this evaluation would be forwarded to Congress with recommendations about the feasibility and advisability of extending MSAs nationwide.

Stage I: When the report is received marking the end of Stage I, a fast-track procedure would be started under which the Congress would have 90 days to consider whether to extend MSAs to large employers (at least 100 full-time employees) nationwide. Any Member could request floor action on the proposal to extend MSAs to all large employers (private businesses, non-profits, and governments). This extension could not take place without being enacted into law in the prescribed time period. In the second year after this extension takes place (if it occurs), a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to smaller employers.

Stage II: When the second report is received (two years after the implementation of the large business MSA), another fast-track procedure would be initiated under which the Congress would consider the extension of MSAs to small employers (under 100 employees). Under this procedure, the extension would take place automatically 90 days after receipt of the Stage II report, unless both Houses of Congress voted to prohibit it. (Any House or Senate Member could request this fast track vote). In the second year after this extension takes place (if it occurs) a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to the individual market.

Stage III: When the third report is received (two years after the implementation of the small business MSA), another fast-track procedure would be started under which the Congress would consider the extension of MSAs to the individual purchaser market. The extension would take place automatically 90 days after receipt of the report , unless both houses of Congress vote to prohibit it. -- (under the procedures outlined in Stage II).

MEDICARE TRUST FUND TALKING POINTS

June 7, 1996

file

UPCOMING MEDICARE TRUSTEES' REPORT CAN ONLY CONFIRM WHAT WE ALREADY KNOW -- REPUBLICANS SHOULD ACCEPT PRESIDENT CLINTON'S CALL TO BALANCE THE BUDGET AND STRENGTHEN THE MEDICARE TRUST FUND.

- As CBO said in its April 30th Hill testimony, "*.... the projected date of insolvency should be viewed not as telling us something new, but confirming what we already know.*"

WE WELCOME REPUBLICANS' CONCERN ABOUT THE TRUST FUND, BUT LONG BEFORE THEY STARTED TALKING ABOUT THE PROBLEM, THE PRESIDENT WAS ACTING TO ADDRESS IT.

- The President's 1993 Economic Plan extended the life of the Trust Fund by *3 years -- without a single Republican vote.*

- The President's Health Care Reform Plan would have extended the life of the Trust Fund by *another 5 years.*

THE PRESIDENT'S BALANCED BUDGET GUARANTEES THE LIFE OF THE TRUST FUND FOR A DECADE -- THE SAME AS THE SENATE REPUBLICAN BUDGET

- In a June 4th letter, the Medicare trust fund's Chief Actuary confirmed that the life of the trust fund would be extended until "mid-calendar year 2006 under the Administration's proposal."

ACTION IS NEEDED -- BUT THE ONLY CAUSE FOR ALARM IS THE REPUBLICANS' REFUSAL TO MEET WITH THE PRESIDENT ON BUDGET AND MEDICARE ISSUES.

- **The need for responsible intervention to improve the Trust Fund is real.** The President's plan addresses this need in a responsible way, without imposing devastating provider cuts, increasing beneficiary costs, or enacting structural changes that hurt the program and the people it serves.

- **Over $125 billion remains in the Trust Fund.** While incoming revenues are somewhat less than outgoing payments, the current balance in the Trust Fund means that there is absolutely no danger that claims will not be paid.

- **Reports should not be used irresponsibly.** The upcoming Trust Fund report should not be used to recklessly frighten the 37 million Medicare beneficiaries and their families into thinking that their benefits are in imminent danger. They simply are not.

IT IS TIME TO PUT PARTISAN DIFFERENCES ASIDE AND AGREE ON THE COMMON MEDICARE SAVINGS BOTH REPUBLICAN AND DEMOCRATIC PROPOSALS HAVE.

- We have tens of billions of dollars in common Medicare savings that we could agree on tomorrow to strengthen the Trust Fund. All the Republicans need do is set aside their structural changes that would segment the wealthy and healthy from other beneficiaries and cause Medicare to *"wither on the vine."* (E.G., the Republican Medical Savings Account would actually weaken the Medicare Trust Fund, as it would cost $4 billion.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date June 4, 1996

From Chief Actuary, HCFA

Subject Estimated Year of Exhaustion for HI Trust Fund under Administration's Balanced Budget Proposal

To Administrator, HCFA

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under the Medicare provisions in the Administration's balanced budget proposal. Based on the intermediate set of assumptions in the 1996 Trustees Report, we estimate that the assets of the HI trust fund would be depleted in mid-calendar year 2006 under the Administration's proposal.

In the absence of corrective legislation, trust fund depletion would occur early in calendar year 2001 under the intermediate assumptions. Thus, the Administration's proposal would postpone the year of exhaustion by roughly 5½ years.

The financial operations of the HI trust fund will depend heavily on future economic and demographic trends. For this reason, the estimated year of depletion under the Administration's balanced budget proposal is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of the Administration's Medicare proposals, we would be happy to provide it.

Richard S. Foster, F.S.A.

THE HOME HEALTH TRANSFER AND THE MEDICARE TRUST FUND: THE FACTS

June 3, 1996

FALSE CLAIM: *Without its home health transfer gimmick, the President's budget only extends the life of the Trust Fund by one year.*

THE FACTS: **Not True.**

1. **The President's balanced budget guarantees the life of the Medicare Trust Fund for a decade -- the same as the Senate Republican budget.** The Congressional Budget Office projects that the President's Medicare reforms would extend the life of the Medicare Trust Fund to 2005. The reforms build on the President's 1993 deficit reduction plan, which extended the life of the Trust Fund by 3 years -- *without a single Republican vote.*

2. **The President's budget strengthens the Trust Fund by:**

   a. **Reducing provider payments; and**

   b. **Restoring the pre-1980 law on Part A home health benefits -- This is NOT a gimmick:**

      - Prior to 1980, home health care services unrelated to hospital stays were not financed by the Hospital Insurance (Part A) Program. Only the first 100 home visits after a three-day hospital stay were financed under Part A. All other visits were financed by Part B. This is because Medicare Part A was intended to finance costs related to hospital stays.

      - In 1980, the law was changed and nearly all home health costs were shifted to Part A.

      - The President's proposal simply restores the pre-1980 law because home health care expenditures unrelated to hospital stays should not be financed by the Part A Trust Fund. Shifting home health spending unrelated to hospitalization back to the Part B programs helps extend the life of the Medicare Part A Trust Fund. (This shift will not affect the Part B premiums, coinsurance or deductibles.)

3. REPUBLICANS ARE BEING HYPOCRITICAL: **The 1995 House Republican budget also shifted some home health costs from Part A to Part B.** The House-passed Republican reconciliation bill also transferred certain home health care expenditures from Part A to Part B -- similar to the proposal in the President's balanced budget. *So if Republicans say it's a gimmick, it's a gimmick every Republican in the House voted for.*

4. **President Clinton's budget extends the life of the Trust Fund as long as the Senate Republican budget, but without their $167 billion Medicare cut and without their damaging structural changes.** The President's balanced budget proves the Republican $167 billion Medicare cut and damaging structural changes are not necessary to balance the budget and strengthen the Trust Fund for a decade.

REPUBLICAN BUDGET STILL THREATENS MEDICARE

June 3, 1996

*"No, we don't get rid of it in round one because we don't think it's politically smart....
But we believe it's going to wither on the vine"* -- Newt Gingrich, 10/24/95

REPUBLICANS STILL INSIST ON EXCESSIVE MEDICARE CUTS THAT WOULD MOVE MEDICARE TOWARD SECOND CLASS HEALTH CARE. The Republican budget reduces Medicare spending by $167 billion -- $51 billion or 44% more than CBO scored the President's balanced budget. It would reduce spending by over $1,100 per beneficiary in 2002 -- a 50% greater cut than the President's Medicare savings from the current CBO Medicare baseline.

WHILE HOUSE REPUBLICANS HAVE FINALLY AGREED NOT TO RAISE MEDICARE PREMIUMS, THEY HAVE NOT LOWERED THEIR TOTAL CUTS. Rather than raising costs on beneficiaries directly they now do it indirectly through even deeper cuts in payments to the hospitals and home health providers that serve beneficiaries, jeopardizing quality and access to health services.

- **Extreme Cuts Threaten Viability of Many Hospitals.** Their $167 billion cut could mean hospitals get lower payments tomorrow than today--even in nominal terms--and will result in cost-shifting, undermine quality, and threaten the financial viability of many rural and urban hospitals. According to the American Hospital Association, nearly 700 hospitals derive *67% or more* of net patient revenues from Medicare & Medicaid.

- **American Hospital Association and National Association of Children's Hospitals are "gravely concerned about the level of reductions proposed"** by Republicans in Medicare and Medicaid. [May 10, 1996 letter to Chairmen Roth, Archer, and Bliley from ten hospital associations.]

MORE THAN DOLLARS ARE AT STAKE -- THEIR DAMAGING STRUCTURAL CHANGES WOULD FORCE MEDICARE TO "WITHER ON THE VINE." The Republican budget still contains the damaging structural changes that President Clinton vetoed last year. These changes would segment the Medicare population, leaving the traditional program with fewer dollars and sicker beneficiaries.

- MEDICAL SAVINGS ACCOUNTS (MSAs). Republicans insist on the immediate adoption of untested changes to the Medicare program, such as MSAs, that appeal to the healthiest and wealthiest beneficiaries, leaving the sickest and most costly beneficiaries in a weakened fee-for-service program. CBO projects that MSAs will *increase* Medicare costs by more than $4 billion over seven years.

  New York Times [11/18/95]: "A hallmark of the [Republican] Medicare legislation is the encouragement of private health plans....But many experts fear a balkanization of healthy and sick....If some experts worry that managed care plans would skim healthy recipients from the conventional Medicare program, many of the large plans are *concerned that the healthy would be skimmed from them by medical savings accounts.*"

- OVER-CHARGING IN PRIVATE PLANS. Republican proposals permit physicians to charge beneficiaries extra -- through "balance billing" -- in private Medicare plans, increasing out-of-pocket costs for beneficiaries and slowly draining the fee-for-service system of both doctors and dollars.

- HARD SPENDING CAP. Republicans impose a hard cap on Medicare spending. If costs increase faster than projected, spending would no longer keep up -- leading to cuts exceeding $167 billion.

  Wall Street Journal: "Republicans also would apply a cap to these services. If health-care costs rose faster than the GOP budget allots, doctors, hospitals and other providers would have to absorb the losses. *That, in turn, could come back to bite the beneficiaries.*" [12/27/95]

- **PRESIDENT CLINTON'S BUDGET SHOWS THAT THEIR DEEP CUTS AND DAMAGING STRUCTURAL CHANGES ARE NOT NECESSARY TO BALANCE THE BUDGET AND GUARANTEE THE LIFE OF THE MEDICARE TRUST FUND FOR 10 YEARS.**

KEY REPUBLICAN QUOTES ON MEDICARE

Senator Bob Dole: "I was there, fighting the fight, one of twelve, voting against Medicare in 1965 ... because we knew it wouldn't work."

American Conservative Union Speech
10/24/95

Speaker Newt Gingrich: "No, we don't get rid of it in round one because we don't think it's politically smart..... But we believe it's going to wither on the vine."

Blue Cross/Blue Shield Association Speech
10/24/95

Senator D'Amato: "If I had my druthers ... I would have said to my distinguished colleagues, both in the House and in the Senate, 'Don't link this business of tax cuts with fixing this badly flawed system. Put it aside.

Senate Finance Committee
09/26/95

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 2, 1996

STATEMENT BY DR. LAURA D'ANDREA TYSON
NATIONAL ECONOMIC ADVISER

Rather than joining President Clinton in passing common savings in Medicare to strengthen the Trust Fund and balance the budget, Speaker Gingrich has chosen to reargue and defend the extreme Medicare cuts and policies in the Republican Reconciliation bill that President Clinton already vetoed and the American people soundly rejected.

Speaker Gingrich should drop the political attacks and look at the facts. He should go back and listen to the many voices that agree that the Republican Medicare cuts and damaging structural changes would -- in his own words -- cause Medicare to "whither on the vine:"

- "We think that cuts of this magnitude call into question our ability to provide the world class medical care." [American Academy of Physicians, October 5, 1995]

- "This legislation...is not in the best interest of patients, communities, and the men and women who care for them. ...the reductions in the conference report will jeopardize the ability of hospitals and health systems to deliver quality care, not just to those who rely on Medicare and Medicaid, but to all Americans." [America Hospital Association, Catholic Health Association, and Voluntary Hospitals of America, and State Hospital Associations from 47 states, November 17, 1995]

- "Four hundred billion dollars in cuts from these two major health care programs that serve older and low-income Americans do not meet the fairness test. Reductions in Medicare called for in the conference report are much more than is necessary to keep the program solvent into the next decade." [American Association of Retired Persons (AARP), November 16, 1995.]

Even under the current Republican plan, Medicare spending would still be cut by $167 billion -- $51 billion or 44% more than CBO scored the President's balanced budget. Their new plan maintains the damaging structural changes in their reconciliation bill that would segment the Medicare population and leave the traditional program with fewer dollars and a sicker pool of beneficiaries.

- "It's impact on hospitals appears worse. ...We are gravely concerned about the level of reductions proposed" by Republicans in Medicare and Medicaid. [American Hospital Association, Federation of American Health Systems, Catholic Health Association, and 7 other national hospital associations, May 10, 1996.]

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REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE
May 28, 1996

THEY ARE STILL INSISTING ON A BLOCK GRANT FORMULA THAT THE GOVERNORS HAVE ALREADY REJECTED. *The Federal–State partnership is severed. The Republican proposal does not meet the Governors' principle that funding must automatically adjust for all changes in enrollment.* Under the Republican proposal, fully 97% of Federal Medicaid spending is a block grant. The remaining 3% is dedicated to an umbrella fund posing as protection for States with high enrollment growth. However, this umbrella is full of holes because it is difficult to access and provides only a one–time payment for population increases, not sustained support for States with higher than expected enrollment.

MEDICAID CUTS COULD STILL TOTAL $265 BILLION. While the Republicans cut Federal Medicaid spending by $72 billion, the total Medicaid cuts could still reach $265 billion over 6 years if States spend only the minimum required to receive their full grant allocation. This is because the Republican proposal reduces State matching requirements.

MEDICAID GUARANTEE TO MEANINGFUL BENEFITS NO LONGER SECURE FOR MILLIONS OF CHILDREN, PEOPLE WITH DISABILITIES, AND OLDER AMERICANS. The Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts reaching up to $265 billion, States could be forced to deny health benefits to millions of children, people with disabilities, and older Americans, putting millions of middle class families at risk of paying for health care for their parents, children or family members with disabilities.

- **Children.** Deep total cuts in Medicaid would put severe financial pressure on States to reduce health benefits for many of the 18 million children who currently receive Medicaid. In addition, the Republican proposal would deny the guarantee of coverage for 2.5 million children aged 13–18.

- **People with Disabilities.** The Republican plan still jeopardizes the Medicaid guarantee for the over 6 million people with disabilities who currently receive Medicaid by allowing States the option to define who meets the disability criteria. Their excessive Medicaid cuts may force States to restrict the scope of eligible disabilities, or cut back on benefits.

- **Older Americans.** Many of the Medicaid benefits critical to older Americans and people with disabilities are optional -- including prescription drugs, home and community–based care, and assistive devices such as wheelchairs and communication devices -- and cuts reaching up to $265 billion could force States to cut back on these optional benefits.

THE GUARANTEE OF FINANCIAL PROTECTION FOR THE MIDDLE CLASS IS ENDED. Under the Republican bill, current law protections for Medicaid beneficiaries who own homes appears to be eliminated. As such, States may have the option to treat homes as assets, which would result in ineligibility for nursing home coverage. The only way to then obtain coverage could be to sell the home or family farm as an asset and spend down until the beneficiary met the State–defined resource threshold. In addition, States and providers will face overwhelming financial incentives to shift long–term care costs to patients and their families. Since Federal protections against excessive cost–sharing requirements are eliminated, many patients and their families will pay more for less.

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.

May 28, 1996

THE REPUBLICANS' FINANCING PROPOSAL -- CENTRAL TO MEDICAID REFORM -- IGNORES THE GOVERNORS' RECOMMENDATIONS. Unanimously, the Nation's Governors agreed to a financing formula that increases Federal funding when caseload and inflation increase. *The Republican bill's financing formula does not meet this principle.*

- **It is still a block grant.** The Federal–State partnership in financing Medicaid is severed. Under the Republican bill, fully 97 percent of Federal Medicaid spending is block granted. The Federal spending formula is permanently set in legislation so that if States experience a recession or a period of inflation, they are virtually unprotected.

- **Funding does not follow the people.** There is no component of the block grant that adjusts for caseload increases. Without incorporating caseload increases, funding will not keep pace with the caseload, possibly forcing States to deny health benefits to millions of children, people with disabilities, and older Americans.

- **The "umbrella" is full of holes.** Although 97 percent of Federal Medicaid spending is fixed in the block grant, there is a small "umbrella" fund that is supposed to protect states with high enrollment growth. However, this "umbrella" fund is full of holes because it is difficult to access and provides only a one–time payment for population increase, not sustained support for States with higher than expected enrollment.

THE REPUBLICAN BILL GOES BACK TO A MEANINGLESS BENEFITS PACKAGE. The NGA proposal moved towards standards for the amount, scope, duration, and benefits.

- **The Republican bill moves away from the NGA acknowledgement of the need for benefits standards.** Without standards, there is no such thing as meaningful benefits or a guarantee of coverage. For example, "coverage" of inpatient hospital care could consist of one day a year.

THE REPUBLICAN BILL ENDS A GUARANTEE OF FINANCIAL PROTECTION FOR MIDDLE CLASS FAMILIES. The NGA proposal did not remove protections against excessive cost sharing requirements for Medicaid beneficiaries.

- **The Republicans will force families to pay more for less.** The Republican bill removes current protections against excessive cost sharing requirements -- although the NGA proposal did not endorse this. Since total Medicaid spending will be cut by $265 billion over six years under this proposal, providers will face overwhelming financial incentives to shift long–term care costs to patients and their families.

VACCINES FOR CHILDREN PROGRAM (VFC) IS ELIMINATED. The NGA proposal did not recommend that the Vaccines for Children program be repealed.

- **Children would suffer without adequate vaccinations.** The Republican bill ends the Vaccine for Children program and lets States establish their own vaccinations programs. Repeal of VFC funding will reduce the number of children immunized.

File: Medicaid

House Republican Medicaid Plan: Placing Families of All Generations at Risk

Medicaid Guarantee to Meaningful Benefits No Longer Secure for Millions Of Americans. The House Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts possibly reaching up to $250 billion and States having complete flexibility to decide the amount duration, and scope of Medicaid benefits, States could be forced to deny health benefits to millions of families, children, people with disabilities, and older Americans. As a result, beneficiaries could pay more to maintain current coverage or go without care.

Coverage of Critical Health Services Is Jeopardized.
Significant funding cuts proposed by the Republicans may force States to cut back or altogether eliminate optional Medicaid benefits, critical to older Americans and people with disabilities. These benefits include: prescription drugs, home and community–based care, and assistive devices such as wheelchairs.

Beneficiaries' Out–of–Pocket Costs Could Increase.
Under the House Republican plan, States, driven by significant funding cuts, could reduce the scope of benefits they cover to inadequate levels. As a result, beneficiaries may be forced to pay more out–of–pocket to maintain their current coverage. For example, if physician services were limited to 2 visits per month, the elderly or children with disabilities, who see physicians more often because of medical need, would have to pay more to get the proper care.

Protections for Nursing Home Residents and Their Spouses Are Eroded.
Many older Americans and persons with disabilities are at risk of selling their family home to qualify for Medicaid nursing home benefits. Protections against spousal impoverishment may be further eroded if States reduce the amount of assets that community spouses are allowed to keep or if spouses pay for benefits no longer covered by Medicaid.

Access to Nursing Home Care May Be Limited.
The House Republican plan does not require states to provide a comparable level of services throughout the state. In effect, states could discriminate among beneficiaries by reducing services to arbitrary or insufficient levels, or by providing more limited benefits to certain geographic areas or groups.

Families Vulnerable to Paying More to Care For Elderly Parents.
The House Republican plan allows States to shift costs to families by imposing higher levels of copayments, deductibles, and premiums for all services to some seniors. Families could pay more just to preserve the coverage their elderly parents receive.

Health Care Services for Children may Cost Families More.
Under the House Republican plan, states would not be required to cover the care needed to treat a medical condition or illness diagnosed during a child's health screen and exams. Additionally, States could require children and pregnant women to make co–payments toward all needed health services.

July 2, 1996

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE
June 21, 1996

Conference Report

THEY ARE STILL INSISTING ON A BLOCK GRANT FORMULA THAT THE 'ERNORS HAVE ALREADY REJECTED. *The Federal–State partnership is severed. Republican proposal does not meet the Governors' principle that funding must automatically adjust for all changes in enrollment.* Under the Republican proposal, fully 97% of Federal Medicaid spending is a block grant. The remaining 3% is dedicated to an umbrella fund posing as protection for States with high enrollment growth. However, this umbrella is full of holes because it is difficult to access and provides only a one–time payment for population increases, not sustained support for States with higher than expected enrollment.

MEDICAID CUTS COULD STILL TOTAL $250 BILLION. While the Republicans cut Federal Medicaid spending by $72 billion, the total Medicaid cuts could still reach $250 billion over 6 years if States spend only the minimum required to receive their full grant allocation. This is because the Republican proposal reduces State matching requirements.

MEDICAID GUARANTEE TO MEANINGFUL BENEFITS NO LONGER SECURE FOR MILLIONS OF CHILDREN, PEOPLE WITH DISABILITIES, AND OLDER AMERICANS. The House Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts possibly reaching up to $250 billion, States could be forced to deny health benefits to millions of children, people with disabilities, and older Americans, putting millions of middle class families at risk of paying for health care for their parents, children or family members with ' 'ilities.

- **Children.** Deep total cuts in Medicaid would put severe financial pressure on States to reduce health benefits for many of the 18 million children who currently receive Medicaid.

- **People with Disabilities.** The Republican plan still jeopardizes the Medicaid guarantee for the over 6 million people with disabilities who currently receive Medicaid by allowing States the option to define who meets the disability criteria. The Republican's excessive Medicaid cuts may force States to restrict the scope of eligible disabling conditions, or cut back on benefits.

- **Older Americans.** Many of the Medicaid benefits critical to older Americans and people with disabilities are optional –– including prescription drugs, home and community–based care, and assistive devices such as wheelchairs and communication devices –– and cuts reaching up to $250 billion could force States to cut back on these optional benefits.

THE GUARANTEE OF FINANCIAL PROTECTION FOR THE MIDDLE CLASS IS ENDED. Under the Republican plan, most Medicaid beneficiaries could be forced to sell their home in order to qualify for Medicaid nursing home benefits. The Republican plan repeals the current protections for the homes of all but the poorest Medicaid beneficiaries. States would have the option to count homes as assets in determining Medicaid eligibility, which could force older Americans and people with disabilities to sell their home or family farm in order to qualify for nursing home benefits.

' 'lition, the Republican plan could put overwhelming pressure on states and providers to shift i. ig home care costs to patients and their families. Because it makes deep funding cuts and weakens the current protections against excessive cost–sharing requirements, many patients and their families would pay more for less.

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.

June 21, 1996

Conference Report

HE REPUBLICANS' FINANCING PROPOSAL -- CENTRAL TO MEDICAID REFORM -- IGNORES THE GOVERNORS' RECOMMENDATIONS. Unanimously, the Nation's Governors agreed to a financing formula that increases Federal funding when caseload and inflation increase. *The Republican bill's financing formula does not meet this principle.*

- **It is still a block grant.** The Federal-State partnership in financing Medicaid is severed. Under the Republican bill, fully 97 percent of Federal Medicaid spending is block granted. The Federal spending formula is permanently set in legislation so that if States experience a recession or a period of inflation, they are virtually unprotected.

- **Funding does not follow the people.** There is no component of the block grant that adjusts for caseload increases. Without incorporating caseload increases, funding will not keep pace with the caseload, possibly forcing States to deny health benefits to millions of children, people with disabilities, and older Americans.

- **The "umbrella" is full of holes.** Although 97 percent of Federal Medicaid spending is fixed in the block grant, there is a small "umbrella" fund that is supposed to protect states with high enrollment growth. However, this "umbrella" fund is full of holes because it is difficult to access and provides only additional payments for year-to-year population increases, not sustained support for States with higher than expected enrollment.

THE REPUBLICAN BILL GOES BACK TO A MEANINGLESS BENEFITS PACKAGE. The NGA proposal moved towards standards for the amount, scope, duration, of benefits.

- **The Republican bill moves away from the NGA acknowledgement of the need for benefits standards.** Without standards, there is no such thing as meaningful benefits or a guarantee of coverage. In addition, the limits of federal funds may force States to offer meaningless benefits. For example, "coverage" of inpatient hospital care could consist of one day a year.

THE REPUBLICAN BILL ENDS A GUARANTEE OF FINANCIAL PROTECTION FOR MIDDLE CLASS FAMILIES. The NGA proposal did not remove protections against excessive cost sharing requirements for Medicaid beneficiaries.

- **The Republicans will likely force families to pay more for less.** The Republican bill removes current protections against excessive cost sharing requirements -- although the NGA proposal did not endorse this. Since total Medicaid spending will be cut by $250 billion over six years under the Republican proposal, providers will face overwhelming financial incentives to shift long-term care costs to patients and their families.

ACCINES FOR CHILDREN PROGRAM (VFC) IS ELIMINATED. The NGA proposal did not recommend that the Vaccines for Children program be repealed.

- **Children would suffer without adequate vaccinations.** The Republican bill ends the Vaccine for Children program and lets States establish their own vaccinations programs. Repeal of VFC funding will reduce the number of children immunized.

THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable federal guarantee of coverage for a defined benefit package
- Adequate and appropriately shared federal and state financing
- Beneficiary protections through quality standards and accountability

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, e House Commerce Republican bill would alter existing eligibility criteria thereby eliminating the guarantee of coverage. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal Poverty Level (FPL).**

- **offers each state the option of using either: 1)the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of current policy, which has a federal definition. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.

- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**

- **eliminates the current guarantee of transitional medical assistance for individuals losing cash assistance due to proposed time limits or other provisions in welfare reform.**

- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid. For example, it appears states may even have flexibility to restrict eligibility based on home ownership. Under current law, a home of any value does not affect a person's eligibility. Under the Republican bill, home owners could be found ineligible.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefit packages. There would be no "required" services for optional eligibility groups.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the "amount, duration, and scope" of benefits).** The Secretary does not have clear authority to affect states' decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.

- **Statewideness requirements would be eliminated.** States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain populations that tend to live in specific areas.

- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries). Alternatively, states could provide richer benefits to favorable groups.

- **"Treatment" under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services.** Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they would be optional services.

- **The Vaccines for Children Program is repealed,** while making childhood immunization a mandatory service. States are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.

- **Federal funding for abortion services would be permanently limited to instances of rape, incest, or where the life of the mother is in jeopardy.**

- **Family planning services are limited to "pre-pregnancy" family planning services and supplies.**

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in

federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** Beneficiaries could file a petition for certiorari before the Supreme Court of the United States, but only after all state appeal mechanisms are exhausted. Otherwise, only the Secretary of HHS would be able to sue in federal court on behalf of individuals. No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.

- Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns, nd from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The base funding formula in the Republican bill has been seen before: it's the basic Medigrant II formula. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigrant II block grant formula. About 3 percent is attributable to the new umbrella fund.

The funding formula provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.

- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they may be forced either to raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to decrease total Medicaid funding and the state contribution required to generate the capped federal share of dollars spent on Medicaid. States have the incentive to withdraw large amounts of state Medicaid funding, making total cuts much larger than the proposed $72 billion in federal cuts.

- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year. Repealing these limitations would give states the incentive to use these schemes to reduce the state contribution to Medicaid even further.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.

- **The Republican bill does not include critical federal quality standards for institutions caring for people with mental retardation and developmental disabilities.** There are no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.

- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.

- **The Republican bill expands states' ability to impose cost sharing on Medicaid beneficiaries.** Unlike current law, which bars states from imposing co-payments on children or on pregnancy related services, the Republican bill would allow cost sharing for children and pregnant women for any service except preventive and primary services, as defined by the state. In addition, co-payments could be imposed for all other services to the elderly and disabled.

- **Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.**

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as "nursing home services." Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.

- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries. Assets, including the home, needed by survivors could be at risk of being claimed by the state.

Re: Medicaid/IGT

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NEWS RELEASE

Illinois Department of Public Aid
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FOR IMMEDIATE RELEASE
Sept. 7, 2000

Contact: 217-782-3458

PUBLIC AID DIRECTOR CALLS FOR FEDERAL GOVERNMENT TO END PROPOSAL TO CUT $500 MILLION IN HEALTH CARE SERVICES FOR THE STATE'S POOR

CHICAGO, ILL. – Illinois Department of Public Aid Director Ann Patla today called on the federal government to end its threatened $500 million cut to Illinois' health care program for the poor—including a $200 million cut to Cook County Hospital and other Cook County health providers—and to renew its commitment to ten years of working with Illinois to provide health care services to sick children, families, seniors, people with disabilities and pregnant mothers.

"With this proposed $500 million cut, the Administration in Washington is reversing course on a longstanding commitment to the health care needs of poor children, women, seniors and pregnant mothers in Illinois," Patla said. "Make no mistake. Cutting ten percent of the Medicaid budget will produce consequences that are real and tragic: kids going without immunizations from disease; people with disabilities without the resources to afford prescription medicine; seniors unable to afford doctor visits and lab tests—even pregnant mothers forced to go without prenatal care. In a time of surplus in Washington, these proposed cuts are unconscionable."

- more -

"Since 1991, the federal government, the state, Cook County Hospital and other Cook County health providers have worked cooperatively to offer health care services to the poor through the state's Medicaid plan. Suddenly, in the last several weeks, the Administration is threatening to renege on its commitment to these health services for the poor and has begun calling into question the funding for this program. For the record, the federal government did not characterize this program as a "loophole" while it was acknowledging and officially approving our plan 22 times in the last ten years."

The Illinois Public Aid Medicaid program serves more than 1.5 million Illinois citizens with a Fiscal Year 2001 general funds budget of more than $5 billion.

"The federal government has charged that other states—not Illinois—have used Medicaid money for non-health-related purposes. Indeed, in Illinois Medicaid dollars have been used for health care services for the poor. "

"It is not too late to save these vital health care services from the cutting block. Today we are calling on the Administration in Washington to revisit its commitment to working with the State of Illinois to continue to provide these vital health care services for our state's neediest and poorest citizens."

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Editorials

Federal squeeze play on Medicaid

Vice President Al Gore may want to interrupt his campaign-trail bashing of the way Texas treats its welfare poor and check out the damage his own administration is about to visit upon Medicaid patients in states like Illinois.

It seems the federal Health Care Financing Administration (HCFA) is having second thoughts about its longstanding practice of reimbursing state and local governments for half of what it costs to treat indigent patients at public hospitals and clinics.

The payments were a godsend to states like Illinois and counties like Cook, which previously had spent billions of local dollars providing direct care for Medicaid-eligible patients with little assistance from Washington. So back in 1991 HCFA agreed to match these expenditures just as it matches Medicaid spending for services provided by private-sector hospitals and doctors.

That agreement, over time, helped Illinois get current on a billion dollars worth of overdue Medicaid bills, and it bolstered Cook County's health care budget to the point that it could justify construction of a new County Hospital.

Only now, HCFA is deciding to cut back. One concern is that eleven more states are petitioning to join the 17 already in the funds-matching program. Another is that some participating states—Illinois *not* included—are using their extra federal matching funds to repave highways, pay down deficits and even fund tax cuts. If true, that's a legitimate complaint and warrants specific, state-by-state sanctions. Taxpayers deserve to know their Medicaid dollars are being used to reimburse care for the indigent. Period.

But government bureaucracies have a habit of punishing the many for the sins of the few.

HCFA is about to propose an across-the-board scaling back of federal reimbursement levels, replacing the relatively generous price list used by Medicare—the federal insurance program for seniors—with a cut-rate menu based on the marginal costs incurred by the local public hospitals and clinics.

That may sound reasonable, but the practical effect of such a change would be to slash federal payments to Illinois by $500 million a year, $200 million of that from Cook County.

All this at a time when candidate Gore is plucking the health care chord at every whistle stop, claiming the states, especially Gov. George Bush's Texas, aren't doing enough for the poor.

Here's a case where the Clinton-Gore administration needs to mind its own business.