MEDICAID BLOCK GRANT PROPOSAL

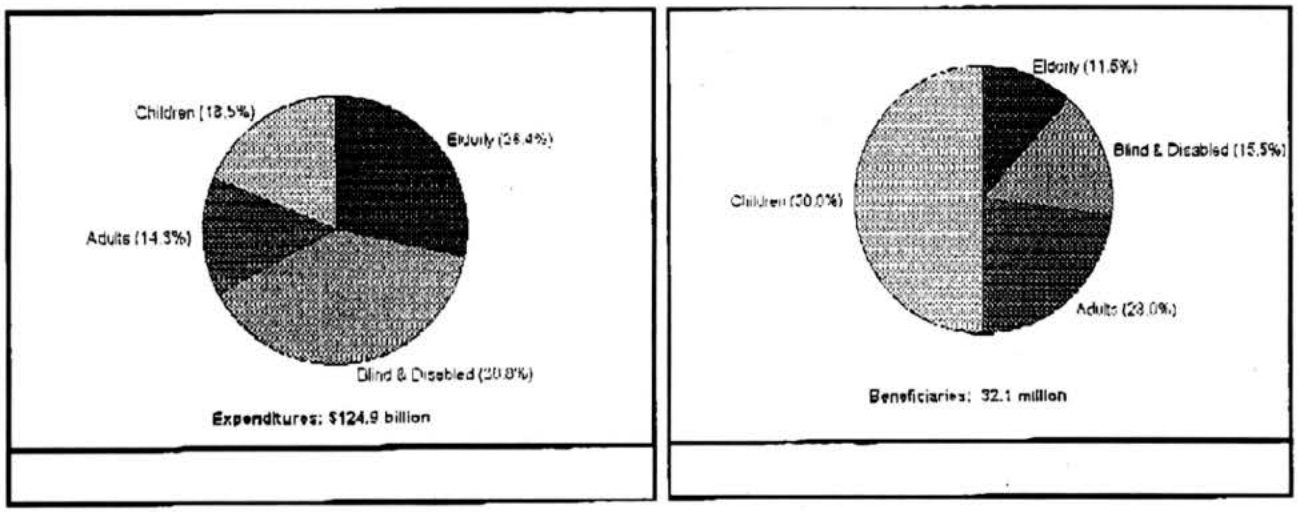
- Republicans are proposing to cap federal payments to states under the Medicaid program as part of their effort to balance the federal budget.

- House leaders have discussed a target of $180 - 190 billion in savings from Medicaid between 1996 and 2002. This is approximately equivalent to capping annual growth in federal Medicaid payments at 5% beginning in 1996.

- While there are no specific Congressional block grant proposals for Medicaid, the presumption is that states would be given broad flexibility to determine eligibility, benefits, and provider payment levels.

CURRENT MEDICAID PROGRAM

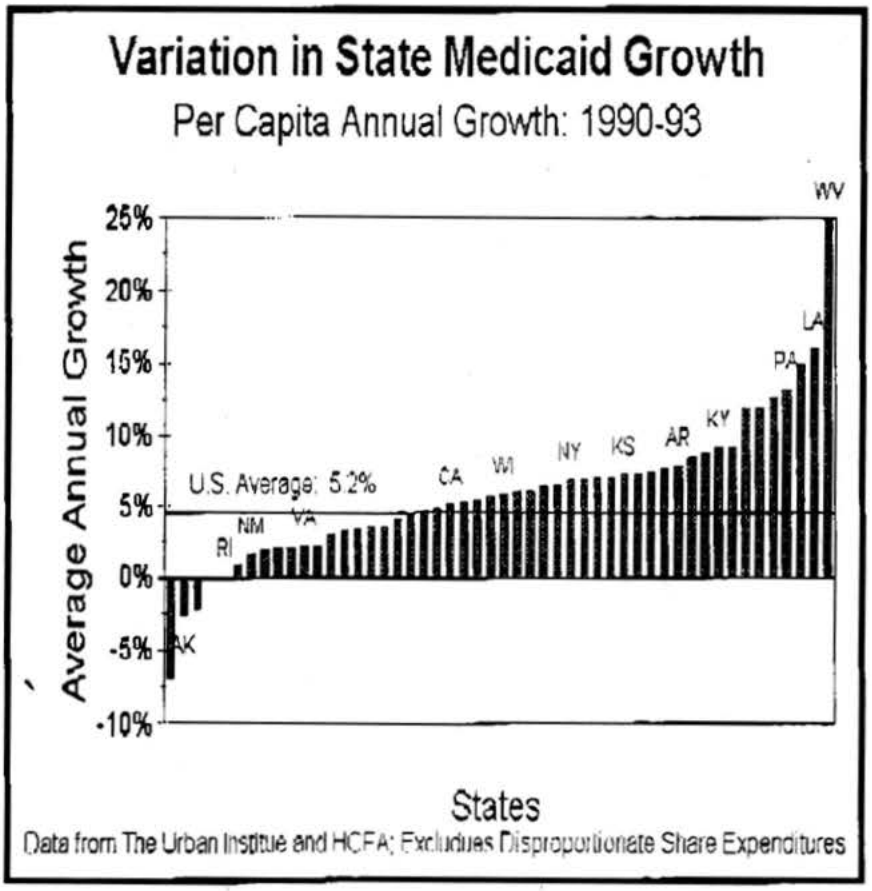
Medicaid Expenditures and Beneficiaries: 1993



Note: Does not include Arizona or U.S. Territories
Source: The Urban Institute, 1994, Prepared for the Kaiser Commission on the Future of Medicaid

- Adults and children comprise about three quarters of enrollment, but account for only one-third of spending. Non-elderly, non-disabled adults account for only 14% of spending.
- The elderly and disabled comprise only 27% of enrollment, but account for 67% of the spending.

STATE VARIATIONS IN GROWTH RATES



The rate of growth in Medicaid spending varies significantly from state to state. Growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns, or service mix.

ENTITLEMENT VERSUS BLOCK GRANT

As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the number of people covered in a state.

- **Block Grants Do Not Recognize Differences Among State Programs.**
  - State growth rates can vary significantly.
  - States also have very different opportunities to achieve savings through managed care. For example, some states already have achieved savings, rural states have less capacity to implement capitated payment arrangements, and some states have a larger proportion of elderly and disabled recipients.
- **States At Risk from Inflation and Recession.** When a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, federal payments to the state would rise, but under a block grant with a fixed growth rate they would not.
- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services for an increasing number of elderly people.

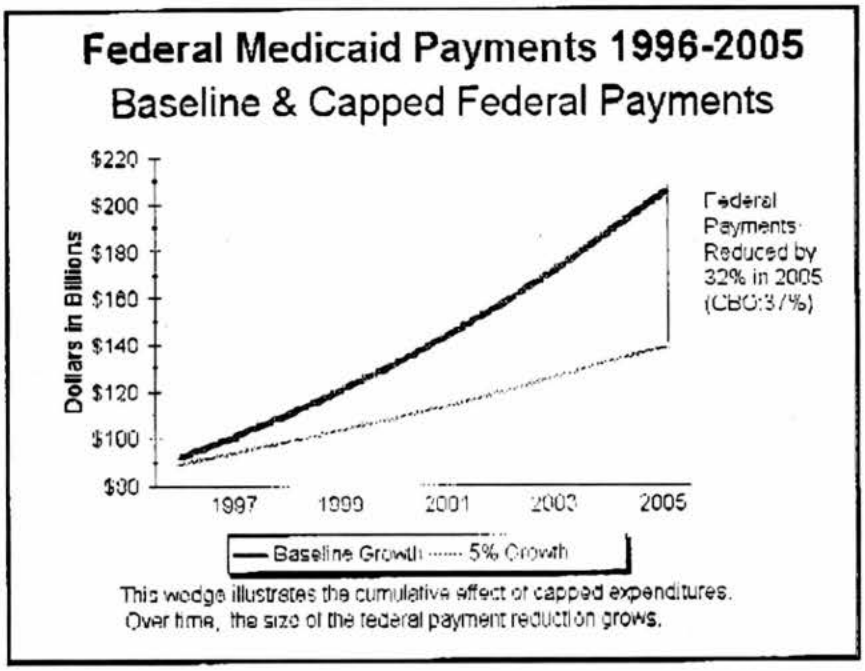
CAPPING MEDICAID SPENDING

Reduction of Federal Spending Under a 5% Growth Cap (Billions of Dollars, Fiscal Years)

	1996-2000	1996-2002	1996-2005
CBO Baseline			
Growth at 5%	$97	$193	$417
President's Baseline			
Growth at 5%	$62	$131	$299

- Under the President's baseline, Medicaid is projected to grow at 9.3% through the end of the decade.
- Under the CBO baseline, Medicaid is projected to grow at 10.2% through the end of the decade.
- Due to the cumulative effect of the annual reductions, the reduction in federal payments to states doubles (from $97 billion to $193 billion under the CBO baseline) between FY 2000 and FY2002.

CAPPING MEDICAID SPENDING



- Between 1996 and 2000, federal payments to states would be 11% below the baseline projection (16% under the CBO baseline).
- Between 1996 and 2005, the cumulative reduction in federal payments is 21% (26% under CBO baseline).
- In FY 2005 alone, federal payments to states would be 32% below the baseline projections (37% under the CBO baseline).

STATE-BY-STATE EFFECTS OF CAPPING FEDERAL MEDICAID PAYMENTS

- The state-by-state effects of capping federal Medicaid payments have been analyzed two ways.
  - The first method estimates the reduction in federal payments for each state assuming that every state grows at the national rate of growth in Medicaid spending projected by CBO.
  - The second method estimates the reduction in federal payments for each state assuming that each state grows between 1996 and 2002 at the same annual rate that the state is projecting for the period 1993 to 1996.
- Assuming that all states grow at the projected national average growth rate, a block grant with 5% growth would reduce federal payments in every state.
- Assuming state-specific growth rates, changing federal Medicaid payments into a block grant with 5% growth would disproprotionately harm states with high growth rates and benefit states with lower rates of growth.
  - For example, New York, which has a high rate of growth, would lose almost $70 billion between 1996 and 2002. (Their loss would be only about $30 billion if they were growing at the national average rate of growth).
  - Some states with low growth rates would actually benefit from a block grant. For example, Colorado would gain about $500 million between 1996 and 2002 under a block grant.
  - States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements).

Illustrative Effect of a Medicaid Block Grant Reduction in Federal Payments Assuming 5% Growth Cap
(Dollars in millions, fiscal years)

	State Baseline Growth at National Rates	State Baseline Growth at State Projected Rates
US	**(192,580)**	**(155,793)**
Alabama	(2,842)	(537)
Alaska	(330)	204
Arizona	(2,527)	(3,064)
Arkansas	(1,880)	(49)
California	(19,035)	(3,318)
Colorado	(1,719)	782
Connecticut	(2,865)	(3,174)
Delaware	(364)	(221)
District of Columbia	(912)	(1,391)
Florida	(7,926)	(12,899)
Georgia	(4,805)	(5,848)
Hawaii	(572)	(776)
Idaho	(549)	(404)
Illinois	(6,454)	(2,951)
Indiana	(4,073)	2,176
Iowa	(1,648)	(1,031)
Kansas	(1,251)	1,123
Kentucky	(3,020)	215
Louisiana	(6,538)	728
Maine	(1,345)	(222)
Maryland	(2,916)	(4,500)
Massachusetts	(5,171)	(2,308)
Michigan	(6,552)	(4,248)
Minnesota	(3,269)	(3,743)
Mississippi	(2,488)	(1,542)
Missouri	(3,551)	(1,471)
Montana	(555)	(130)
Nebraska	(904)	(918)
Nevada	(465)	129
New Hampshire	(753)	(812)
New Jersey	(5,391)	2,174
New Mexico	(1,178)	(1,744)
New York	(27,369)	(61,922)
North Carolina	(5,238)	(8,253)
North Dakota	(426)	49
Ohio	(8,175)	(6,548)
Oklahoma	(1,681)	349
Oregon	(1,808)	(4,477)
Pennsylvania	(8,810)	1,844
Rhode Island	(1,003)	577
South Carolina	(3,305)	468
South Dakota	(488)	(496)
Tennessee	(5,319)	(2,193)
Texas	(12,687)	(19,204)
Utah	(927)	(783)
Vermont	(404)	(148)
Virginia	(2,290)	(982)
Washington	(3,314)	(3,174)
West Virginia	(2,036)	(167)
Wisconsin	(3,117)	(727)
Wyoming	(237)	(221)

Base year: State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.
Assumes that Federal payments to states grow at the CBO projected national average growth rates (column 1) or the average compound growth rates between FY 1995 (actual data) and states' projected expenditures for FY 1996 (column 2). The states submitted these projected expenditures in November, 1994.

POTENTIAL STATE RESPONSES TO OFFSET FEDERAL PAYMENT REDUCTIONS

- Medicaid Managed Care
- Reduction in Benefits
- Reduction in Payments to Providers
- Reduction in Eligibility/Recipients
- Increase or Decrease in State Medicaid Spending

MEDICAID MANAGED CARE

- While many point to managed care as a source of significant savings under Medicaid, studies (including by CBO) have generally found that it produces a one-time savings of about 5 to 15% over baseline costs without slowing the rate of growth.

- States have applied managed care primarily to AFDC and noncash children, who account for less than one-third of Medicaid spending.

- Any additional savings that can be achieved through managed care is limited by two factors:

  - Baseline projections already assume that a substantial proportion of Medicaid recipients will be in managed care arrangements (33% of AFDC and non-cash children currently, growing to over 50% by the end of the decade).

  - Over two-third of Medicaid spending is for the elderly or the disabled, who use services (like long term care) that are not typically more efficient under managed care arrangements. Therefore, any savings from managed care can largely be applied only to one-third of Medicaid spending.

- Preliminary estimates show that if <u>all</u> AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be approximately $3.7 billion, a very small proportion of the $299 billion needed to offset the reduction in federal payments over this period.

REDUCTION IN BENEFITS

States could choose to reduce covered services in response to the reduction in federal payments.

- For example, eliminating home health, hospice, and Medicare premium and cost sharing assistance -- which would affect the low-income elderly and disabled -- would achieve the savings necessary in 1997 to offset a 5% cap on Medicaid growth.

- By 2002, however, eliminating these benefits would achieve only about one-third of the necessary savings because the size of the federal reduction increases each year.

- In 2002, for example, eliminating all of the following benefit categories would not even achieve the savings necessary to offset a 5% cap: home health, hospice, Medicare premium and cost sharing assistance, dental, drugs, and personal care services.

REDUCTIONS IN PAYMENTS TO PROVIDERS

States could choose to reduce payments to providers response to the reduction in federal payments.

- If states chose to make proportional reductions in payments to hospitals, physicians, and nursing homes, the reductions would be **13.7% on average** between 1996 and 2002.

- Because the size of the federal payment reduction under a block grant would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow.

  - In 1997, a 6% reduction in provider payments would be needed.

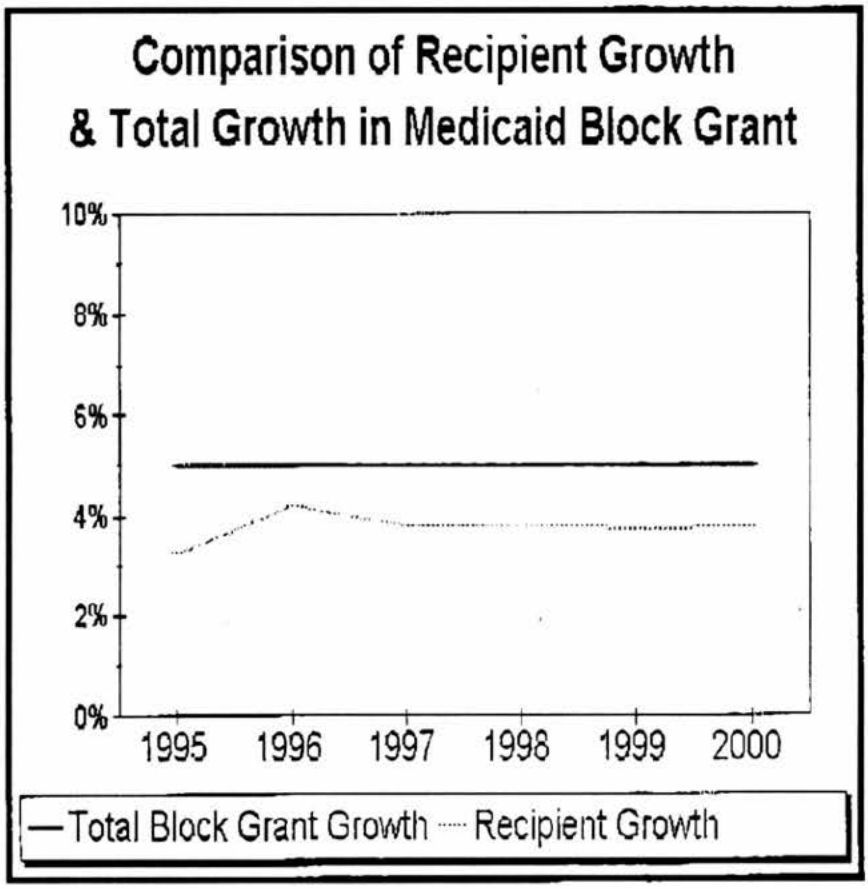
  - In 2002, a 22.9% reduction in provider payments would be needed.

  - In 2005, a 32.8% reduction in provider payments would be needed.

- These reductions are on top of Medicaid's already low payment rates, and would disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- The required reductions could be lowered if payment reductions were applied to other service categories (e.g., prescription drugs), but payment rates for these other services are more difficult for states to control.

REDUCTION IN ELIGIBILITY/RECIPIENTS



- The number of people covered by Medicaid is projected to grow by an average of 3.8% a year from 1996 to 2000.
- If states did not reduce coverage under Medicaid, a block grant growing at 5% per year would allow only 1.2% growth in federal Medicaid payments per person. This is far less than the x% projected annual growth in medical inflation.
- Since states are unlikely to be able to hold growth in Medicaid spending per person to such a low rate, cutting the number of people covered by Medicaid is a likely outcome.

REDUCTION IN ELIGIBILITY/RECIPIENTS

States could also choose to reduce eligibility to offset federal payment reductions.

- In 1997, eliminating eligibility for non-cash children (the OBRA expansions) would achieve only about 62% of the savings necessary to offset the reduction in federal payments.

- In 2002, eliminating eligibility for this population would offset only about 23% of the reduction in federal payments, and eliminate coverage for over 6 million children.

- In 2002, eliminating eligibility for both non-cash kids and AFDC adults would offset about three-quarters of the reduction in federal payments and would eliminate 11 million people from Medicaid. Alternatively, eliminating the medically needy program (for both acute and long-term care) would offset a little over 80% of the necessary savings.

INCREASE OR DECREASE IN STATE SPENDING

- If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections.

- However, because of the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;

  - In 2005, the increase in state spending would be 43% over baseline projections.

- Given state budgetary pressures, they are not likely to increase Medicaid spending, and may, in fact, want to decrease spending.

  If states permitted the state share of Medicaid spending to grow at the same 5% rate as a block grant, total Medicaid program spending would decrease by $229 billion below the President's baseline ($338 billion below the CBO baseline).

CAPPING MEDICARE SPENDING

- Republican efforts to balance the federal budget may also lead to proposals to cap federal spending for the Medicare program.

- While there are no specific Medicare cap proposals, we have estimated the effects of capping the growth in Medicare at 5% annually. Medicare is currently projected to grow at an average annual rate of 9.8% between fiscal years 1996 and 2002.

- Using CBO budget estimates, a 5% growth cap would reduce federal Medicare spending below baseline projections by $311 billion from fiscal years 1996 to 2002, and by $701 billion from 1996 to 2005.

- The following table shows the potential effects of a 5% growth cap on a state-by-state basis. This analysis assumes that Medicare spending in each state under the status quo would grow at same rate as overall Medicare spending is projected to grow.

Illustrative Effect of Medicare Capped Expenditures
Reduction in Federal Payments Assuming 5% Growth Cap
(Dollars in millions, fiscal years)

	1996 - 2002
US*	(311,000)
Alabama	(5,354)
Alaska	(212)
Arizona	(4,740)
Arkansas	(2,842)
California	(35,877)
Colorado	(3,111)
Connecticut	(4,467)
Delaware	(780)
District of Columbia	(2,419)
Florida	(25,607)
Georgia	(7,184)
Hawaii	(1,029)
Idaho	(744)
Illinois	(13,353)
Indiana	(6,257)
Iowa	(2,840)
Kansas	(2,938)
Kentucky	(4,262)
Louisiana	(5,673)
Maine	(1,222)
Maryland	(5,374)
Massachusetts	(9,764)
Michigan	(11,253)
Minnesota	(4,583)
Mississippi	(2,889)
Missouri	(6,794)
Montana	(804)
Nebraska	(1,500)
Nevada	(1,444)
New Hampshire	(1,006)
New Jersey	(10,335)
New Mexico	(1,211)
New York	(24,910)
North Carolina	(7,055)
North Dakota	(755)
Ohio	(13,243)
Oklahoma	(3,365)
Oregon	(3,141)
Pennsylvania	(20,174)
Rhode Island	(1,368)
South Carolina	(3,134)
South Dakota	(721)
Tennessee	(7,076)
Texas	(17,423)
Utah	(1,285)
Vermont	(496)
Virginia	(5,267)
Washington	(4,715)
West Virginia	(2,213)
Wisconsin	(5,016)
Wyoming	(302)

Federal payment reductions are allocated across states in proportion to the states' FY 1995 share of Medicare spending.

POTENTIAL RESPONSES TO ACCOMPLISH REDUCED MEDICARE SPENDING GROWTH

- Reduction in Medicare Benefits
- Reduction in Medicare Payments to Providers
- Increases in Medicare Premiums

REDUCTION IN MEDICARE BENEFITS

Medicare covered services could be reduced or eliminated in response to the growth cap.

- For example, eliminating Medicare home health and hospice services would achieve the savings necessary in 1997 to offset a 5% cap on Medicare growth.

- However, by 2002, eliminating these benefits would achieve only about one-third of the necessary savings because the size of the reduction increases each year.

- In 2002, eliminating all of the following Medicare benefits would be necessary to offset a 5% cap: home health, skilled nursing facility, end-stage renal disease facility, hospice, hospital outpatient department and lab services.

REDUCTION IN MEDICARE PAYMENTS TO PROVIDERS

Medicare payments to providers could be reduced in response to the growth cap.

- Because the size of the reductions under a Medicare cap grow each year, the percent reduction in Medicare spending for providers would also need to grow.

- If all the savings come from providers in proportion to their share of Medicare dollars:

  - In 1997, a 10 percent reduction in Medicare spending for hospitals, physicians and all other providers would be needed.

  - In 2002, a 25 percent reduction would be needed.

  - In 2005, a 34 percent reduction would be needed.

EFFECTS ON SPECIFIC PROVIDERS

- Hospitals would be particularly affected by reductions in Medicare spending of this magnitude because Medicare accounts for more than one-third of hospital revenues.
  - In 1997, rural hospitals would lose $1.2 billion in Medicare revenues and teaching hospitals would lose $4.5 billion.
  - Because of the effects of compounding, in 2002, rural hospitals would lose nearly $5 billion in Medicare revenues and teaching hospitals would lose $18 billion.
  - In 2005, rural hospitals would lose about $9 billion in Medicare revenues and teaching hospitals would lose $32 billion.
- Reductions in Medicare expenditures for physicians' services to offset a 5% growth cap would also be significant.
  - In 1997, a reduction of $4 billion in Medicare expenditures for physicians' services would be needed.
  - By 2002, a reduction of $15 billion in Medicare expenditures for physicians' services would be needed.
  - By 2005, a reduction of $28 billion in Medicare expenditures for physicians' services would be needed.

INCREASES IN MEDICARE PREMIUMS

- Federal Medicare spending reductions resulting from a 5% growth cap could be offset by increases in Part B premiums or by establishing a Part A premium.
  - In 1997, a beneficiary premium increase of $510 per year ($20 per month) would be needed.
  - In 2002, a $2,100 per year ($175 per month) increase would be needed.
  - In 2005, a $3,610 per year ($300 per month) increase would be needed.
- States now pay Medicare premiums and cost sharing for low-income Medicare beneficiaries, and might feel pressure to shoulder at least some of these increases. This would be particularly burdensome for states if federal Medicaid payments were capped, as well.

POTENTIAL FOR COST SHIFTING AND BARRIERS TO ACCESS

- Between 1996 and 2002, 5% caps on the growth in Medicaid and Medicare would reduce federal health payments by $504 billion.

- This magnitude of reductions raises questions about how providers would respond, particularly as the number of uninsured and therefore uncompensated care continues to rise. Providers could respond by:

  - Increasing revenues from private patients.
  - Reducing their costs per patient.
  - Treating fewer uninsured, Medicare, or Medicaid patients.

- In the past, hospitals and physicians have in the past been able to recoup shortfalls from Medicare, Medicaid and uncompensated care by charging increasingly higher rates to private payers. For example, as hospital shortfalls have increased from public sources, private hospital payments have grown from 120% of hospitals costs in 1980 to 131% of costs in 1992.

- Recently, it appears that private payers -- particularly large employers -- have intensified their cost containment efforts. These efforts appear to have forced hospitals to rely more heavily on reducing expenses.

- At issue is how providers will respond in the future to continued reductions in the growth of public revenues, coupled with increases in uncompensated care.

  - In areas without a strong managed care presence, private payers will likely continue to bear the burden of provider cost shifting. While large groups may be able to exert market power to reduce their cost shifting burden, small groups and individuals will remain vulnerable.

  - To the extent that providers are constrained from cost shifting to private payers hospitals will be forced to reduce expenses or reduce access for the uninsured, and Medicare and Medicaid beneficiaries.

Illustrative Effect of a Medicaid Block Grant & Medicare Capped Expenditures Reduction in Federal Payments Assuming 5% Growth Cap
(Dollars in millions, fiscal years)

	State Baseline Growth at National Rates	State Baseline Growth at State Projected Rates
US	**(503,580)**	**(466,793)**
Alabama	(8,196)	(5,892)
Alaska	(541)	(8)
Arizona	(7,267)	(7,805)
Arkansas	(4,722)	(2,891)
California	(54,912)	(39,195)
Colorado	(4,830)	(2,328)
Connecticut	(7,332)	(7,641)
Delaware	(1,144)	(1,001)
District of Columbia	(3,331)	(3,811)
Florida	(33,433)	(38,406)
Georgia	(12,090)	(13,032)
Hawaii	(1,601)	(1,805)
Idaho	(1,293)	(1,148)
Illinois	(19,807)	(16,304)
Indiana	(10,330)	(4,081)
Iowa	(4,488)	(3,872)
Kansas	(4,189)	(1,815)
Kentucky	(7,283)	(4,048)
Louisiana	(12,211)	(4,945)
Maine	(2,566)	(1,443)
Maryland	(8,289)	(9,874)
Massachusetts	(14,935)	(12,073)
Michigan	(17,805)	(15,502)
Minnesota	(7,852)	(8,327)
Mississippi	(5,377)	(4,432)
Missouri	(10,345)	(8,264)
Montana	(1,359)	(934)
Nebraska	(2,404)	(2,419)
Nevada	(1,909)	(1,315)
New Hampshire	(1,758)	(1,817)
New Jersey	(15,725)	(8,161)
New Mexico	(2,389)	(2,955)
New York	(52,279)	(86,832)
North Carolina	(12,293)	(15,308)
North Dakota	(1,181)	(706)
Ohio	(21,418)	(19,791)
Oklahoma	(5,046)	(3,016)
Oregon	(4,949)	(7,619)
Pennsylvania	(28,984)	(18,330)
Rhode Island	(2,371)	(791)
South Carolina	(6,439)	(2,666)
South Dakota	(1,209)	(1,218)
Tennessee	(12,394)	(9,269)
Texas	(30,110)	(36,628)
Utah	(2,213)	(2,069)
Vermont	(900)	(644)
Virginia	(7,557)	(6,258)
Washington	(8,029)	(7,889)
West Virginia	(4,249)	(2,380)
Wisconsin	(8,134)	(5,743)
Wyoming	(538)	(523)

Base year. State projected FY 95 federal expenditures. Assumes capped payments effective FY 1996.
Assumes that Federal Medicare and Medicaid payments grow at the CBO projected national average growth rates (column 1) or the Medicaid average compound growth rates between FY 1993 (actual data) and states' projected expenditures for FY 1996 (column 2).

Medicaid

OUTLINE

1. Background
   a. What is Medicaid
   b. Who is covered
   c. What is covered
   d. Accomplishments
   e. Future

2. Effects of Republican Budget Resolution Conference Agreement
   a. Magnitude of the cuts
   b. Potential state responses: managed care
   c. Potential state responses: service and provider cuts
   d. Potential state responses: eligibility reduction
   e. Problems with a block grant

3. President's proposal

1. BACKGROUND

A. What is Medicaid

- Medicaid was enacted in 1965 to pay for health care services for persons who were poor enough, or almost poor enough, to qualify for cash welfare payments. Amendments to Medicaid since 1965 have changed both the number and categories of eligible people and kinds of services they receive, especially for persons with special or long-term health care needs that are unaffordable on an out-of-pocket basis and inadequately covered by private insurance.

- States administer Medicaid under broad federal guidelines, and receive federal matching paymetns based on their per capita income.

- In 1994, states paid $80 billion and the federal government paid $90 billion to cover 36 million Americans.

B. Who is covered

- Children and adults (non-elderly, non-disabled) comprise about three quarters of enrollment, but account for only one-third of spending (DSH excluded).

  - **Adults** who care for an eligible child or are pregnant comprise 23% of recipients (7 million recipients), but account for only about 14% of spending.

  - **Children** represent more than about half of Medicaid recipients -- about 17 million in 1994. They are responsible for only 19 percent of Medicaid

expenditures, however,.

In 1994, over 15 percent or 11 million children of workers were covered by Medicaid.

- The elderly and people with disabilities comprise only 27% of enrollment, but account for 67% of the spending.
  - **Persons with disabilities** are 16 percent of recipients (8 million), but consume about 39 percent of total Medicaid expenditures.

    This group is composed of:
    Mentally retarded - developmentally disabled: 27 percent
    Mentally ill: 27 percent
    Physically ill: 46 percent
  - **The elderly** comprise 12 percent of enrollment (4 million), but are responsible for 28 percent of non-DSH expenditures.
  - About 5 million Medicare beneficiaries also have Medicaid coverage, which covers Medicare premiiums and cost sharing, and for those who are dually eligible, Medicaid services.
- Medicaid is not just a "poor people's progrm".
  - In 1994, over 6.5 million people with income betwee 100 and 200 percent of povery were covered by Medicaid.

C. What is covered

- All states who participate in Medicaid cover a minimum set of services including inpatient and outpatient hospital services, physician services, early and periodic screening, diagnosis and treatment for children, and nursing home and home health services for mandatory eligibles over age 21.

  States have the option of covering an additional XXX services, including prescription drugs, intermediate care for the developmentally disabled, personal care services and dental services.
  - Less than half of Medicaid expenditures pays for mandatory services for mandatory populations
- **Acute care services** accounts for over 50 percent of Medicaid spending.
  - Over 90 percent of Medicaid expenditures for adults and children are for services that would be covered by a Blue Cross/ Blue Shield Federal Employee Health

Benefits Plan (FEHBP).

- **Long-term care** accounts for more than one-third of all Medicaid spenidng.
  - In 1993, 2.9 million people relied on Medicaid for nursing home or community-based long-term care. About 1.6 million Medicaid recipients are residents of nursing homes.
  - The cost of nursing home care is, on average, $38,000 per year -- whilc can be devastating for middle-income Americans.
  - Medicaid pays for over 40 percent of all formal long-term care, and over half of all nursing home care.
  - Home and community based care waivers have served about:
    - 135,000 eldery and disabled persons;
    - 40,000 people with mental retardation / developmental disabilities;
    - 6,200 people with AIDS;
    - 976 children with chronic illnesses or disabilities.

D. Accomplishments

- Medicaid has been a significant and growing source of health insurance for many people.
  - Between 1989 and 1994, the percentage of the population covered by Medicaid grew from 9% to over 14%, while the percentage covered by private health insurance fell from 66% to about 59%.
  - Without this growth in Medicaid, the number of uninsured would likely have increased significantly.
- This trend could be partially reversed by Republican welfare reform proposals, which could eliminate Medicaid eligibility for up to 2 million people (over 6 million if all AFDC adults lose eligibility for Medicaid).
- Prior to Medicaid, poor people had both worse health status and fewer physician visits. However, by the mid-1970s, access to physician services had increased enormously for the poor due to Medicaid.
- Only one percent of Medicaid children lack adequate immunization relative to six percent of privately insured children and 16 percent of uninsured children.
- Over 90 percent of children with AIDS are covered by Medicaid.

E. Future

Medicaid enrollment increases are responsible for the relatively high rates in Medicaid expenditure growth.

- On a per person basis, Medicaid actually is projected to grow at a slower rate than private health spending — about 5.3% annually per recipient as compared to about 7.9% annually per insured person.

- Medicaid is projected to cover an additional 10 million people by 2002 (for a total of 47 million people).

  - Between 1996 and 2000, the number of AFDC recipients covered by Medicaid is projected to grow 2.3% annually.

  - The number of aged and disabled recipients is projected to grow by 4.7% annually during the period.

- The rate of growth in Medicaid spending varies significantly from state to state. Growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns, or service mix.

2. EFFECTS OF REPUBLICAN BUDGET RESOLUATION CONFERENCE AGREEMENT

A. Magnitude of the cuts

- The Republican Budget Resolution Conference Agreement would cut $182 billion from Medicaid over the next seven years. It would do this by capping the growth in federal expenditures at 4 percent per year after 1997 through a block grant.

- This magnitude of cut is 20 percent reduction in spending over the period, and a 30 percent cut in 2002 alone.

B. Potential State Responses: Medicaid Managed Care

- While many point to managed care as a source of significant savings under Medicaid, studies (including one by CBO) have generally found that it produces a one-time savings of about 5 to 15% over baseline costs without slowing the rate of growth.

- States have applied managed care primarily to children and AFDC adults, who account for less than one-third of Medicaid spending. Applying managed care techniques to the services typically used by the elderly and disabled (such as long term care) is largely untried and difficult, making the potential for achieving savings hard to predict.

- Baseline projections already assume that a substantial proportion of Medicaid recipients will be in managed care arrangements (33% of AFDC and non-cash children currently,

growing to over 50% by the end of the decade).

- Therefore, the percentage of Medicaid spending for which there is some evidence that managed care could produce saving is relatively small, and varies significantly by state (e.g., the percentage of state Medicaid enrollees that are aged or disabled ranges from 15% to 40%).

- Preliminary estimates show that if **all** AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be less than $4 billion, a very small proportion of the $309 billion (under Administration baseline) needed to offset the reduction in federal payments over this period.

C. Potential State Responses: Reduction in Provider Payments and Services

Provider payments:

- Since over 25 percent of the discharges in teaching hospitals are Medicaid patients, these hospitals will be disproportinately affeced by tye cuts.

- Reductions to already low payment rates would limit acess to needed services, especially services needed by the elderly and disabled.

[to be completed]

Acute Care:

- Since the cost of acute care is projected to grow faster than that of long-term care, states with higher proportions of acute care will be harder hit by a block grant.

Long-Term Care:

- Over **1.7 million long-term care beneficiaries** would lose services or be unable to secure services by 2000 under a block grant with 5 percent growth, according to an analysis by Lewin-VHI.

- States particularly hard hit by capping long-term care expenditures include New Hampshire, Oregon, Vermont, Hawaii, West Virginia, North Carolina and Utah.

- If states eliminate home and community-based services to compensate for the reduced federal spending, Alabama, Indiana, Louisiana, Mississippi and Tennessee would have to completely eliminate their programs in 2002, and another 19 states would be forced to cut their programs in half, according to Lewin-VHI.

- The elderly and persons with disabilities are already paying **$23 billion in out-of-pocket costs for nursing home care** -- almost three times what they spent in 1980. Increasing this burden by either reducing or elimating coverage could impose a signficant burden on the elderly and their families.

- Without Medicaid, the **13 million Americans with an elderly parent or spouse who is disabled** would face nursing home bills that average $38,000 a year.

D. Potential State Responses: Reduction in Eligibility/Recipients

- If states were able to hold the growth in expenditures per beneficiary to inflation plus 2 percent, about half of the target of $182 billion could be met through provider payment and service reductions, and the other half would require states to eliminate coverage for 8.8 million individuals in 2002 alone, according to the Urban Institute.

  - States in the south and in the mountain states would have to cut more recipients, because they have high recipient growth and would be harder hit by the caps.

Effect on Adults and Children

- According to the Urban Institute, 6.3 million aduls and children in families could lose Medicaid coverage in 2002 alone.

Effect on the Elderly and Disabled

- According to the Urban Institute, 920,000 elderly and 1.4 million disabled Medicaid recipients could lose coverage in 2002 alone.

- Any limits on Medicaid spending will almost certainly disproportionately affect the elderly and disabled because:

  * Two-thirds of total Medicaid payments are made on behalf of this population for acute and log-term care services.

  * Rate of growth for elderly and disabled Medicaid recipients is expected to exceed that of other Medicaid eligibility categories. The number of elderly and disabled Medicaid recipients is expected to increase to 13 million by the year 2000 -- one in three Medicaid recipients.

- States will be more likely to elminate optional eligibility categories -- the very categroies that allow many middle income eldelry and disabled to receive coverage for their long-term care needs.

- Similarly, optional services, which supply critical health services to the elderly and disabled such as home and community-based health services, will probably be reduced.

- There are two ways that states could reduce coverage for the elderly and disabled:

  * Restricting income eligibility standards: States can cover institutionalized persons and those receiving home and community-based care under a waiver up to 300 percent of the SSI benefit. States can also have a

medically needy program, which alllows certain people with income that exceeds the state's basic Medicaid eligibility level to deduct the cost of care to receive nursing home services. All states have either the 300 percent and / or medically needy program. The income standard in these programs could be reduced to limit eligibility.

- * Restricting long-term care disability standards: States can change the disability criteria by, for instance, requiring a higher number of dependencies in activities of daily living or restricting access by people with cognitive impairment.

- o States could also limit spousal impoverishment as a means of compensating for the lost federal funds.

  - * Medicaid allows the community-based spouse of a nursing home resident to protect a certain level of monthy income (minimum of $1,230) and resources (minimum of $14,964 in 1995). These protections could be lowered or eliminated.

- o Since two-thirds of people with sever disabilities live below poverty, any reduction in coverage for people with disabilities could

E. Problems with a Block Grant

As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the number of people eligible in a state.

- **Block Grants Do Not Recognize Differences Among State Programs.**
  - ▸ State growth rates can vary significantly across states (e.g., for differences in population, regional medical costs, enrollment patterns, or service mix) and over time in a given state.

  - ▸ States also have very different opportunities to achieve savings through managed care. For example, some states already have achieved savings, rural states have less capacity to implement capitated payment arrangements, and some states have a larger proportion of elderly and disabled recipients (for whom managed care is largely untested).

- **States At Risk from Inflation and Recession.** When a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, federal payments to the state would rise, but under a block grant with a fixed growth rate they would not.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear

Repub Medicaid File

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

September 18, 1995

MEMORANDUM

TO: Members, Committee on Commerce

FROM: Howard J. Cohen, Counsel
Eric S. Berger, Professional Staff Member

SUBJECT: Markup of Transformation of the Medicaid Program legislation

On Wednesday, September 20, 1995, the Committee on Commerce will markup a Committee Print regarding the transformation of the Medicaid Program.

Background and Need for Legislation

Established by President Lyndon Johnson in 1965, Medicaid is a joint federal-State matching open-ended entitlement program that pays for medically necessary health care services provided to eligible beneficiaries by qualified providers. There are Medicaid programs in all States except Arizona, which runs a similar medical assistance program under a Federal waiver. (Federal funds for the Arizona program come from the Medicaid budget.) In addition, the Medicaid program is operated in the District of Columbia and U.S. territories, such as Puerto Rico and Guam.

According to the Congressional Budget Office (CBO), the Medicaid program will cost $156.5 billion in Fiscal Year 1995. Of this amount, the federal government will be responsible for an estimated $89.2 billion. This expenditure represents a 11,050 percent increase over the program's initial cost to the federal government of $800 million in Fiscal Year 1966. Since 1990, Medicaid has been the fastest-growing segment of the federal government's budget, with costs soaring at annual rates as high as 31 percent. Placed in broader context, the Medicaid program's average annual rate of growth since 1990 has been four times that of private sector health care costs, which are rising at roughly 4-5 percent annually. Although CBO projects Medicaid spending will rise at a comparatively "stable" rate of 10 percent per year, at that rate total program costs will double by the year 2002 absent reform.

Medicaid's extraordinary rate of growth has made it the single largest item in many State budgets. According to the testimony of Governors and Medicaid officials appearing before the Committee on Commerce, States have been compelled by the program's cost to restrict investment in other critical human services, including child welfare, education, mental health, and public safety.

Generally, people who receive cash assistance under the major welfare programs -- Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) -- are granted categorical eligibility for Medicaid. In addition, States are required to provide Medicaid benefits to certain low-income pregnant women and children who have no ties to the welfare system. They also are required to pay Medicare premiums and cost-sharing charges for low-income Medicare beneficiaries. States are permitted, but not required, to provide Medicaid coverage to certain other aged, blind, disabled, or AFDC-related groups.

Due to the makeup of the Medicaid-eligible population, State programs focus upon two major coverage priorities: basic acute care for most recipients and long-term care for the elderly, disabled, and retarded. Families with dependent children make up over 70 percent of the Medicaid population but account for only 30 percent of the spending. By contrast, the aged, blind, and disabled make up about 30 percent of Medicaid recipients but account for 70 percent of spending.

Federal Medicaid law requires that States offer certain services including hospital, physician, nursing facility, laboratory, and x-ray services. The federal Medicaid statute (Title XIX) also sets very proscriptive requirements on the amount, scope, and duration of benefits. The statute also requires that comparable benefits be provided to all eligible recipients (comparability of benefits) in every part of each State (statewideness).

Primary administrative authority over the Medicaid program rests with the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. For their part, States have only limited flexibility in the administration and operation of their Medicaid programs. Title XIX gives States the option of offering benefits other than those listed above, such as prescription drugs, dental care, or eyeglasses. Each State may also determine what it will pay for services, and providers must accept Medicaid payment as payment in full for services rendered except where the State has imposed nominal cost-sharing charges. However, the Medicaid program does not permit States the flexibility to develop innovative and efficient service delivery mechanisms to meet the health care needs of their low-income residents. As a result, State officials have testified that they have been compelled to shoulder the rising costs of what they describe as a rigid and ineffective health care program.

Summary and Relationship to Current Law

Please see attached.

TITLE XXI--MEDICAID BLOCK GRANT FOR LOW-INCOME INDIVIDUALS AND FAMILIES

Purpose; State MediGrant Plans

Current Law. Medicaid is authorized under Title XIX of the Social Security Act to enable each State to furnish medical assistance and rehabilitation and other services on behalf of families with dependent children and aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services. Each State is required to have a State plan approved by the Secretary of the Department of Health and Human Services (HHS). The plan describes the State's basic eligibility, coverage, reimbursement, and administrative policies and is updated periodically to reflect changes.

Explanation of Provision. The proposal would create an entitlement to States under Title XXI of the Social Security Act to provide block grants to States to enable them to provide medical assistance to low-income individuals and families. A State would be required to provide the Secretary with a MediGrant plan that sets forth how the State intends to use the funds provided to provide medical assistance. An approved plan would continue in effect unless and until (1) the State amends the plan, (2) the State terminates participation in the program, or (3) the Secretary finds substantial noncompliance of the plan with the program's requirements.

PART A--OBJECTIVES, GOALS, AND PERFORMANCE UNDER STATE PLANS

Description of Strategic Objectives and Performance Goals

Current Law. There are no provisions for objectives and goals, except that States are to meet participation goals in their early and periodic screening, diagnostic, and treatment (EPSDT) programs for eligibles under age 21.

Explanation of Provision. A State would be required to include in its MediGrant plan a description of its objectives and goals for providing health care services, and the manner in which the plan is designed to meet the objectives and goals. Goals and objectives related to rates of childhood immunizations and reductions in infant mortality and morbidity would be required. With regard to other objectives and goals, the State could consider factors such as priorities for providing assistance to low-income populations, priorities for general public health and health status for low-income populations, the State's financial resources and economic conditions, and the adequacy of the State's health care infrastructure. To the extent practicable, a State would be required to establish one or more performance goals for each strategic objective and describe how performance would be measured and compared against goals. Strategic objectives would be required to cover a period of at least 5 years and would have to be updated and revised at least every 3 years. Performance goals would have to be established for dates not more than 3 years apart.

Annual Reports

Current law. State plans must provide for reports, in such form and containing such information, as the Secretary may require. In addition, the law requires States to report annually certain information relating to EPSDT services.

Explanation of Provision. By March 31 (beginning in 1998), each State with a MediGrant plan in effect for the preceding fiscal year would be required to submit a report to the Secretary and the Congress on program activities and performance for that Federal fiscal year. Each report would be required to include data on the following:

- Aggregate expenditures for each category of eligible individuals, expenditures by each category of eligibles for covered services provided on a fee-for-service basis, expenditures for payments to capitated organizations by each category of eligibles, and administrative expenditures;

- Utilization of services, including summary statistics, for each category of eligible individuals, of items and services provided on a fee-for-service basis and a summary of data reported by capitated health care organizations;

- Achievement of performance goals including actions to be taken in case a goal was not met;

- Program evaluations;

- Fraud and abuse and quality control activities; and

- Plan administration, including a description of the roles and responsibilities of State entities responsible for administering the program and organization charts for each, a description of any interstate compact entered into, and citations to State law and rules governing the State's activities under the program.

For subsequent fiscal years, expenditures and utilization reports would be required to fit the reporting format specified by the Medicaid Task Force established under Title XXI.

Categories of eligible individuals would include children, blind or disabled adults under age 65, persons 65 or older, and other adults.

Periodic, Independent Evaluations

Current Law: No provision.

Explanation of Provision. Beginning in FY1998 and at least every third year thereafter, each State would be required to provide for evaluation of the operation of its MediGrant plan, conducted in accordance with a State-approved research design, by an entity that is not responsible for submission of the State plan or for administering any activity under the plan.

Consultation in Medigrant Plan Development

Current Law. A State plan must provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan. Based on this statutory provision, Medicaid regulations require that each State establish a medical care advisory committee.

Explanation of Provision. State MediGrant plans would be required to include a description of the process for development and implementation of the plan. In addition, before submitting a plan or amendment to the Secretary, each State would be required to provide a public notice with a description of the plan or amendment, a means for the public to inspect or obtain a copy of the plan or amendment, and an opportunity for submittal and consideration of public comments. This provision would apply except when the State submitted a revision of a plan or amendment in response to a determination of disapproval by HHS.

Each State with a MediGrant plan would be required to establish and maintain an advisory committee for consultation in the development, revision, and monitoring the performance of the plan. Such consultation would include the development of strategic objectives and performance goals, the annual report, and the research design for evaluating the State's plan operations. Members of the advisory committee should represent different geographic regions of the State although proportional representation would not be required. A State would be permitted to establish more than one advisory committee, including committees that represent the interests of specific population groups, provider groups, or geographic areas.

MediGrant Task Force

Current Law. No Provision.

Explanation of Provision. The Secretary of HHS would be required to establish a MediGrant Task Force consisting of 6 members appointed by the chair of the National Governors Association (NGA) and 6 appointed by the vice chair of the NGA. The Task Force would be assisted by an advisory group composed of one representative from each of the following associations: National Committee for Quality Assurance; Joint Commission for the Accreditation of Healthcare Organizations; Group Health Association of America; American Managed Care and Review Association; Association of State and Territorial Health Officers; American Medical Association; American Hospital Association; American College of Gerontology; American Health Care Association; an association representing the interests of disabled individuals; and an association representing the interests of children. The Task Force would be required to (1) specify the format of expenditure and utilization summaries by December 31, 1996; (2) study and report to Congress and the States by April 1, 1997 recommendations on models for strategic objectives and performance goals; methodologies for measuring and verifying each objective or goal recommended; an assessment of the usefulness to States of quality assurance safeguards, utilization data sets, and accreditation programs used in the private sector; and designs and methodologies for providing for independent evaluations. States would not be required to adopt any of the objectives or goals suggested by the Task Force. The Agency for Health Care Policy and Research, or the Secretary, would be required to provide administrative support for the Task Force.

PART B--ELIGIBILITY, BENEFITS, AND SET-ASIDES

General Description of Eligibility and Benefits

Current Law. Each State designs its own Medicaid program within Federal guidelines. States must provide Medicaid to certain population groups and have the option of covering others. Similarly, a State must cover certain basic services and may cover additional services if it chooses. States set their own payment rates for services, with some limitations.

The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all States and those that may be covered at a State's option. These generally fall into five basic groups: *current and some former recipients of cash assistance*, either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI); *low-income pregnant women and children* who do not qualify for AFDC; *the medically needy*, persons who do not meet the financial standards for cash assistance programs but meet the categorical standards and have income and resources within special medically needy limits established by the States; *persons requiring institutional care* and covered under special eligibility rules; and *low-income Medicare beneficiaries*, for whom Medicaid pays required Medicare premiums, deductibles, and coinsurance. Applicants' income and other resources must be within program financial standards. These standards vary among States, and different standards apply to different population groups within a State.

Mandatory services for all groups except the medically needy and qualified Medicare beneficiaries (QMBs) include: inpatient and outpatient hospital services, nursing facility (NF) services for individuals 21 or older, physicians' services, laboratory and X-ray services, early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21, family planning services, home health services for any individual entitled to NF care, rural health clinic and federally qualified health center (FQHC) services, and services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners. States may also offer any of a broad range of optional services. Among the most important, in terms of program expenditure, are prescribed drugs, dental and optical services, clinic services, and care in ICFs/MR and in institutions for mental diseases (IMDs).

In general, States develop their own methods and standards for reimbursement of Medicaid services. However, two Federal statutory provisions have had a significant effect on program spending: the so-called Boren amendment, which requires that payments to hospitals and NFs be "reasonable and adequate to meet the costs [of] efficiently and economically operated facilities," and requirements for payment adjustments to disproportionate share hospitals (DSHs), those that serve a higher than average number of Medicaid and other low-income patients.

Explanation of Provision. The Medigrant plan would be required to include a description of (a) the eligible population, including categories, duration of eligibility, and financial standards and methodologies; (b) duration and scope of covered services, including variations by population group; (c) the delivery method, such as use of vouchers, fee-for-service, or managed care arrangements; (d) required beneficiary cost-sharing; and (e) any incentives or requirements to encourage appropriate utilization. A State using a fee-for-service system would also have to describe how it determines provider qualifications and sets reimbursement rates. The plan would have to include coverage of immunizations for eligible children, in accordance with a schedule developed by the State health department in consultation with those responsible for administering the plan.

Set-Asides of Funds for Population Groups

Current Law. No provision.

Explanation of Provision. States would be required to devote specified minimum percentages of total program spending to services for each of three groups: low-income families, low-income elderly, and low-income disabled. (Funds set aside for low-income families would have to be spent on families below 185 percent of poverty that included a pregnant woman or child.) For each group, the minimum percentage to be spent would be set equal to 85 percent of the average percentage of the State's Medicaid spending during FY1992 through FY1994 devoted to mandatory services for members of that group who were required to be covered under Federal Medicaid law. The 85 percent requirement would also be applicable to payments for Medicare premium assistance for low-income elderly persons. (The percentage would be set at 75 percent in the case of a State that covered only mandatory services during the base period.)

In computing the base period spending percentages, payments to disproportionate share hospitals (DSH) would not be treated as payments for mandatory services and payments for services to illegal aliens would not be counted. Members of covered low-income families who were not children, pregnant women, or mothers would not be considered as persons required to be covered under Medicaid law for purposes of establishing the base period expenditures for low-income families; all elderly persons who were in nursing homes would be treated as persons whose coverage was required.

A State could establish a set-aside percentage for a population group below the specified minimum percentages if it determined and certified to the Secretary that the health care needs of that group (and any related performance goals in the plan) could be met with a lower level of expenditure. Such exceptions could not apply in the first year of operation under the MediGrant plan, and determinations would have to be renewed at intervals of no more than three years. A State that spent less on any group than the required set-aside amount would not be found in substantial violation of the requirements if its spending for each of the three population groups was less than 95 percent of the required amounts and an independent actuary certified that the plan was reasonably designed to result in expenditures of the required amounts.

Funds not required to be spent under the set-asides could be spent for additional medical assistance, program administration, or medically-related services, defined as services not included in the definition of medical assistance (see Part F) but related to or supporting the attainment of the strategic objectives and performance goals established under the State's plan.

Premiums and Cost-Sharing

Current Law. States may impose "nominal" deductible and coinsurance requirements for services. Cost-sharing requirements may not apply to services to children, pregnancy-related services, or emergency, family planning, or hospice services; certain other restrictions apply. Premiums or enrollment fees are generally precluded except for the medically needy, for pregnant women and infants with income over 150 percent of poverty, or for certain families receiving work-transition coverage after loss of AFDC benefits.

Explanation of Provision. States would be permitted to impose premiums, copayments, coinsurance, or deductibles pursuant to a public schedule. Cost-sharing could be designed to encourage primary and preventive care and discourage unnecessary or less economical care and inappropriate use of emergency services. Amounts could vary for different population groups and could be scaled to reflect economic factors, employment status, family size, availability of other health insurance, or participation in employment training, drug abuse or alcohol treatment, counseling, or other programs

promoting personal responsibility. For a family below 100 percent of poverty and including a pregnant woman or child, no premium could be imposed and cost-sharing amounts would have to be nominal (except for cost-sharing designed to deter inappropriate emergency services).

Description of Process for Developing Capitation Payment Rates

Current Law. States may enter into risk contracts with health maintenance organizations (HMOs) or comparable entities. Under a risk contract, the organization agrees to make available a specified set of medical services to an individual beneficiary in return for a fixed periodic payment (capitation) issued by the Medicaid program on the beneficiary's behalf. Certain restrictions apply to a "comprehensive" contract under which the organization has agreed to accept risk for any three of the mandatory Medicaid services, or for inpatient hospital care and any other mandatory service. Generally, no more than 75 percent of the enrollees of a contractor may be Medicaid or Medicare beneficiaries, and beneficiaries must ordinarily be permitted to disenroll at any time. Premium rates must be established on an actuarially sound basis. The Secretary has provided by regulation that rates may not exceed the amount which the State would have spent to provide the set of services covered by the organization to an equivalent group of beneficiaries not enrolled in the organization and continuing to receive care on a fee-for-service basis.

Explanation of Provision. If a State contracted with HMOs or similar entities on a risk basis for a package of services including at least inpatient hospital and physician care, the MediGrant plan would have to describe (a) the use of actuarial science in projecting expenditures and utilization for enrollees and setting capitation payment rates; (b) required qualifications for participating organizations; and (c) a process for dissemination to prospective contractors of information on historic cost and utilization data. The State would also have to provide for public notice and an opportunity to comment on all this information before each contract year; the notice would have to include the amounts of capitation payments made under the plan in the preceding year (unless exempt from disclosure under State law).

Construction

Current Law. Medicaid is an entitlement program; that is, Federal payments must be made to States that make expenditures in accordance with an approved State plan, and States must furnish covered services to individuals who meet eligibility requirements. In addition to the eligibility, coverage, and reimbursement rules imposed on States by Medicaid law, State plans must meet three general requirements: comparability (the services available to any categorically needy beneficiary in a State must generally be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State); statewideness (generally, the amount, duration, and scope of coverage must be the same statewide); and freedom of choice (beneficiaries must be free to obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services and is qualified to perform the services).

Explanation of Provision. The bill would specify that no provision would be construed as creating an individual or group entitlement to medical assistance under Federal law. In addition, nothing would be construed as requiring (a) coverage of any particular service or type of provider or any level of payment; (b) statewideness or comparability of services; or (c) freedom of choice of providers; or as limiting the State's ability to contract with managed care plans or individual providers on a capitated or other basis, to contract for case management or coordination services, or to set capitation rates on the basis of competition or negotiation.

Limitation on Causes of Action

Current Law. The current Medicaid statute does not establish a private right of action for denials of benefits. Therefore, one may not sue a State or a State official, under the statute itself, in Federal or State court. In addition, the Eleventh Amendment to the United States Constitution, as construed by the Supreme Court, prohibits suits against a State in Federal court. It does not, however, prohibit suits against a State official in Federal court; and a Federal statute, 42 U.S.C. section 1983, authorizes such suits against State officials who, under color of State law deprive any person of rights under Federal law or the Federal Constitution.

If a person sues a State official and seeks a Federal court to order that the State official comply with a Federal statute, such an order effectively operates against the State. Such an order, however, may operate prospectively only, because an award of past benefits wrongfully withheld "resembles far more closely the monetary award against the State itself . . . than it does the prospective injunctive relief" that is permitted notwithstanding the Eleventh Amendment. *Edelman v. Jordan*, 415 U.S. 651, 665 (1974).

Explanation of Provision. The bill would remove the existing right to sue a State official under 42 U.S.C. §1983 to require prospective enforcement of the Medicaid statute.

PART C--PAYMENTS TO STATES

Allotment of Funds Among States

Current Law. Medicaid services and associated administrative costs are jointly financed by the Federal Government and the States. The Federal share of a State's payments for services is known as the Federal medical assistance percentage (FMAP). The Federal share of administrative costs is 50 percent for all States, though higher rates are applicable for specific items. Federal matching payments for States and the District of Columbia are open-ended; that is, there is no limit on the amount a State may receive for expenditures that are allowable under its approved Medicaid State plan. Payments for Commonwealths and territories are subject to annual maximums fixed in the statute.

Explanation of Provision. Beginning with FY1996, the bill would limit Federal matching payments to each State to a fixed allotment. For FY1996, the allotment for each State and the District of Columbia would be based on the State's spending in FY1994, increased by 14.3193649139 percent. For FY1997 and later years, the allotment would be based on a formula allocation from a fixed pool. A State could carry over any unused allotment amount to a subsequent year.

The pool would be $102.135 billion for FY1997, $106.221 billion for FY1998, $110.469 billion for FY1999, $114.888 billion for FY2000, $119.483 billion for FY2001, and $124.263 billion for FY2002. For later years, the pool amount would be the previous year's amount increased by the lesser of 4 percent or the growth in the consumer price index for all urban consumers (CPI-U) for the 12-month ending in June before the start of the year in question. Pool amounts would be reduced by the amount of allotments to Commonwealths and territories. The increase in the pool amount over that for the preceding year would be designated the "national medicaid growth percentage" (NMGP).

For FY1997 and later years, each State's allotment from the pool would equal the greatest of a needs-based amount, a floor equal to 102 percent of the State's allotment in the previous year, or (beginning in FY1998) a higher floor for certain States based on the one-time increase in the State's

allotment from FY1996 to FY1997. For a State whose FY1996-97 increase was greater than 125 percent of the FY1997 NMGP, the floor for any year would be 104 percent of the previous year's allotment. For a State whose FY1996-97 increase was between 75 and 100 percent of the FY1997 NMGP, the floor would be 103 percent of the previous year's allotment.

The needs-based amount for a State would be the product of its aggregate need, its old Federal medical assistance percentage (FMAP; see below), and a scalar factor (a constant multiplier for all States used to ensure that floor and ceiling provisions do not cause total allotments to exceed the pool amount). The needs-based amount for a State could not exceed the State's allotment for the previous year by more than 133 percent of the NMGP, or 150 percent of the NMGP in the case of the 10 States with the lowest rates of Federal Medicaid spending per resident-in-poverty.

The State's aggregate need would be the product of four factors: residents in poverty, a case mix index, an input cost index, and national average spending per resident in poverty. Residents in poverty would be the average number of individuals in the State below the Federal poverty threshold in the most recent period of 3 calendar years for which data were available. The case mix index would equal the ratio between the State's expected per recipient spending and national average per recipient spending, given the State's relative proportions of aged, disabled, and other recipients and assuming that the State's per recipient spending for each group was equal to the national average for that group. The case mix index could not be less than .9 or more than 1.15. The input cost index would be the sum of .15 and the product of .85 and a hospital wage index. This index would equal the ratio between annual average wages for hospital employees in the State and the national average; it would be based on the area wage indices computed under Medicare's prospective payment system for inpatient hospital services (or a comparable index if the Medicare index should no longer be available). National average spending per resident in poverty would be computed for FY1997 using FY1994 data; for FY1998 and later years data from the second previous fiscal year would be used.

Allotments for Commonwealths and territories would equal their previous year's allotments increased by the NMGP (in place of the percentage increases provided under current law).

The Secretary would publish preliminary allotments for each fiscal year by April 1 of the preceding fiscal year. The General Accounting Office (GAO) would report to Congress by May 15 on the extent to which the allotments comply with statutory requirements. The Secretary would publish final allotments by July 1, taking into account the GAO analysis and explaining any changes from the preliminary allotments; the Secretary could not modify allotments thereafter. By August 1, GAO would report to Congress on the statutory compliance of the final allotments.

Payments to States

Current Law. The FMAP for each State is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capita incomes. No State may have an FMAP lower than 50 percent or higher than 83 percent. The FMAP for Commonwealths and territories is set at 50 percent.

Explanation of Provision. Subject to the allotments, payments to States for medical assistance and medically-related services would equal the State's spending for the services times the applicable FMAP. This would be the greater of the old FMAP, computed as under current law, or a new FMAP. The new FMAP would equal 100 percent minus the product of (a) an applicable percentage designed to ensure

budget neutrality and (b) the ratio of the total taxable resources (TTR) ratio for the State to the population in poverty ratio for the State. The TTR ratio would be the ratio of the most recent 3-year average of the State's TTR, as determined by the Secretary of the Treasury, to the sum of the average TTRs for all States (for the District of Columbia, a per capita income ratio would be substituted). The population in poverty ratio would be the ratio of the 3-year average number of persons below poverty in the State to the sum of the averages for all States. The new FMAP could not be less than 40 percent or greater than 83 percent. Old and new FMAPs for Commonwealths and territories would be 50 percent. The FMAP for services in Indian Health Service facilities would continue to be 100 percent. For administrative services, the Federal matching percentage would generally be 50 percent, with enhanced matching for specified expenditures as under current law.

Limitation on Use of Funds

Current Law. Federal funds are available for expenditures made in accordance with the approved State plan. A State may exclude a provider on its own or in response to action by the Secretary; if the Secretary excludes a provider from Medicare, the State must exclude the provider from Medicaid. Payment for medically-related services that do not meet the definition of medical assistance is generally not permitted. There is no restriction on total State spending for administration. Federal matching payments are not available for services that would have been paid for by a private insurer but for a provision of the insurance contract making the insurer secondary to Medicaid. Payments may be made for services to illegal aliens only in the case of emergency services. Payment for abortion services is required in cases of rape or incest, or when necessary to save the life of the mother.

Explanation of Provision. States could use Federal funds only to carry out the purposes of Title XXI. Federal payments would not be made to a State for nonemergency services by providers excluded under the maternal and child health or social services block grant, Medicare, or Medicaid. Spending for medically-related services could not exceed 5 percent of total spending under the MediGrant plan. After the first two years the plan was in effect, spending for administration could not exceed the sum of $20 million plus 8 percent of total spending under the plan. This limit would not apply to spending for quality assurance, utilization review, and similar activities or to spending needed to comply with reporting requirements. As under current law, Federal matching would not be available for services that would have been paid for by a private insurer but for a provision of the insurance contract making the insurer secondary to Medicaid. The definition of allowable emergency services for illegal aliens would be clarified. Payment for abortions would be permitted only to save the life of the mother.

PART D--PROGRAM INTEGRITY AND QUALITY

Use of Audits to Achieve Fiscal Integrity

Current Law. States are required to make such reports as the Secretary may require, and comply with provisions to assure the correctness and verification of such reports. Regulations state that the HHS Office of Inspector General (OIG) periodically audits State operations in order to determine whether (1) the program is being operated in a cost-efficient manner, and (2) funds are being properly expended for the purposes for which they were appropriated. The OIG releases audit reports simultaneously to officials of the State and HHS.

Explanation of Provision. Each MediGrant plan would be required to provide for an annual audit of the State's medical assistance expenditures in compliance with chapter 75 of title 31, United States Code. If the Secretary determined that a State's audit was performed in substantial violation of the chapter 75 provision, the Secretary would be permitted to conduct a verification audit or require that the State do so. Within 30 days of completion of an audit or verification audit, the State would be required to provide a copy of the audit report to the Secretary along with the State's response to the auditor's recommendation. The State also would be required to make the audit report available for public inspection.

Each State would be required to maintain fiscal controls, accounting procedures, and data processing safeguards that are reasonably necessary to assure the fiscal integrity of the State's activities. The State's controls and procedures would be required to be generally consistent with generally accepted accounting principles as recognized by the Governmental Accounting Standards Board or the Comptroller General.

Each MediGrant plan would be required to provide that the records of any provider could be audited to ensure that proper payments were made under the plan.

Fraud Prevention Program

Current Law. States are required to operate systems for the detection of fraud. Where fraud is found, the law provides for civil and criminal penalties.

Explanation of Provision. To detect fraud and abuse by beneficiaries, providers, and others, each MediGrant plan would be required to have a program that includes the following. Certain program contractors and providers would be required to disclose ownership and control information to State agencies in accordance with sections 1124 and 1124(a) of the Social Security Act. An entity (other than an individual practitioner or a group of practitioners) would be required to supply information on ownership, controlling interests, and conviction of certain offenses upon request by the Secretary or the State agency. A State could exclude a provider from participation in the MediGrant plan on its own initiative, and would be required to exclude any entity when required to do so by the Secretary pursuant to section 1128 or 1128A of the Act. Whenever a provider was terminated, suspended, sanctioned, or prohibited from participating under a State's plan, the State agency would be required to notify the Secretary and, in the case of a physician, the State medical licensing board. States would be required to provide information and access to information respecting sanctions taken against practitioners and providers by State licensing authorities.

Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners and Providers

Current Law. The law includes details on the information reporting requirements respecting sanctions taken against practitioners and providers by State licensing authorities.

Explanation of Provision. The provision is identical to the current law provision. Each State would be required to have in effect a system for reporting and providing access to information for use by the Secretary and other officials concerning licensing revocations and other sanctions taken against providers and practitioners by State licensing authorities, peer review organizations, or accreditation entities. A State would be required to report any adverse action taken, whether a provider had surrendered a license

or left the State, any other loss of license, and any negative action taken by a reviewing authority. The State would be required to provide the Secretary with access to whatever documents the Secretary needed to determine the facts and circumstances concerning the actions taken. Such information would have to be provided under arrangements made by the Secretary in the form the Secretary determined to be appropriate to (1) provide for the Secretary's activities, and (2) provide information to other specified authorities in order to protect their programs and services.

The Secretary would be required to safeguard the confidentiality of information furnished. However, any party authorized to disclose information would be permitted to do so. In implementing this section, the Secretary would be required to provide for maximum coordination of section 422 of the Health Care Quality Improvement Act of 1986.

State Medicaid Fraud Control Units

Current Law. Each State is required to have a Medicaid fraud control unit, independent of the State Medicaid agency, unless the State demonstrates that operation of such a unit would not be cost-effective, because minimal fraud exists, and beneficiaries will be protected from abuse and neglect without such a unit. Each unit is required to submit an annual report to the Secretary.

Explanation of Provision. Each MediGrant plan would be required to provide for a State Medigrant fraud control unit (FCU) unless the State demonstrated that such a unit would not be cost-effective because minimal fraud existed, and that beneficiaries would be protected from abuse and neglect without such a unit. The FCU would be required to be separate and distinct from the State agency responsible for the operation and administration of the MediGrant plan. It would have to be a part of the State Attorney General's office or coordinate with that office. It would be required to have statewide prosecutorial authority or the ability to refer to local prosecutors. The FCU would investigate and prosecute violations of State fraud laws, and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities. It would be required to provides for the collection of overpayments it had discovered were made to health care providers. It would be required to employ auditors, attorneys, investigators, and other necessary personnel.

Recoveries from Third Parties and Others

Current Law. States are required to ascertain the potential third party liability for payment of a beneficiary's medical claims and, where legal liability exists, seek reimbursement from the third party unless it would not be cost-effective to do so. States generally are limited in the circumstances which permit them to place liens against property or seek other recovery from estates.

Explanation of Provision. Each Medigrant plan would be required to ascertain the legal liability of third parties to pay for care and services available under the plan and seek reimbursement to the extent of legal liability unless the cost of recovery was expected to exceed the amount of reimbursement.

Medigrant plans would be required to prohibit a provider from refusing to furnish a covered service to a beneficiary because of a third party's potential liability for the service, and from trying to collect payment from a beneficiary that exceeded payment that would be made under the plan. For violation of the collection provision, a MediGrant plan could provide for a payment reduction up to 3 times the amount sought to be collected.

States would be required to prohibit any health insurer, in enrolling an individual or in making payments for benefits, from taking into account that the individual was eligible for or is provided medical assistance under a MediGrant plan.

A State would be required to have laws in effect under which the State is considered to have acquired the rights of an individual to payments by a party that is liable for the individual's health care items and services. Each State would be required to provide for mandatory assignment of rights of payment for medical support and care to beneficiaries.

Each State with a MediGrant plan would be required to have in effect laws relating to medical child support. Each State would have to prohibit an insurer from denying enrollment of a child because the child was born out of wedlock, is not claimed as a dependent on the parent's Federal income tax return, or does not reside with the parent or in the insurer's area. In a case in which a parent was required by a court or administrative order to provide health coverage for a child, and the parent was eligible for family health coverage through an employer in the State, State laws would have to require the employer and insurer to permit the parent to enroll the child upon application by either parent or by the State child support agency, and limit the circumstances under which the insurer could disenroll such a child. State laws would be required to prohibit an insurer from imposing requirements on a State agency that has been assigned the rights of an individual that are different from requirements applicable to an agent of any other covered individual; require an insurer, in the case of a child who has health coverage through the insurer of a non-custodial parent, to provide information to the custodial parent; permit the custodial parent to submit claims for covered services without the approval of the non-custodial parent, and make payment on claims to the custodial parent, the provider, or the State agency; permit the State agency to garnish the employment income of, and require withholding amounts from State tax refunds to, any person who is required by court or administrative order to cover the medical costs of a child who is eligible for medical assistance, has received payment from a third party for the costs of the child's services, and has not used the payment to reimburse the appropriate party.

A State would be permitted to take appropriate action to adjust or recover from an individual or the individual's estate amounts paid as medical assistance under a MediGrant plan.

Assignment of Rights of Payment

Current Law. At each eligibility determination, an applicant, as a condition of eligibility, must assign to the State any rights to medical support and payment.

Explanation of Provision. As a condition of eligibility for medical assistance under a State's MediGrant plan, an individual would be required to assign to the State any rights to medical support and payment for medical care from any third party of the individual or any other person who is eligible and on whose behalf the individual has the legal authority to execute an assignment of such rights. An individual would be required to cooperate with the State agency in establishing paternity of a child born out of wedlock and in obtaining support and payments for the individual and child unless the individual was a pregnant woman or was found to have good cause for refusing to cooperate as determined by the State. An individual would be required to cooperate with the State in identifying and providing information to assist the State to pursue any liable third party unless the individual had good cause for refusing to cooperate as determined by the State. The State would be required to provide for entering into cooperative arrangements (including financial arrangements) with any appropriate agency of any State and with appropriate courts and law enforcement officials, to assist the agency or agencies

administering the State plan with respect to the enforcement and collection of rights to support or payment that had been assigned.

Any amount collected by the State under an assignment would be retained by the State to reimburse it for payments made on behalf of an individual with respect to whom the assignment was executed (with appropriate reimbursement to the Federal Government of its share of the payment). The remainder of such amount collected would be paid to the individual.

Quality Assurance Standards for Nursing Facilities

Current Law. OBRA 87 comprehensively revised Medicaid requirements for nursing homes participating in the program. These provisions, collectively referred to as nursing home reform law, have three major parts: (1) requirements that nursing homes must meet in order to be certified to participate in Medicaid, including requirements about assessments of residents, available services, nurse staffing, nurse aide training, and resident rights; (2) provisions revising the survey and certification process that State survey agencies must use for determining whether nursing homes comply with the requirements for participation; and (3) provisions that expand the range of sanctions and penalties that States and the Secretary of HHS may impose against nursing homes found to be out of compliance with the requirements for participation.

Explanation of Provision. OBRA 87 nursing home reform provisions would be replaced with new requirements. State plans would be required to establish and maintain standards in the following areas for nursing facilities providing services under the State's program: the treatment of resident medical records, policies, procedures, and bylaws for operation; quality assurance systems; resident assessment procedures, including care planning and outcome evaluation; the assurance of a safe and adequate physical plant for the facility, qualifications for staff sufficient to provide adequate care, as defined by the State, and utilization review.

Standards for nursing facilities would also be required to provide for the protection and enforcement of resident rights, including rights to exercise the individual's rights as a resident of the facility and as a citizen or resident of the U.S.; to receive notice of rights and services; to be protected against the misuse of resident funds; to be provided privacy and confidentiality; to voice grievances; to examine the results of State certification program inspections; to refuse to perform services for the facility; to be provided privacy in communications and to receive mail; to have the facility provide immediate access to any resident by any representative of the State's certification program, the resident's individual physician, the State long-term care ombudsman, and any person the resident has designated as a visitor; to retain and use personal property; to be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion; and to be provided with prior written notice of a pending transfer or discharge.

States would be required to promulgate standards either through the State's legislature, regulatory, or other process, and they could take effect only after the State had provided the public with notice and an opportunity for comment.

State plans would also be required to provide for the establishment and operation of a program for the certification of nursing facilities that meet specified standards as well as the decertification of those facilities that fail to meet the standards. State's would be required to ensure public access (as defined by the State) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the State regarding ownership, compliance

histories, and services provided by certified facilities. States would be required to audit their expenditures under the program, not less often than every 4 years, through an entity designated by the State which is not affiliated with the program.

States would be required to impose certain sanctions against nursing facilities not meeting requirements. If a State determines that a certified nursing facility no longer substantially meets specified requirements and further determines that the facility's deficiencies immediately jeopardize the health and safety of residents, then the State would be required to provide at least for the termination of the facility's certification for participation. If the facility's deficiencies do not immediately jeopardize the health and safety of residents, the State could, in lieu of termination, provide lesser sanctions, including denial of payment for persons admitted after a specified date. States could not impose sanctions until a facility has had a reasonable opportunity to correct its deficiencies, following the initial determination that it no longer substantially meets the requirements for certification, and, has been given reasonable notice and opportunity for a hearing. A State's decision to deny payment for new admissions would be effective only after notice to the public and the facility, as may be provided for by the State. Denial of payment for new admissions would end when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance). Facilities would, however, be required to be in compliance by the end of the eleventh month following the month when the decision to deny payments becomes effective. If facilities did not substantially meet the requirements by that time, States would be required to terminate their certification for participation.

Other Provisions Promoting Program Integrity

Current Law. Each State, and the Secretary, are required to make available to the public information respecting all surveys of nursing facilities within 14 days after such information is made available to the facilities. Copies of cost reports, statements of ownership, and other information required to be disclosed also must be made public.

Each State Medicaid plan must provide for agreements with all providers of services to keep such records as are necessary to fully disclose the extent of the services provided to Medicaid recipients, and to furnish information regarding payments claimed for providing services.

Explanation of Provision. State agencies responsible for surveying health care facilities or organizations would be required to make public, in readily available form and place, pertinent findings on the compliance of the facility or organization with the requirements of law. Persons or institutions providing services under the State's plan would be required to keep such records (including ledgers, books, and original evidence of costs) as are necessary to fully disclose the extent of the services provided, and to furnish information about payments claimed, as the State may from time to time request.

PART E--ESTABLISHMENT AND AMENDMENT OF STATE MEDICAL ASSISTANCE PLANS

Submittal and Approval of MediGrant Plans

Current Law. Each State is required to establish and maintain a State plan for medical assistance that is approved by the Secretary. The process for approval of State plans and State plan amendments is set forth in Medicaid regulations, not in statute.

Explanation of Provision. States would be required to submit to the Secretary a MediGrant plan that meets the requirements of Title XXI. (A State with a Title XXI FY1996 allotment of more than $10 billion would be required to have specific authorization of its State legislature to submit an plan.) A plan would be deemed approved unless the Secretary determined and notified the State in writing within 30 days of submission that the plan substantially violates a requirement. Plans would be effective no earlier than the first calendar quarter that begins at least 60 days after the plan is submitted.

Submittal and Approval of Plan Amendments

Current Law. According to regulation, States may submit amendments to their Medicaid plans at any time, and are considered approved unless written notice is sent to the State within 90 days.

Explanation of Provision. A State would be permitted to submit an amendment to its MediGrant plan at any time. However, any amendment that would eliminate or restrict eligibility or benefits under the plan could not take effect before it was transmitted to the Secretary, unless there was prior or contemporaneous public notice of the change, as provided under State law. Nor could it be effective for longer than a 60-day period unless the amendment had been transmitted to the Secretary before the end of the period. Any other amendment could not remain in effect after the end of a State fiscal year (or if later, the end of the 90-day period on which it becomes effective) unless the amendment had been transmitted to the Secretary.

Process for State Withdrawal from Program

Current Law. States can withdraw from Medicaid, but there is no formal process included in current law.

Explanation of Provision. A State could rescind its plan and discontinue participation in the program at any time after providing 90 days prior notice to the public and to the Secretary. Such discontinuation would not apply to Federal payments to States for expenditures made for items and services furnished under the plan before the effective date of the discontinuation.

Sanctions for Substantial Noncompliance

Current Law. If the Secretary finds, after reasonable notice and opportunity for hearing, that either the plan does not comply with the provisions of Federal law, or that in administration of the plan there is a failure to comply substantially with any provision(s), then the Secretary is required to notify the State that payments will be withheld, in whole or in part, until the Secretary is satisfied regarding the State's compliance. (Under Medicaid regulations, these duties and responsibilities are delegated to the Administrator of the Health Care Financing Administration (HCFA) in HHS.)

Explanation of Provision. The Secretary would be required to review promptly MediGrant plans and plan amendments to determine if they substantially comply with requirements. If the Secretary determined that a plan or plan amendment substantially violates the requirements and, within 30 days of submittal, provides written notice to the State, the Secretary would be required to issue an order specifying that the plan or amendment would not be effective at the end of the 30-day period. Before

making such a determination, the Secretary would be required to consult with the State and consider any clarifications and additional information submitted. The Secretary would be required to explain and justify any determination inconsistent with any previous determination. A plan or amendment would be considered to substantially violate a requirement if a provision were material and substantial in nature and effect, and were inconsistent with an express requirement. Failure to meet a strategic objective or performance goal would not be considered a substantial violation.

Secretarial Authority

Current Law. No provision. Medicaid regulations, however, specify the State and the HCFA may, at any time, negotiate to resolve issues.

Explanation of Provision. The Secretary would be permitted to negotiate a satisfactory resolution to any dispute concerning the approval of a plan or the compliance of a plan. The Secretary would be prohibited from delegating authority for approval of plans other than to the Administrator of the Health Care Financing Administration. The Administrator would be prohibited from making any further delegation of such authority. The Secretary would be required to administer the program only through a prospective formal rulemaking process, including issuing notices of proposed rule making, publishing proposed rules or modifications to rules in the Federal Register, and soliciting public comment.

PART F--GENERAL PROVISIONS

Definitions

Current Law. "Medical assistance" means payment of part or all of the cost of a number of specified services States are required to provide some services (including hospital, physicians', and laboratory and x-ray services) and permitted to cover others (such as prescription drugs and intermediate care facilities for the mentally retarded). The law also provides that medical assistance expenditures may include payments for Medicare cost-sharing; Medicare Part B premiums for certain persons; payments for group health plan premiums, deductibles, and coinsurance and certain other cost-sharing obligations; and payments to Indian Health Service facilities for services provided to eligible recipients. The law excludes any payments for care or services for (1) an inmate of a public institution (except as a patient in a medical institution) or (2) payments for care for an individual under age 65 who is a patient in an institution for mental diseases, except that States may cover inpatient psychiatric services for individuals under age 21

The term "child" means an individual under 19 years of age. The term "pregnant woman" includes a woman during the 60-day period beginning on the last day of pregnancy. The term "poverty line" means the income official poverty line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

Explanation of Provision. Medical assistance would be defined as including a list of services similar to those specified under current law, and, in addition, enabling services to increase accessibility to primary and preventive services. "Medicare cost sharing" would include Medicare premiums and coinsurance.

"Eligible low-income individual" would mean an individual whose family income does not exceed a percentage specified in the plan that is not greater than 300% of the poverty line.

Definitions of child, pregnant woman, and poverty line would be the same as in current law.

Treatment of Territories

Current Law. For American Samoa and the Northern Mariana Islands, the Secretary is authorized to waive or modify any requirement other than a waiver of the Federal matching share of expenditures, the annual expenditure limit, or the requirement that payment may be made only with respect to amounts expended for certain care and services.

Explanation of Provision. The Secretary's waiver authorization would be extended to include Puerto Rico, Guam, and the Virgin Islands.

Requirements for Manufacturers of Outpatient Prescription Drugs

Current Law. Federal reimbursement to States for covered outpatient prescription drugs is available only for products of a manufacturer that has agreed to grant rebates to Medicaid programs for the manufacturer's products that they purchase. A drug manufacturer must comply with the provisions of section 8126 of Title 38 of the U.S. Code (relating to prices of drugs procured by the Department of Veterans Affairs and other Federal agencies), including entering into a master agreement with the Secretary of Veterans Affairs.

Explanation of Provision. No Federal funds would be available to a State for covered outpatient drugs unless the drug's manufacturer had entered into a MediGrant master rebate agreement with the Secretary and is complying with the provisions of section 8126 of Title 38 of the U.S. Code, including entering into a master agreement with the Secretary of Veterans Affairs.

States would not be required to participate in the MediGrant master rebate agreement. States would be permitted to enter into rebate agreements on their own. States could opt to cover drugs for which there was no rebate agreement in effect. If a State had a rebate agreement already in effect which provided for a minimum rebate equal to or greater than the minimum rebate that would be paid under the master agreement, then at the State's option the agreement would be considered to meet the requirements of the MediGrant master rebate agreement and the State would be considered to have elected to participate in the master agreement.

Under the MediGrant master agreement, a drug manufacturer would be required to provide a rebate to each State not later than 30 days after receipt of certain information from participating States. Not later than 60 days after the end of a rebate period, each State participating in the master rebate agreement would be required to report to each manufacturer, with a copy to the Secretary, information on the drugs for which the State made payment during the period. A manufacturer would be permitted to audit the State's information. Adjustments would be made as necessary.

Not later than 30 days after the end of a rebate period, each manufacturer subject to the master agreement would be required to report to the Secretary on the average manufacturer price (AMP) and the best price of each of the manufacturer's covered products. In addition, within 30 days of entering into the agreement, the manufacturer would have to report the AMP as of Oct. 1, 1990. The Secretary would be permitted to verify the manufacturer's prices and impose a civil monetary penalty of up to $10,000 for refusal of the Secretary's request for information. For failure to provide timely information, the penalty would be $10,000 paid to the Treasury for each day information was not provided. After 90

Disappointment & dismay

(4)

Talk without
~~Without~~ question this proposal will force states to make harsh choices: ~~[illegible]~~ higher taxes or cutting off people. And remember 2/3 of Medicaid expenditures in this program are for the elderly & people with disabilities / the millions of people.

& economic downturn.
— Vulnerable to recessions

cost-shifting to families & women who give care

The spirit of ~~[illegible]~~ [illegible] (It addresses & experienced)

~~Repeals~~ Repeals the bipartisan quality nursing home standards enacted during the Reagan Administration & substitutes far less defined state standards

The many for the [illegible] gone

They [illegible] lost back.

days, the agreement would be suspended until the information was reported. For the provision of false information, a civil money penalty of up to $100,000 could be imposed in addition to other penalties. Information disclosed by manufacturers or wholesalers would be confidential. The Secretaries of HHS and Veterans Affairs and State agencies or contractors would be prohibited from disclosing information in a form that discloses the identity of a specific manufacturer or wholesaler or their prices except as the Secretary determined appropriate, and to permit review by the Comptroller General and the Congressional Budget Office.

Unless terminated, a MediGrant master rebate agreement would be effective for at least 1 year and automatically renewed for 1 year. The Secretary could terminate an agreement for violation of requirements or for good cause. A manufacturer could terminate participation for any reason. In case of termination, another agreement could not be entered into with that manufacturer for at least 1 calendar quarter, unless the Secretary found good cause for earlier reinstatement.

The provision provides for a basic rebate and an additional rebate. The basic rebate would be based on the number of products paid for by the State during the period, and the greater of (1) the minimum rebate percentage, or (2) the difference between the AMP and the best price. The minimum rebate percentage would be 15.1 percent of the AMP. The best price would be the lowest price available from the manufacturer during the rebate period. The additional rebate amount would be based on the amount, if any, by which the AMP of a product exceeded the product's AMP as of July 1, 1990, increased by the increase in consumer price index for all urban consumers since September 1990.

For certain drugs, including a brand name drug that a physician has certified as "medically necessary," the minimum rebate amount would be 11 percent of the AMP. The Secretary may, upon request of a manufacturer, limit the rebate amounts of covered products of which most were dispensed to inpatients of nursing facilities.

A State that participated in the master rebate agreement would be permitted to subject a product to a prior authorization controls that meet specified requirements, exclude or restrict coverage of specified drugs or classes of drugs that are updated periodically by the Secretary, establish formularies that meet specified requirements, and impose minimum and maximum quantities on prescriptions and refills.

A State would be permitted to operate a drug use review programs under standards established by the State. The Secretary would be required to encourage each State to establish a point-of-sale electronic system for processing claims for covered outpatient drugs. The Secretary would be required to submit annual reports on the drug rebate program to the Senate Committee on Finance, the House Committee on Commerce, and the Senate Committee on Aging.

The requirements of the MediGrant master rebate agreement would not apply to covered outpatient drugs dispensed by a capitated health care organization or a hospital or nursing facility that uses a formulary. Amounts paid by such entities could be included in the determination of best price.

If the MediGrant plan of a State participating in the master rebate agreement included coverage of drugs that could be sold without a prescription (known as over-the-counter drugs), those drugs would be regarded as covered outpatient drugs for purposes of the State's participation in the agreement.

CHILES

look for cuts

Any specific ... we are discussing with.

$1,82 billion recommended for block charts

- MOE
- Block grants
- complicated

It is as bad if not worse than we thought

Last night the BOC gave to members of committee the details of the Medicaid projects it [illegible]. One of 2. were for [illegible]

- MOE - [illegible] 95% exposure of our members.
- not one low income is entitled to health ins
- [illegible] expansion / Medicaid home resp group
- QMB?

Nursing Home Quality

children & families
adult dental
QMB

→ [illegible] Medicaid & non-Medicaid services 85%

In fact, not one Medicaid recipient NOT one is required to be covered under these plans

- No requirement that any portion of services will be continued,

Understand there is 2 school sites, that's

SD's cut by the new DHA, I am very worried it will mean that millions of our most vulnerable Americans will lose coverage

White House Medicaid Briefing Document

September, 1995

Revised 9/7/95 -- 12:15 p.m.

White House
Medicaid Briefing Document

Outline

Overview

- Medicaid covers over 36 million Americans.
- Medicaid provides three types of critical health protection:
  - Health insurance for low-income families and people with disabilities.
  - Long-term care for older Americans and people with disabilities.
  - Medigap coverage that helps low-income elderly fill in the gaps of the limited Medicare benefit.

State and Federal Partnership

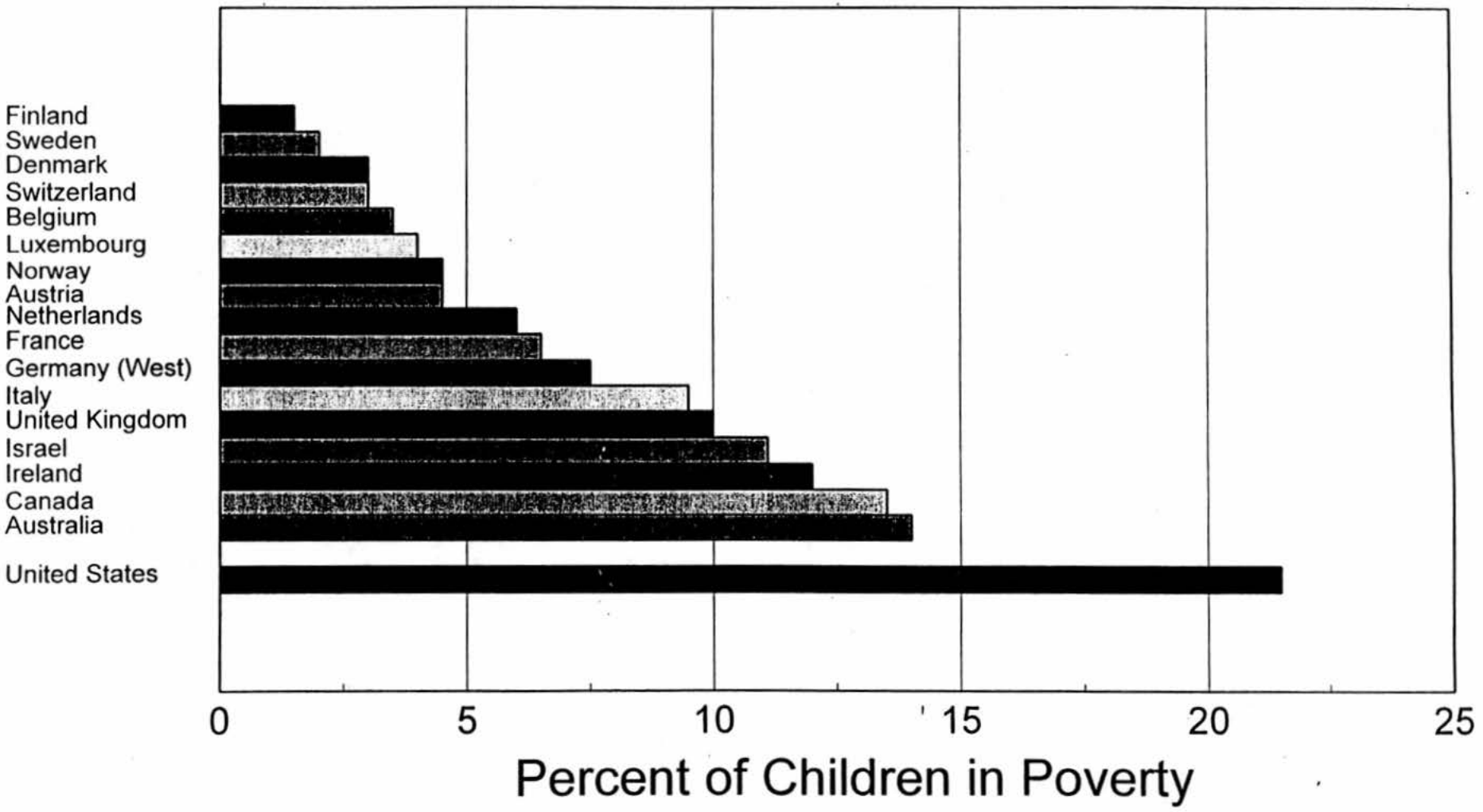
- In 1995, Medicaid will spend $156 billion: states will pay an estimated $67 billion and the federal government will pay $89 billion.

- States administer Medicaid under broad federal guidelines, and receive federal matching payments related to each state's per capita income.

Health Care for Children

- Medicaid currently covers over 18 million children: one out of every five children in the nation.
- About 1/3 of all babies born in the United States are covered by Medicaid.
- Over 90 percent of children with AIDS are covered by Medicaid.
- It is important to note than an August, 1995 study has found that the U.S. leads the advanced world in the percentage of children in poverty. It also points out that poor children in America are poorer than poor children in almost all other industrialized nations [note chart on next page].

Child Poverty Rates in 18 Countries



Source: Center for the Study of Population, Poverty, and Public Policy, August 1995. Poverty is defined as percent of children living in families with adjusted disposable incomes less than 50 percent of adjusted median income for all persons. Income includes all transfers and tax benefits. Year for each estimate is most recent data available.

Health Care for Children

- Children can be eligible for Medicaid if they are:
  - In a family receiving Aid For Families and Dependent Children (AFDC).
  - In a family with income at or near poverty (varies by state).
  - Disabled and poor enough to qualify for Suplemental Security Income (SSI).
  - In some states, impoverished by medical expenses or living in a medical institution.

Health Care For People With Disabilities

- Medicaid will cover 6 million people with disabilities in 1995.
- Medicaid is the primary insurer for people with disabilities, since private insurance is not affordable for people with pre-existing conditions.
- Persons with disabilities can get Medicaid if they:
  - In some states, have been impoverished by medical expenses.
  - Reside in an institution and cannot afford the full cost of care.
  - Are poor enough to qualify for SSI.
  - Are entitled to Medicare as a Social Security beneficiary and have income at or slightly above poverty.

Long-Term Care and "Medigap" for the Elderly

- Over 4 million older Americans will be covered by Medicaid in 1995.
- Although most elderly are covered by Medicare, its benefits are limited. Because of high deductibles and copayments and no prescription drug coverage, the Medicare benefit is in the 20th percentile of benefit packages in the country.
- Medicaid pays for the services not covered by Medicare by paying for premiums and cost-sharing for all elderly at or slightly above the poverty threshold.
- Medicaid also covers long-term care for older Americans who have spent most of their resources and income on health care.

Long-Term Care and "Medigap" for the Elderly

- Older Americans can get Medicaid if they:
  - In some states, have been impoverished by medical expenses.
  - Reside in an institution and cannot afford the full cost of care.
  - Are poor enough to qualify for SSI.
  - Are entitled to Medicare and have income at or slightly above poverty.

Medicaid Coverage and Spending

- States and the federal government will spend an average of $3,700 per person on Medicaid in 1995.

- However, spending varies for the different people and types of coverage in the program. Medicaid spends about:

  - $1,400 per child.

  - $8,300 per person with disabilities.

  - $9,800 per elderly recipient.

Medicaid Coverage and Spending

- Only 28 percent of the people enrolled in Medicaid are elderly and disabled, but they account for 69 percent of the spending.

- Conversely, while 72 percent of the people on Medicaid are children and their families, they account for only 31 percent of the spending.

- These contrasting statistics are due to the fact that health care costs for the elderly and the disabled are much more expensive than costs for children and their families.

Medicaid Beneficiaries and Expenditures: 1995

Beneficiaries

	Millions of People	Percentage
Children	18	51%
Elderly	4	12%
Disabled	6	16%
Adults	8	21%
TOTAL	36	

Expenditures

	Billions of Dollars	Percentage
Children	$25	18%
Elderly	$43	32%
Disabled	$50	37%
Adults	$18	13%
TOTAL	$136	

Source: CBO estimates for fiscal year 1995.
* Excludes disproportionate share and administrative costs ($20 billion).

What Medicaid Covers:
States' Flexibility

- All states cover a minimum set of services, including hospital, physician, and nursing home services.
- States have the option of covering an additional 31 services, including prescription drugs, hospice care and personal care services.
- States' flexibility in designing their Medicaid program is highlighted by the fact that over 50 percent of Medicaid benefit payments in 1993 were for optional services and populations selected by the states.

What Medicaid Covers: Long Term Care

- Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Medicaid covers 68 percent of nursing home residents and over 50 percent of nursing home costs.

- Medicaid covers skilled nursing facility care, intermediate care facilities for the mentally retarded and developmentally disabled, and home-and-community-based services.

- Although most long-term care spending is for institutional care, Medicaid has made great strides in shifting the delivery of services to home and community settings.

- Cost-effective community-based long-term care increased from 13 to 21 percent of long-term care spending between 1990 and 1995.

A Critical Safety Net

- Medicaid has slowed the rapid increase in the number of people without health insurance.

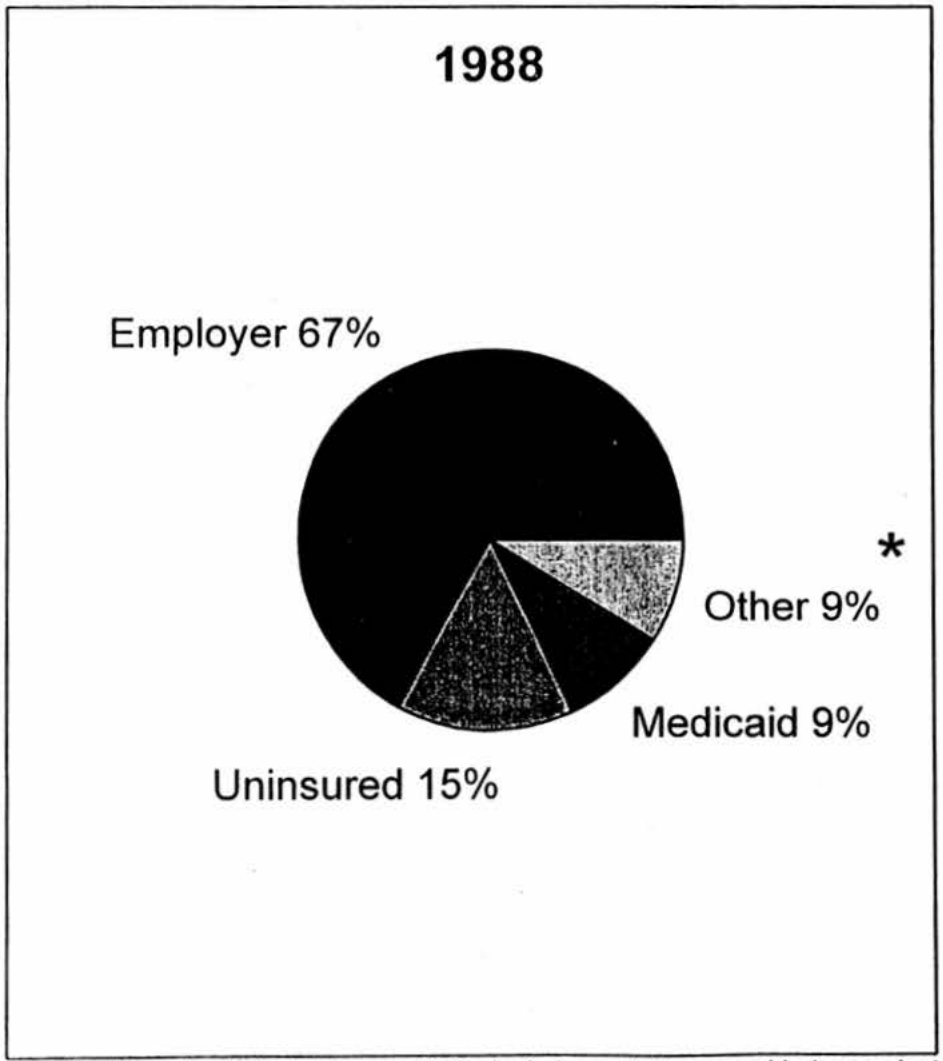
- Medicaid coverage is especially important since employer coverage has been declining. Between 1988 and 1994:

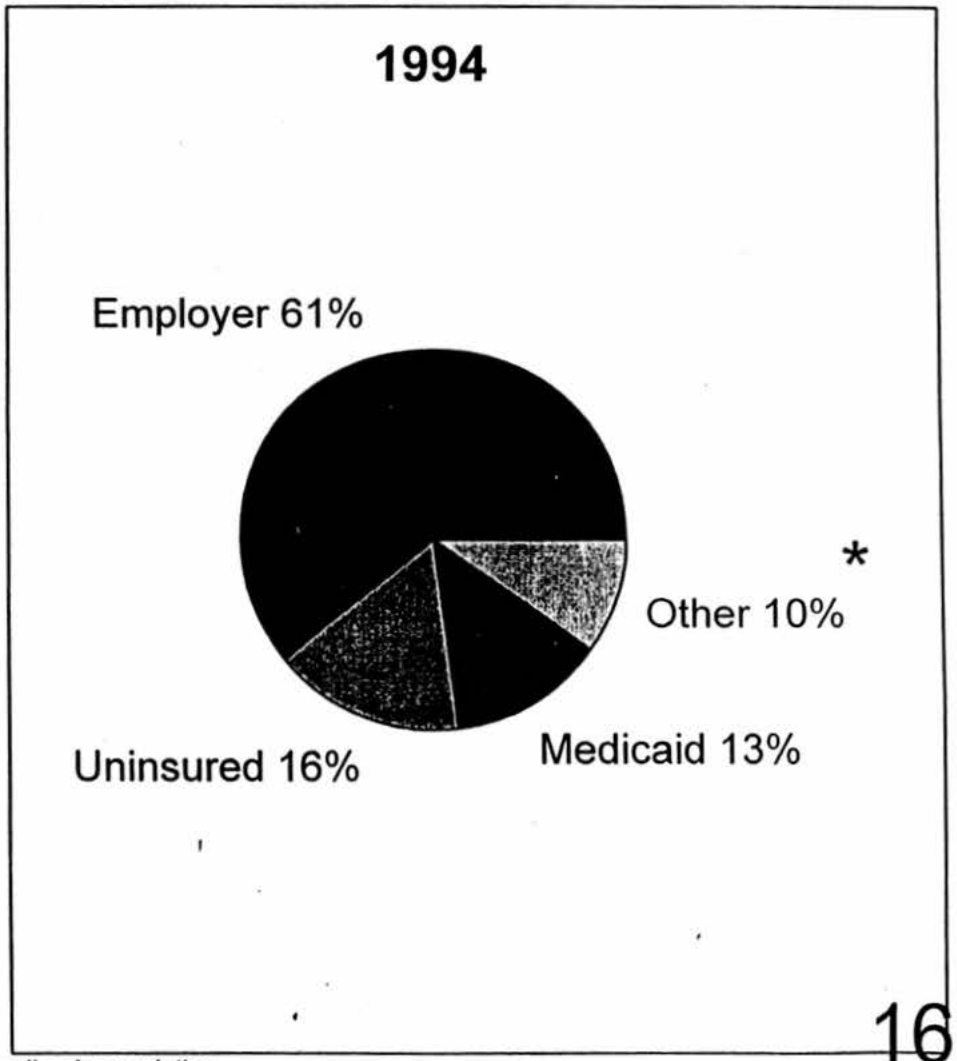
  - The percentage of Americans covered by employer-sponsored health insurance fell from 67 percent to about 61 percent.

  - Medicaid coverage increased from 9 to 13 percent.

- If Medicaid coverage had not increased, there would be more uninsured, more uncompensated care, and more cost-shifting.

Changes in Insurance Coverage: 1988 to 1994





Source: The Urban Institute, February 1995. Includes only the non-elderly, non instutionalized population.
* Includes individually purchased insurance and other public insurance.

Medicaid Spending Growth

- CBO projects that aggregate Medicaid spending will grow at an average rate of 10.2 percent between 1996 and 2002.
  - This is lower than the growth of expenditures in the early 1990s, when the average rate was closer to 20 percent.
- Medicaid spending growth results from three different pressures: increases in the price of health care, utilization and intensity of health care, and the number of people covered.

Enrollment Growth Drives Medicaid Spending Growth

- Medicaid growth is largely driven by enrollment growth, especially among the elderly and disabled. According to CBO, about 45 percent of the total spending increases results from a rising number of people in the program.

- The number of Medicaid beneficiaries is projected to grow by 3.0 percent a year between 1996 and 2002 -- more than three times the general population growth, and twice the growth in the number of Medicare beneficiaries.

- Medicaid enrollment growth reflects the fact that the population is aging. The number of aged and disabled beneficiaries is growing at 4.6 percent per year -- almost twice the rate for adults and children, whose projected average growth rate is 2.4 percent.

Medicaid Spending Growth Per Person is Low

- Since Medicaid enrollment growth is high, it distorts the overall Medicaid spending growth. Thus, when comparing Medicaid to other health programs, it should be done using Medicaid growth per beneficiary.

- **Medicaid spending per beneficiary is projected to grow at 7 percent per year between 1996 and 2002.**

- This growth rate is the same as the projection of the private health insurance spending per insured person under the CBO baseline.

The Republican Budget Resolution: Unprecedented Cuts

- The Republican Budget Resolution would cut Medicaid by 20 percent -- $182 billion over the next 7 years.

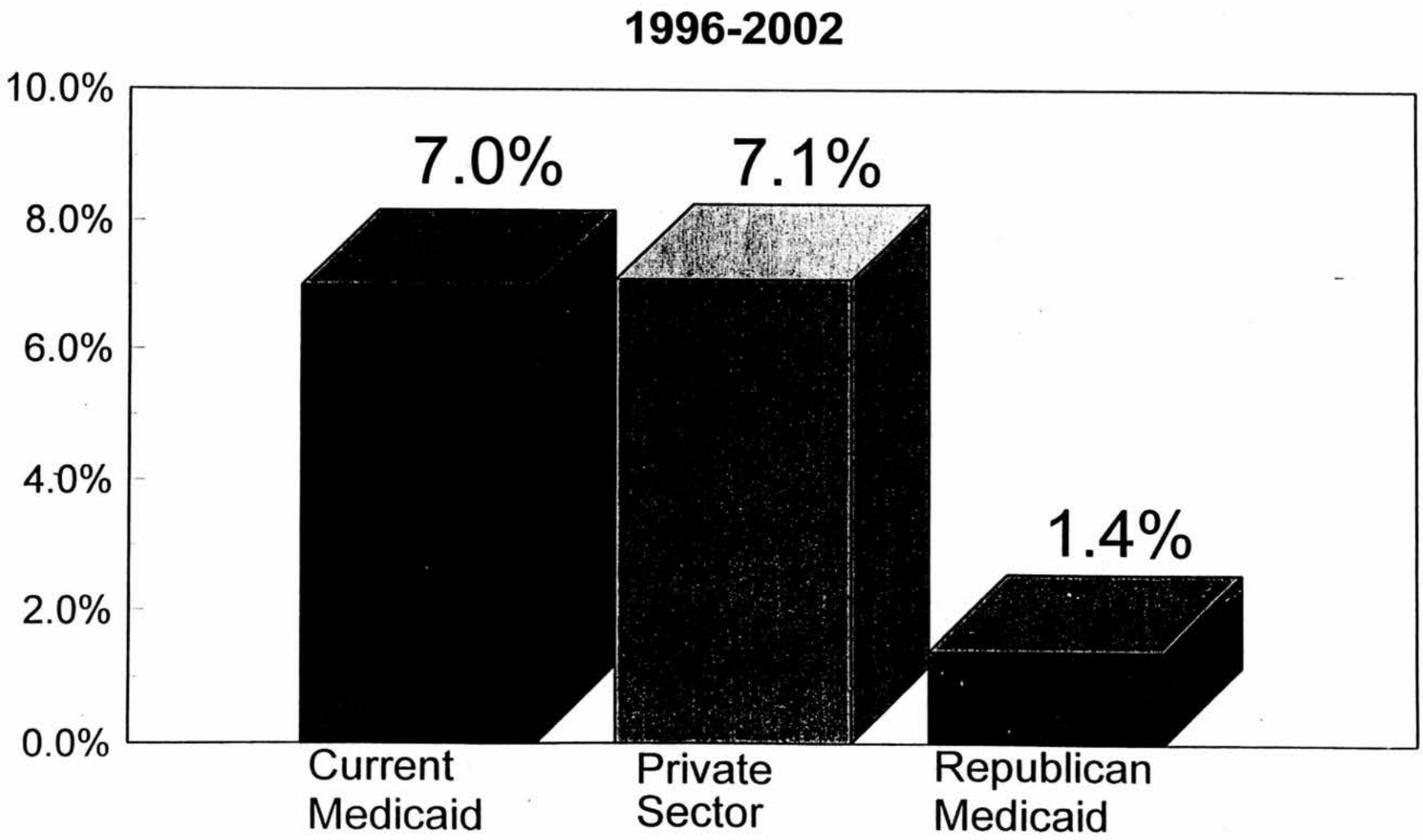
- The Republicans would achieve these savings by imposing a 4.5 percent average annual growth rate cap on aggregate spending. That is less than enrollment growth plus inflation.

- **Taking enrollment growth into account, the Republican Budget would limit growth in Medicaid spending per person to only 1.4 percent annually.**

The Republican Budget: Unprecedented Cuts

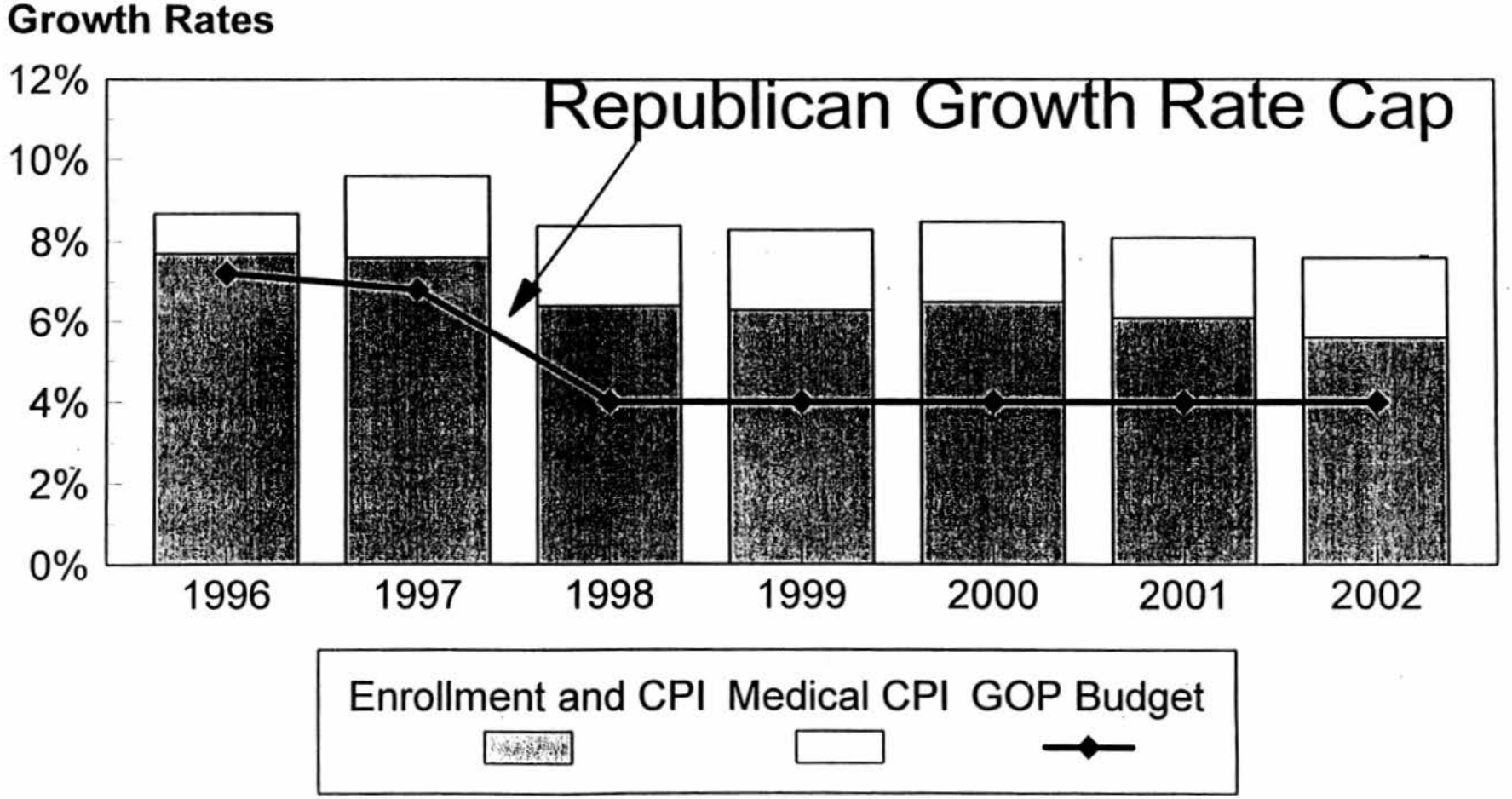
- Republicans say their Medicaid proposal is not a cut. However, a 1.4 percent cap on growth per beneficiary is a cut in real terms. It is:
  - 80 percent below the projected private health spending per person (7.1 percent).
  - 75 percent below projected medical inflation (5.3 percent).
  - 50 percent below the projected consumer price index (3.3 percent).

Medicaid Growth Per Beneficiary:
Effect of the Republican Proposal



Source: CBO Projected Baseline for Fiscal years 1996-2002.

Republican Medicaid Spending Limits Don't Keep Up With Inflation



CBO projected annual increases, fiscal years 1996 - 2002.

The Republican Budget Resolution:
Options for Reaching this Level of Cuts

- There are three ways for states to cut this much (20 percent) from Medicaid:
  - Reduce benefits or provider payments.
  - Eliminate coverage for people on Medicaid.
  - Find savings through increased efficiency and productivity.

The Republican Budget Resolution:

Efficiency Can Only Go So Far

- States have already constrained the growth of Medicaid spending per beneficiary to the same growth rate as the private sector.

- While states can improve productivity and efficiency, savings from these activities do not come close to $182 billion that the Republicans are seeking.

The Republican Budget Resolution:
Managed Care Savings Are Limited

- CBO estimates a one-time, 5 to 15 percent savings from managed care for non-disabled, non-elderly adults and children.

- States have already aggressively pursued managed care. About one-third of Medicaid adults and children are currently enrolled in managed care. And, under current law, states are expected to enroll 50 percent of this population in managed care by 2000.

- There is little Medicaid experience with managed care for the elderly and disabled -- who account for almost 70 percent of Medicaid spending. Therefore, it is unlikely that CBO will score significant savings from this part of the program.

- Thus, managed care cannot be expected to achieve the 1.4 percent growth cap per beneficiary in the Republican Budget.

The Republican Budget Resolution:
People Will Lose Coverage

- The Urban Institute estimates that even if states were able to achieve half the needed savings from reducing services and reimbursement to providers, states would still be forced to eliminate coverage for 8.8 million people in 2002 alone, including:
  - **Families:** 6.3 million adults and children.
  - **Elderly:** 920,000 older Americans.
  - **Disabled:** 1.4 million persons with disabilities.
- This translates into a 19 percent cut off of current projections. In other words, almost one in five beneficiaries would lose coverage.

The Republican Budget Resolution:
Children Will Lose Coverage

- Currently, 20 percent of the nation's children rely on Medicaid for their basic health needs.
- Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for over 18 million low-income children.
- Under the Republican Budget, 4.4 million children would lose Medicaid coverage in 2002.

The Republican Budget Resolution:
Nursing Home Residents Will Lose Coverage

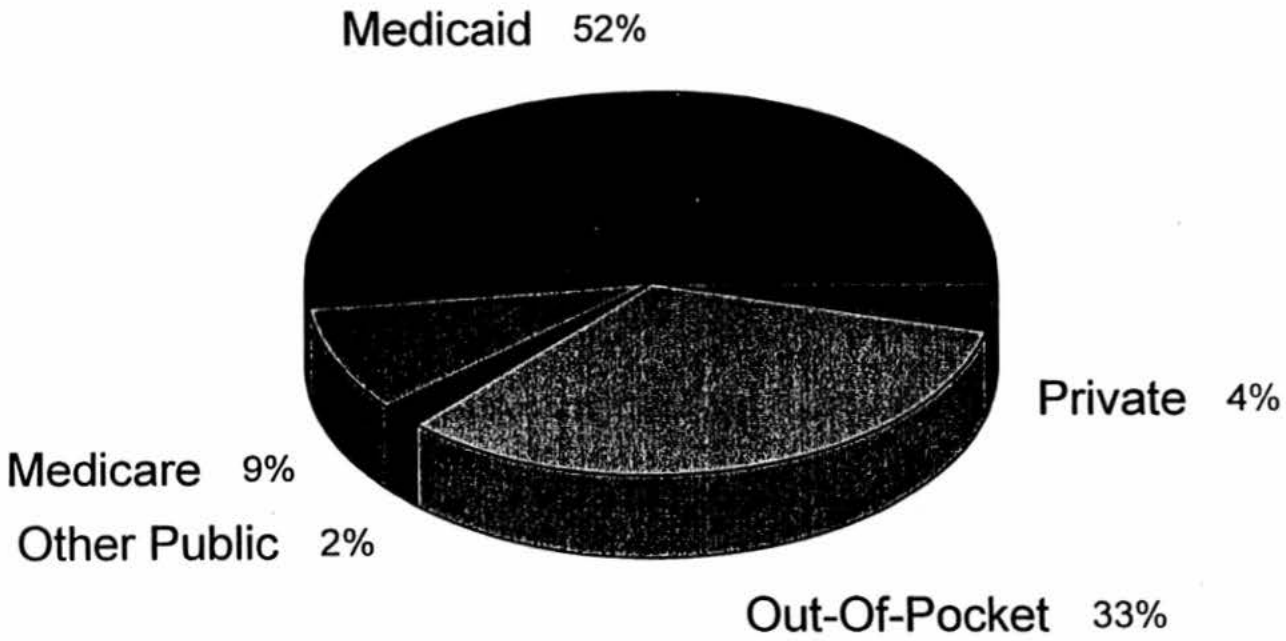
- Over two-thirds of nursing home residents rely on Medicaid to pay the staggering costs of nursing home care.

- On average, families pay $38,000 per year for nursing home care.

- A deep cut in Medicaid would mean that about 350,000 residents of nursing home could lose coverage in 2002.

- For many of these residents, there is nowhere to turn. Two-thirds of nursing home residents are elderly women, and a majority have no spouses.

Nursing Home Care Expenditures: By Payer, 1993



SOURCE: Health Care Financing Administration

The Republican Budget Resolution:
States at Risk

- **States could only avoid these actions by increasing their spending by 40 percent in 2002 -- by raising taxes or cutting other critical state spending.**

- **States At Risk From Inflation And Recession.** When a recession occurs, the number of working people who lose health insurance and apply for Medicaid can rise dramatically, increasing program costs. An aggregate growth cap would not respond to this change in state need.

- **States At Risk For Cost Of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under an aggregate growth cap, states with large elderly populations will bear a disproportionate burden.

The President's Plan

- The President seeks $54 billion in Medicaid savings over seven years.
- The President's plan results in a more realistic growth in spending per beneficiary of 6.3 percent.
- This rate is much closer to the private sector growth rate of 7.1 percent.
- The President's savings from Medicaid are less than one-third of the reductions called for by the Republicans.

The President's Plan

- The President's plan constrains Medicaid growth through a mix of policies, including:
  - Eliminating unnecessary federal strings on states by allowing states to pursue service delivery innovations without seeking federal waivers and by restructuring the Boren Amendment.
  - Reducing and better targeting federal payments to states for hospitals that serve a high proportion of uninsured people.
  - Limiting the growth in federal Medicaid payments to states for each beneficiary (i.e., a per capita cap), so that states do not need to reduce coverage to achieve savings.

The President's Plan

- The President's Medicaid plan is preferable to the Republicans' plan because:
  - It protects states from changing economic and demographic conditions.
  - It gives states flexibility to manage their programs efficiently and responsively.
  - It protects against increases in the number of uninsured, thus avoiding increases in uncompensated care and cost-shifting.
  - Together with the President's health reform initiative (insurance reform, small business purchasing cooperatives, and insurance assistance for the temporarily unemployed), it protects and expands health care coverage.

MEMORANDUM

To: Distribution

From: Gene Sperling
Chris Jennings
Jennifer Klein

Date: May 2, 1995

Re: Latest Health Care Information

Attached for your information are 1) the latest Medicare and Medicaid talking points which have been distributed to Democratic hill staff; 2) the letter that Leon sent to Speaker Gingrich yesterday; and 3) quotes taken from the Republicans of the Ways & Means Committee 1994 "Minority Views," in which they explicitly decry the impact of deep Medicare cuts on Medicare programs.

MEDICARE TRUST FUND SOLVENCY PROBLEM

Unlike the Republicans, This is Not a Problem Democrats Just Discovered. The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed. Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

In Contrast to the Democrats, the Republicans Have Just Discovered this Issue. In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

The Republicans are Using the Trust Fund as a Smoke Screen for Cuts. Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution: Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

REPUBLICAN MEDICARE CUTS

Republicans are considering proposals that would cut Medicare funding by between $250 billion and $305 billion between now and 2002. Slashing Medicare at this level translates into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

COERCION INSTEAD OF CHOICE: Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

ADDING TO ALREADY HIGH COSTS FOR SENIORS: Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or $2,500) of their incomes to pay for out-of-pocket health care expenditures.

$3,100-$3,700 Out-of-Pocket Payments: If the Republican cuts ($250 billion to $305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional $815 to $980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between $3,100 to $3,700 more.

Reduce Half of Social Security COLA: The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

$40-$50 Billion in Cost-Shifting: Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a $125 billion to $150 billion cut over seven years. In 2002 alone, a $33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of $40 billion to $50 billion in increased premiums and health care costs between now and 2002.

Rural and Inner City Hospitals At Risk: Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
  - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
  - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
  - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
  - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. **On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.**

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by $160 to more than $190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if $160 to $190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut $160 to $190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE**; and
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE**; and
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the $190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by $10.7 to $12.8 billion.

MEDICARE/MEDICAID CUTS:
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least $2000 more out of pocket than they would pay under current law. And over the next seven years they would pay $3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

The National Council of Senior Citizens says:

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about go belly-up; a seven-year window does not merit a panic button."

"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to chose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Children's Defense Fund says:

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)

THE WHITE HOUSE

WASHINGTON

May 1, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The President has asked me to respond to your letter of April 28, 1995. As the Administration has shown over the last two and a half years, we are committed to reducing the deficit and achieving meaningful health care reform. We continue to seek progress on both of these fronts, while also making our tax system fairer and our system of investing in education and children even stronger.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by $27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over $300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year $345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconciliations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

The President has long stated that making significant cuts in Medicare and Medicaid outside the context of health care reform will not work. Such dramatic cuts could lead to

less coverage and lower quality, much higher costs to poor and middle income Medicare recipients who cannot afford them, a coercive Medicare program, and cost-shifting that could lead to a hidden tax on the health premiums of average Americans. That is why it is essential to deal with the Medicare Trust Fund in the context of health care reform that protects the integrity of the program, expands not reduces coverage, and protects choice as well as quality and affordability.

The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

Leon E. Panetta
Chief of Staff

FORTNEY PETE STARK
THIRTEENTH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

MEDICARE CUTS? LOOK WHAT REPUBLICANS SAID LAST YEAR!

Dear Democratic Colleague:

The Republicans are about to try to cut Medicare $250 to $310 billion over the next 7 years.

Last year all 14 Republican Members of the Ways and Means Committee signed the following minority views to HR 3600, the Health Reform bill:

> *"The reimbursement levels of medicare have reached potentially disastrous levels, as ProPAC's current report underscores.*
>
> *"Anyone who doubts this only has to look at the current Medicare program for the elderly and the Medicaid program for the poor. For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare and Medicaid patients--and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."*

As you remember, HR 3600 did cut Medicare spending $157 billion over 7 years but returned ALL the money to the health care system by insuring everyone (no more bad debt and uncompensated care for doctors and hospitals) and providing seniors with a prescription drug coverage and better Medicare benefits. The Republican cuts won't go for Medicare improvements or health care reform--they will just be cuts.

We should all remind the Republicans--often--of what they said last year.

Sincerely,

Pete Stark
Member of Congress

FACT SHEET ON LIKELY REPUBLICAN MEDICAID CUTS
Wednesday, May 3, 1995

Congressional Republicans are currently considering cuts in federal Medicaid funding of $160 to more than $190 billion between 1996 and 2002. Republicans claim they are not cutting the program, but reducing its rate of growth. Yet, these technical number disputes avoid the real issue: how their proposals will affect real Americans; who will be hurt; who will lose coverage; and who will lose benefits if their cuts are made. It also ignores the fact that 3 to 4% of growth in Medicaid is due not to inflation but to additional children, elderly, disabled and others being insured under the program.

Impact on Working Families. Most people think Medicaid helps only low-income mothers and children. In fact, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

Insufficient Managed Care Savings. Savings from managed care cannot produce the magnitude of cuts Republicans have proposed. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. Because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

State Finances. Republicans say these cuts merely give states additional flexibility through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous cuts -- forcing them to choose between cuts in education, law enforcement, health care or other priorities.

Cuts in Eligibility, Benefits and Provider Payments. What do these cuts really mean? Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans cut $160 to $190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- 5 to 7 million children would lose coverage; and
- 800,000 to 1 million elderly and disabled beneficiaries would lose coverage; and
- Tens of millions of Americans would lose benefits, because all preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the cuts reach $190 billion; and
- Already low payments to health care providers would be reduced by $10.7 to $12.8 billion.

FACT SHEET ON LIKELY REPUBLICAN MEDICARE CUTS

Wednesday, May 3, 1995

Congressional Republicans are considering proposals that would cut Medicare funding by between $250 billion and $305 billion between now and 2002. Medicare cuts at this level translate into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

Choice or Coercion? Republicans claim their proposals would increase choice by giving vouchers to Medicare beneficiaries to buy insurance in the private market. In reality, the only way that this approach can achieve the magnitude of savings being contemplated is to significantly raise costs for traditional fee-for-service coverage, effectively forcing many beneficiaries to use vouchers to buy managed care. That would put Medicare's 37 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. That is simply a form of financial coercion.

Current Health Care Spending by Older Americans. Today, despite Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, typical Medicare beneficiaries already dedicate a staggering 21% (or $2,500) of their incomes to pay for out-of-pocket health care expenditures.

More Out-of-Pocket Payments: If these cuts are distributed evenly between providers and beneficiaries, Medicare beneficiaries would pay:

- o $815 to $980 more in out-of-pocket expenses in 2002.
- o Between $3,100 to $3,700 more in out-of-pocket over the 7 year period.

Social Security COLAs: The Republicans claim they aren't cutting Social Security, but these Medicare cuts would effectively do that. By 2002, the typical Medicare beneficiary would see 40 to 50% of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries would have 100% or more of their COLAs consumed by the cost increases.

Rural and Inner City Hospitals. Cuts of this magnitude, combined with the growing uncompensated care burden (exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. These cuts would threaten both the quality and access to needed health care in rural America.

President Clinton Addresses White House Conference on Aging:
Vows to Reform Health Care "The Right Way."
Wednesday, May 3, 1995

Today, President Clinton will speak to the White House Conference on Aging where he will renew his commitment to fighting for America's seniors. The Clinton Administration is committed to addressing the concerns of older Americans, particularly making sure that they are economically secure. That is why President Clinton has taken steps to:

- o Ensure the long-term integrity of the Social Security Trust Fund;
- o Vowed to make sure that Social Security benefits are not used to balance the budget or pay for tax cuts for the wealthy;
- o Signed the Retirement Protection Act to make the pension system more reliable;
- o Proposed IRAs to allow Americans to save money and withdraw it tax-free for the cost of a major medical expense or the care of a sick parent;
- o Invested in the Older Americans Act that provides benefits to millions of Americans; and, **most importantly,**
- o Vowed to fight for real health care reform and against cuts in Medicare and Medicaid to fund tax cuts for the wealthy.

Medicare and Medicaid have provided a safety net for our nation's elderly for 30 years. Today, Medicare covers 37 million elderly and disabled Americans. And, while the myth is that Medicaid helps only low-income women and children, the reality is that about two-thirds of Medicaid funds are spent on services for older Americans and people with disabilities.

These programs are an example of government that works. This year, as we celebrate the 30th anniversary of their passage, we must remember that:

- o Medicare and Medicaid have lifted millions of older Americans out of poverty. Before Medicare, almost 30 percent of our nation's elderly lived in poverty -- as compared with 12 percent today.

- o Before Medicare, about 45 percent of the elderly had no health insurance and even more were underinsured. For 30 years, Medicare has guaranteed health security to older Americans -- even as the number of uninsured in this country continues to rise.

- o And Medicaid has helped middle class families who have exhausted their savings to manage the overwhelming costs of nursing home care. Without Medicaid, families with a parent or spouse who needs long-term care would face nursing home bills that average $38,000 a year.

We Must Address Health Care Spending. We cannot get hold of the deficit without addressing growing health care entitlement spending. This is a real problem that must be addressed. Federal health care costs are growing faster than the economy, faster than overall inflation, and faster than almost all other government spending. **We must contain costs in**

these programs, but there is a right way and a wrong way to do so.

- **The Wrong Way to Address Health Care Spending.** The wrong way is to:

  - Simply slash Medicare and Medicaid;
  - Use these programs to pay for tax cuts for the wealthy and campaign promises;
  - Increase Medicare out-of-pocket expenses so much that health care becomes unaffordable.
  - Go backward and reduce coverage; and
  - Make changes in Medicare that lead to coercion over choice.

- **The Right Way to Address Health Care Spending.** President Clinton has said that the right way to contain costs in Federal health programs and to deal with the deficit and the long-term problem of the Medicare Trust Fund is through health care reform. As we reform health care, we must ensure that changes to Medicare and Medicaid maintain coverage, choice, quality and affordability.

  President Clinton will have a simple test for every proposal. He will ask:

  (1) **Coverage.** Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans?

  (2) **Choice.** Does it expand choice in Medicare? Or does it financially coerce beneficiaries into managed care plans?

  (3) **Quality.** Will this proposal reform the Medicare and Medicaid programs to make them more efficient without harming the delivery system, threatening quality and increasing cost shifting to small businesses? Or are these simply arbitrary and excessive cuts used to pay for other priorities -- like tax cuts for the wealthy?

  (4) **Affordability.** Will this proposal increase costs for beneficiaries so much as to make quality medical care unaffordable for older Americans? Will it take responsible steps to contain costs?

Cracking Down on Fraud and Abuse. The Clinton Administration is taking steps now to reform our health care system and to improve our health care programs. Simply put, fraud jeopardizes the health of beneficiaries and rips off the government, and we must do all we can to stop it. Since the Clinton Administration began, we have vigorously cracked down on fraud and abuse in Medicare and Medicaid. In just another example of our consistent efforts to combat fraud and abuse -- as part of our "Reinventing Government" proposal -- we will create a partnership between government and private agencies to fight fraud in five states.

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Comments: Just some stuff for your files if you ever need.

COVERAGE IMPLICATIONS OF MEDICAID CAPS

Status Quo

Under the status quo, state Medicaid programs must operate on a individual entitlement basis, but states still have substantial flexibility with respect to eligibility (and therefore coverage).

- Overall, 35% of Medicaid spending is for optional eligibility categories. Most of the spending for optional eligibility categories (26% out of the 35%) is for the aged and disabled adults.

- This 35% figure understates the true extent of optional eligibility, because even within a mandatory eligibility category, states have substantial discretion in setting the income level for eligibility.

- Conceptually, the fact that the federal government matches state Medicaid spending means that coverage is broader than it would be without federal matching payments. In a state with a 50% matching rate, the state is able to provide one dollar in coverage in exchange for only 50 cents of state spending.

  In theory, this coverage effect (relative to what coverage would be without federal matching payments) is highest in states with the highest federal matching rates.

The Effect of an Aggregate Cap or Block Grant

Aggregate Cap:

- Under an aggregate cap, the current federal/state matching arrangement would continue, but federal matching payments to a state would be capped at a predefined level. States would presumably have greater flexibility in determining eligibility, covered services, and provider payment levels. The expectation is that the cap is below (potential significantly below) projected spending levels.

- There is little reason to believe that states would respond by spending less

than the cap, since they could be doing that now if they wanted to.[1]

- It is highly unlikely, however, that states would maintain much spending above the cap (since to do so would require state spending without federal matching payments).

- An aggregate cap is neutral with respect to how a state attempts to keep spending below the level of the cap.

  - A dollar reduction in provider payments or benefits yields the same effect as a dollar reduction in coverage.

  - It is difficult to determine what mix of cuts states would use, though current practices might provide some indication. Currently, states are more likely to expand spending for optional services ($50 billion in FY93) than for optional eligibility categories ($38 billion in FY93).

Aggregate Block Grant:

- Under an aggregate block grant, states would receive a fixed sum of federal money, along with greater flexibility in determining eligibility, covered services, and provider payment levels.

- Effects will vary based on maintenance of effort requirements.

  - If states are required to maintain current effort in some way, then the effects of an aggregate block grant are likely to be similar to the effects of an aggregate cap.

  - If no maintenance of effort is required, then it is likely that many states would respond by spending less than they do today.

Per Capita Cap

- A per capita cap differs from an aggregate cap in that it is determined on a per enrollee basis. States would presumably have greater flexibility in determining covered services and provider payment levels, but not

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[1]Some might argue that states could reduce spending with greater flexibility. It would seem unlikely that this is a large effect, particularly given the amount of spending today that is optional and the availability of waivers.

necessarily in determining eligibility.

- Like an aggregate cap, there is little reason to believe that states would respond by spending less than the cap, since they could be doing that now if they wanted to.

- Unlike an aggregate cap, a per capita cap is not neutral with respect to how a state attempts to keep spending below the level of the cap.

  - Assuming spending is projected to be above the cap, then a one dollar reduction in provider payments or covered services yields a dollar in state savings.

  - However, a dollar reduction in coverage yields less than a dollar in state savings (how much less depends on the state's matching rate).

- Though a per capita cap would lead primarily to reductions in covered services or provider payments, some reductions in coverage are possible.

  - If a state is unable (or unwilling) to hold per capita spending below the cap, then its matching rate is effectively changed.

  - For example, assume that per capita spending were projected to grow at 7% per year and a per capita cap growing at 5% per year were applied. If a state simply absorbed the full cut in federal spending, its federal matching would fall by about 12% after seven years (e.g., from 50% to 44%). The matching rate would continue to fall over time.

  - With a lower matching rate, states might reduce coverage somewhat.

  - The tighter the per capita cap, the more pronounced the effect on coverage. This is because with a tighter cap, states are less likely to be able to meet the cap through reductions in covered services or provider payment levels.

Medicare and Medical Savings Accounts

Description of the Proposal

A recent Wall Street Journal column proposes a series of Medicare reforms intended to maintain solvency in the Medicare Hospital Insurance trust fund ("Gingrich Can Avert GOP Disaster Over Medicare," May 9, 1995). Key elements of the proposal are:

- Add an up-front deductible to Medicare paid by beneficiaries, and increase the deductible each year to ensure that federal spending remains within available revenues.

- Permit beneficiaries to withdraw an amount from Medicare (adjusted for age, geographic area, and health risk) and use it to purchase any type of private insurance or deposit it in a Medical Savings Account (MSA). The growth in the amount a beneficiary could withdraw would be limited to the increase in available revenues for Medicare. Funds left unused in an MSA at the end of a year could be used for any purpose.

Implications

- Speaker Gingrich has indicated that he wants to keep the current Medicare system intact as an option for beneficiaries. This proposal does not do that.

  - In fact, the vast majority of the savings from this proposal would likely come from shifting costs to beneficiaries and employers (who supplement Medicare for retired workers) through an ever-increasing deductible. This deductible would have to rise to $x by 2002 in order to keep the program growing at a rate that maintains trust fund solvency.

  - Under current law, state Medicaid programs are required to pay for Medicare coinsurance and deductibles for low-income beneficiaries. Therefore, increasing Medicare deductibles would amount to a growing unfunded mandate on states.

- The proposal claims that with the amount withdrawn from Medicare plus current average out-of-pocket costs, a beneficiary could purchase a catastrophic insurance policy with a $3,000 deductible and put $3,000 into an MSA. This might be true on average, but not everyone is average.

  - Medicare costs very tremendously based on the health status of the beneficiary. The average cost for the sickest 10% of beneficiaries in any one year is $x, while the average cost for the healthiest 10% of beneficiaries is just $x. Costs

often vary due to sudden illnesses (e.g., a heart attack) that cannot possibly be predicted on a case by case basis.

- Because the proposal would adjust the amount a beneficiary could withdraw from Medicare based on the person's risk characteristics, a seemingly healthy beneficiary might be allowed to withdraw only $1,000 to $2,000 (compared, for example, to an average withdrawal of $5,000 to $6,000 based on current spending). Such a person would obviously not have much left over to deposit into an MSA after paying a premium to an insurance company, and therefore would have significant out-of-pocket costs if faced with an expensive, unforeseen illness.

- A sicker beneficiary would be allowed a larger withdrawal, but would also be subject to a discriminatory insurance market. Someone with an expensive condition might not be able to buy insurance on the private market at any price.

♦ Medicare already offers a wide range of choices to beneficiaries, without putting them at risk as this proposal would.

- In most parts of the country, beneficiaries can already use Medicare funds towards to purchase of coverage from a managed care plan. This system provides beneficiaries with choice without putting them at risk, because plans cannot exclude people who are sick or charge them higher premiums. The Administration is committed to expanded the range of choices available to beneficiaries (e.g., by including preferred provider and point-of-service plans that have been used increasingly by employers to control costs).

- The current Medicare program already has a $x hospital deductible and 20% coinsurance for physician services. Beneficiaries can choose to remain at risk for these up-front charges, or they can purchase private Medigap insurance and avoid them (as the vast majority do).