FAX TRANSMISSION

CENTER ON BUDGET AND POLICY PRIORITIES
777 CAPITOL ST., NE SUITE 705
WASHINGTON, DC 20002
202-408-1080
FAX: 202-408-1056

To: Pauline Abernathy **Date:** January 5, 1996

Fax #: 456-2223 **Pages:** 4, including this cover sheet.

From: Cindy Mann

Subject: The Kassebaum proposal/defined benefit contribution

COMMENTS:

Over the past 24 hours, it seems that the Kassebaum proposal is gaining some attention. The document dated December 19, 1995, is not clear on many points, but it appears to us that it does not suggest a per capita cap and a block grant as some have thought. Enclosed is a piece that makes this point.

Also enclosed is a piece that considers that part of the Kassebaum proposal that suggests turning the defined benefit package into a defined dollar contribution. This idea has some currency beyond those who support the Kassebaum approach.

If you have different interpretations of the proposal, please let us know. At this point, we are not widely circulating these papers.

CENTER ON BUDGET AND POLICY PRIORITIES

January 5, 1996

CONVERTING THE MINIMUM COVERAGE GUARANTEE UNDER THE MEDICAID PROGRAM TO A MINIMUM DOLLAR PAYMENT FOR SERVICES WILL CAUSE PROBLEMS FOR STATES AND BENEFICIARIES

The Kassebaum plan proposes to require states to spend a specified dollar amount on benefits in place of the current requirement that states cover certain specified health care services. Federal law would no longer guarantee services such as hospital care or physician services. The December 19, 1995 draft suggests that states could provide any range or level of health benefits to targeted populations as long as the dollars spent on those benefits were equal to some minimum percentage (75 percent is proposed in the draft) of the value of the services offered to that group of beneficiaries in the base year. The level of funds required to be spent would be adjusted for inflation, and perhaps other factors.

While the proposal may appear attractive to those seeking to increase state flexibility, it is fraught with problems for states and for beneficiaries.

- With no mandated service package requirement, states will be in a weaker position with respect to contract negotiations with managed care providers. Prices will dictate the range of services provided. Overtime as the market advantage shifts to providers, state and federal benefit dollars will purchase fewer and fewer services.

- Without a uniform, national minimum benefit requirement, significant interstate differences will emerge. This will make it difficult for states to contract with national or regional HMO's and other health care providers who do business across state lines. The larger managed care plans often give the best value for the dollar in terms of quality and coverage, and increasingly, the health care service industry is regionalizing and in some cases nationalizing its market.

- The loss of uniform standards could create other troubling and unintended consequences. For example, if one state wants to assure a broad array of services for AIDS patients, it may be concerned that in so doing it will attract people with AIDS from states that choose not to cover such services.

- Without a required minimum set of benefits, the politically strongest providers might dictate, or at least strongly influence, the shape of the services to be offered.

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056

- The benefit package could fluctuate widely with each new legislative session or gubernatorial election. Continuity of care would suffer, as would states' ability to maintain contractual relationships with managed care plans.

CENTER ON BUDGET AND POLICY PRIORITIES

January 5, 1996

A BLOCK GRANT ADJUSTED FOR POPULATION WOULD NOT PROTECT STATES OR GUARANTEE HEALTH CARE COVERAGE

Various Medicaid proposals, including the Kassebaum proposal dated December 19, 1995, appear to blur the distinction between a federal guaranteed entitlement to health care coverage, financed through a per capita cap, and a block grant that directs states to cover certain categories of people and that adjusts for changes in population and other factors such as inflation. There are key differences between the two approaches, with critically different consequences for Medicaid beneficiaries and states.

A Population Adjuster Might Improve the Distribution of Funds Under a Block Grant, But It Would Not Assure That the Federal Government Shares the Cost of Providing Coverage to Vulnerable Groups of People

Under a per capita cap, federal Medicaid payments are based on the number of people served. If a state's Medicaid caseload increases, its federal Medicaid payments would increase accordingly. Federal payments would respond directly and promptly to changes in enrollment.

A block grant adjusted based on changes in population is quite different. It would provide more federal dollars to states that experience high population growth, but it would not assure that federal dollars would be distributed to states in proportion to their expanding Medicaid caseloads and costs.

- Population growth is only one reason why Medicaid enrollment may grow. Plant closings, an increase in the number of poor people in the state, growing numbers of employers who drop employment-based coverage, and epidemics or natural disasters are just some of the factors that will contribute to Medicaid enrollment patterns.

- A population adjuster also does nothing to protect states against higher costs due to a changes in caseload mix. State Medicaid costs will rise if a higher number of more costly elderly or disabled people enroll in the program, even if overall enrollment or state population does not grow. A per capita cap with federal payments that vary by beneficiary group is sensitive to such changes.

- One more adjuster added to the block grant formula won't change the fact that a block grant is a zero sum game. Any adjustment in the

distribution of block grant funds shifts funds from one state to another. If the total amount of federal dollars is capped and the distribution of federal dollars is adjusted based on population changes, states that experience population growth will gain federal funds — but only at the expense of other states that do not experience as much growth in population.

A Block Grant with A Population Adjuster Does Not Guarantee Coverage

The Kassebaum proposal would identify categories of people who must be covered with block grant funds, and direct states to provide a minimum level of services to the persons aided under the block grant. It does not, however, guarantee that all persons within those protected groups will have health care coverage when they need it.

- Coverage would remain subject to a federal cap, and the directive to serve vulnerable people would operate only to the extent that block grant funds are available to pay for coverage. If block grant funds are inadequate to meet the needs in the state, the state could deny coverage to newly eligible persons or take other steps to keep spending below the federal cap.

- Thus, if need rises in a state for any reason, including an economic downturn, a block grant — even one with a population adjuster and a directive to use block grant funds to aid certain groups of people — will not and cannot assure coverage to newly unemployed and uninsured people.

Vulnerable populations cannot be guaranteed coverage unless the law provides that all persons who meet the eligibility requirements established by state and federal rules shall be served. This kind of guarantee, in turn, requires a financing structure that assures states that federal funds will be sufficient and responsive to changes in costs due to enrollment, caseload mix, and the cost of services. Block grant financing that distributes capped federal dollars without regard to the number of people served and their relative costs cannot provide any real guarantee of coverage.