E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

13-Jun-1996 05:09pm

TO: (See Below)

FROM: Amber R. Zealand
Office of Mgmt and Budget, HD

SUBJECT: Senate Finance Committee Hearing re: S 1795

The Senate Finance Committee Hearing on the Personal Responsibility and Work Opportunity Act of 1996 was dominated by discussion of the implications of the Medicaid Restructuring Act. Outside of the Sec. Shalala's testimony, little mention was made of welfare reform or the President's plan. Sen. D'Amato's (NY) angry inquiry into the status of New York's 1115(b) waiver was the greatest source of conflict.

In his opening statement, and during questioning, D'Amato accused the Administration of "deliberate recalcitrance" in delaying NY's waiver approval. Citing NY's "tremendous record" in Medicaid services and the "unprecedented level of detail" in their waiver application, D'Amato demanded to know the source of the delay. Sec. Shalala outlined the requirements of the waiver approval process and pointed out that 1) it has been difficult to determine the budget neutrality of the waiver because NY's budget keeps changing 2) there has been some question about the capacity of NY's health plan to handle large numbers of managed care recipients, specifically those with special needs (she referred to some recent market fraud) 3)there is some problem with enrollment procedures, recognized by both the city and the state 4) the state failed to provide some of the necessary data and 5)she's concerned with the effect of the waiver on academic medical centers. Shalala stated that the size and complexity of NY's waiver and their desire to move too fast has been a source of delay. She cited TN as an example where "we slowed [them] down and they still had problems." D'Amato was relentless and called the Administration's process a "blockade" that proceeds at a "deadly crawl." He warned that he'll continue to persist and claimed that "this is just the beginning."

The discussion of the Medicaid Act revolved around a series of issues: its umbrella provision, DSH policy, flexibility on the definition of disability, treatment of the Hyde amendment, and its impact on children.

The loudest criticism of the Republican's umbrella fund provision was from Sen. Graham (FL) who remarked that "an umbrella and a parasol look very much alike until it starts to rain," and claimed that the Republican's "parasol" did not provide sufficient coverage to the states. Throughout the hearing, Chairman Roth (DE) defended the umbrella by claiming that it is a complex and complicated policy, that may need explaining but nevertheless works. Senators Moseley-Braun (IL) and Conrad (ND) led the charge against the Republican's DSH policy and repeal of the provider taxes and donations statute. Sen. Moseley-Braun

speculated that it would force hospitals to close their doors. Sec. Shalala emphasized its potential impact on rural hospitals claiming that the Republican's plan is potentially a "double hit" to hospitals, because it reduces the amount of federal and state funding. Sen. Conrad proclaimed that by removing the provider taxes and donations provision, the Republican's were "opening the floodgates," whereby 100% of state funding could conceivably be replaced with federal funds. Referring to a large chart, Conrad illustrated the process by which MI's transfers to the Univ. of MI enabled them to obtain $276 million dollars in DSH payments and claimed that the governors support it because it is "the greatest scheme ever created."

The states' ability to change the disability definition under the Republican plan was a recurrent theme touched on by both Moseley-Braun and Shalala. Both mentioned the possibility of different standards across states and the problems created by such a scenario. In her opening statement, Moseley-Braun mentioned its potential impact on disabled children and Sens. Moynihan (NY), Rockefeller (WV), Breaux (LA), Chafee (RI) returned to this issue, citing concerns about the plan's impact on children, specifically abused and neglected children and adolescents. Moynihan angrily stated that the democratic governors, in signing on to the original NGA proposal, "disgraced themselves" because they thought they were going to get free money, without any regard for the children. Chafee said that the bill makes a mistake in not mandating the coverage of children.

Chafee also brought up his concern that the Republican's plan, in effect, writes the Hyde amendment into permanent legislation so that they can "no longer tinker with it." Shalala agreed, stating that the provision, which restricts federal funding for abortion to cases of rape, incest, or endangering the life of the mother, would become part of the underlying statute.

Sec. Shalala's assertion that the Republican's plan did not guarantee benefits was challenged by Chairman Roth with a series of questions. The Secretary was slow to respond to Roth's questions regarding the number of "optional" people covered by the states and the percentage of federal dollars spent on optional services. When they finally agreed that less than half of current benefits are mandated, Roth concluded that there is no "guarantee under current law" and that her criticism was therefore flawed. She responded that her larger concern is the repealing of the "federal right of action" and the elimination of adolescents as a mandatory group.

Shalala cut Sen. Grassley (IA) short on his question regarding the WI waiver, stating that she was recused from discussing the issue, and would have to leave the room if he wished to address his question to Sec. Bane.

During the Senate Finance Committee hearing, the House Commerce Committee was marking up their Medicaid substitute bill which addressed some of the Democrats' criticisms about beneficiary financial liability. More information on this markup will follow.

Distribution:

TO: Nancy-Ann E. Min
TO: Barry T. Clendenin
TO: Mark E. Miller

E X E C U T I V E O F F I C E O F T H E P R E S I D E

14-Jun-1996 12:59pm

TO: (See Below)

FROM: Lisa Kountoupes
Office of Mgmt and Budget, LA

SUBJECT: FYI-Medicaid/Welfare House markup reconciliation p

6/13/96
MEMORANDUM TO THE DIRECTOR AND DEPUTY DIRECTOR
FROM LISA KOUNTOUPES
RE: HOUSE RECONCILIATION MARKUP - WELFARE AND MEDICAID

Schedule

Under the budget resolution reconciliation package #1 (Welfare, Medicaid, and taxes) was to be reported by today. The Ways and Means, Economic and Educational Opportunities, and Agriculture Committees completed their work on the welfare provisions today and the Commerce Committee completed Medicaid. Evidently Ways and Means will not report out a separate tax package, but the leadership will insert tax provisions into the bill at the Rules Committee. The House Budget Committee is slated to meet on Monday June 17. It is expected that Rules Committee and House floor consideration of the package will occur the week of June 24.

Mr. Castle (R-RI) has expressed his intent to bring the Castle/Tanner welfare bill to the House Rules Committee to seek to have it made in order as an amendment to the package. It is not yet clear if the Republican leadership will make it in order as an amendment or if it will make a democratic alternative in order. Also unclear at present is what the democrats in the House would like an alternative to look like (welfare - it would be hard to get everyone behind one approach, Medicaid and would they want to include tax cuts in an alternative? And if so, which ones?).

House Commerce Committee - Medicaid

The Medicaid Title was reported on a roll call vote (26-14). Mr Hall (TX) was the only democrat to vote for the measure (He has voted consistently with the Republicans on the budget this and last year). 21 amendments were offered.

Amendments passed:

- Deal (R-NC) voice vote - transitional Medicaid benefits. As originally offered by Mr. Deal the amendment would have required benefits for a family to be available for one year only if they lost eligibility before the date of enactment of the act. Mr. Waxman offered an amendment to that which eliminated the sunset so made the transitional benefits of one year permanent.

Democrats are assuming that this provision is a likely candidate to be dropped before the bill gets to the Rules Committee for consideration. They did not expect to win the Waxman amendment but did due to lack of Republicans in attendance at the time the roll call was taken.

- Dingell (D-MI) 23-20 - on fraud and abuse as modified by Mr. Bliley calling for a study by states on financing measures
- Ganske (R-IA) voice vote - concerning fraud and abuse providing waiver authority to the Secretary of HHS if determination is made that a state is not gaming the system after 2 years (attempts by Mr. Dingell to amend this amendment to eliminate the waiver failed 17-25)
- Whitfield (R-KY) voice vote - coverage of phase in kids
- Upton (R-MI) voice vote - concerning Federally-qualified health centers and rural health clinics
- Burr (R-NC) voice vote - concerning nursing home waivers
- Bilirakis (R-FL) unanimous consent - package of technical amendments
- Towns (D- NY) voice vote related to providing payment to physicians assistants under the plan

Amendments rejected:
- Ganske (R-IA) 18-22 - related to maintaining current Early Periodic Screening Diagnostic Treatment (EPSDT) benefits for children
- Eshoo (D-CA) 19-23 - to retain benefit levels for children
- Stupak (D-MI) 14-24 - to require states to provide benefits equitably throughout the state
- Furse (D-OR) 14-25 - to provide protection for states that are already operating under the waiver -- allowing them the choice of operating under their current waiver or the new plan. (Mr. Tauzin (R-LA) said this was unacceptable because these states would be allowed to grow under currently assumed growth rates which would be unfair to states operating under the growth rates in the plan.
- Pallone (D-NJ) 16-24 - to repeal the Boren amendment and replay it with a modified version which would require independent actuary rates that are reasonable and public disclosure and other measures

(the following democratic amendments related to benefit guarantees all also contained federal court enforceability:)
- Markey (D-MA) and Pallone (D-NJ) 19-24 - to ensure current entitlement for elderly individuals requiring nursing facility services
- Deutsch (D-FL) 16-20 - to ensure current entitlement for individuals with Alzheimer?s disease
- Gordon (D-TN) 17-22 - to ensure current entitlement for Veterans
- Klink (D-PA) 16-23 - to ensure current entitlement for elderly nursing home residents
- Richardson (D-NM) 18-22 - to ensure current entitlement for Indians
- Brown (D-OH) and Engel (D-NY) 15-24 - providing for nursing

home choice among facilities participating in the plan
- Furse (D-OR) 14-25 - providing benefits at current levels provided by the states for pregnant women and infants under 1 year of age
- Brown (D-OH) 17-23 - providing current benefits levels provided by the states for breast and cervical cancer

The Committee also reported out a provision related to LIHEAP which the majority stated was intended not to change current law related to considering LIHEAP benefits when calculating other state or federal eligibility, but to preserve the Committee?s jurisdiction. This provision was reported out on a voice vote after being amended by Mr. Dingell and Mr. Pallone to take a reference to food stamps out. Not clear what was gained by this since the amendment was intended to do nothing, but it was done as a protective measure in case there was a misunderstanding.

(Attached please find emails from the division describing the welfare markups in Ways and Means and Educational and Economic Opportunities Committees).

Ways and Means Committee Welfare markup
(from Chris Ellerston, HRD)

Chairman Archer offered a substitute for the latest available welfare reform bill. Notable changes:

Health Coverage:
- Not all children may get Medicaid coverage while on the rolls. Theoretically, some 20% could be dropped. States can opt to set the income limits at the median State level, at current law, and at one other option that Ron Haskins (staff director) couldn?t remember. Also there will be 1 year of transitional coverage once a family begins work, with the cut off set at 100% of poverty. It seems theoretically possible that a family might not be covered while receiving AFDC but get coverage once they are in the transition period and earning more (A Medicaid expert would have to verify this).
- Aliens would get emergency medical services
Child Support Enforcement:
- There would be expanded State eligibility for 90% ADP dollars for child support enforcement.
SSBG:
- Annual SSBG cuts would continue at the size of cut enacted in FY96 appropriations bill (15% cut or $419 M)
EIC
- Adopts FY 1997 budget proposals to deny credit for those who lack tax ID numbers, to count cap. gains above a certain threshold as income. The definition of adjusted gross income changes, for phaseout purposes. Also, States would be allowed to

count EIC to offset AFDC benefits (unclear if it?s for eligibility, benefit size or both, but would guess both as this provides maximum flexibility) Current law ignores EIC for these purposes.
Child Care:
- The funding level is now $22 B ($15 B mandatory and $7 B discretionary)

Amendments:
Most were voted down, mostly by party line votes, but Reps. Johnson (R-CT) and English (R- PA) votes several times for amendment adding voucher for kids and expanding Medicaid.

Passed:
- Ensign (R-NV) Medicaid coverage - proposed the EIC not count against Medicaid eligibility when a parent is in the work transition period. A large bi-partisan group supported this.

Failed:
Medicaid
- Levin (D-MI) 14-16 - keep current definition of Medicaid, even for time-limited families. (English and Johnson voted yes)
- Stark (D-CA) - keep current Medicaid coverage for children and for parents whose benefits are time-limited but who have been compliant with work rules.
- Johnson (R-CT) - to cover all current AFDC recipients under Medicaid (not clear how this differed from Stark amendment)

Vouchers for Kids
- English (R-PA) - mandate vouchers (cash or coupons) for kids if cash benefits end before 4 years
- Levin (D-MI) 15-18 Republicans English, Ensign, Johnson, and McCrery (LA) voted yes - require vouchers for kids for up to 5 years if time limit on benefits is shorter than 5 years. The voucher could be funded from case assistance block grant (unlike Castle/Tanner).
Worker Displacement
- English (R-PA) - employers can?t use workfare employee to replace regular worker
Equal Protection
- Ford (D-TN) 14-22 - give due process for recipients who stand to lose benefits. Mr. Nussle (R- IA) said ?this is a lawyers bonanza. The Constitution already provides due process and we needn?t reproduce this in every bill.?

(Continued from Mathew Vaeth, HRD)

TITLE I AMENDMENTS
PASSED

- Cardin (D-MD)- Amendment which requires states to report on their progress with out-of-wedlock and teen pregnancies, education, etc. Passed 19-12 with bipartisan support, although some Republicans saw this as a way to promote abortion. Archer took the opportunity to rally against providing high school students free condoms.
- Lewis (D-GA)- Amendment requiring HHS to provide an annual update on the results of the family and teen pregnancy provisions. Adopted without objection.
- Cardin (D-MD)- strikes down the provision that agencies which accept tax dollars much "advertise" this on any of their publications; Cardin complained that this regulation stigmatizes those which accept tax dollars and silences their public voice. Passed on voice vote, although some GOP reps did not see the original provision as a violation of free speech.

FAILED
- Rangel (D-NY)- amendment which would allow a waiver of 5 year benefit limits for those unable to find employment for reasons ranging from lack of education to medical conditions. Defeated 10-19.
- Johnson (R-CT)/Kennelly (D-CT)- amendment which would raise the age (of the child) at which
parents lose benefits for not finding child care from 6 to 10. Defeated on voice vote.
- Neal (D-MA)/Payne (D-VA)- amendment which would allow HHS to withhold payments to states which were determined to be performing poorly with regards to entitlements. Failed 13-19.
- Neal (D-VA)- amendment to provide supplemental funds for states to draw from during tough economic times. Failed on voice vote. Rep. Shaw claimed that the GOP would be proposing a similar piece soon.
- Coyne (D-PA)/Matsui (D-CA)- amendment which would restrict states from considering EITC benefits as income when determining welfare eligibility. Failed 13-18.
- Kleczka (D-WI)- reintroduced English amendment which would clarify guidelines for filling job vacancies with welfare recipients. This is to eliminate the possibility of workers being replaced by low-wage welfare recipients. Failed 17-19.
- Levin (D-MI)- amendment which would set up a contingency fund to allow more welfare
recipients to return to work. Failed 15-19.
- Matsui withdrew an amendment which would disqualify SSI disability payments to foster children to be considered as income for the sponsor family. Shaw agreed to change original language to accommodate for this amendment.

TITLE II AMENDMENTS
PASSED
- Levin (D-MI)/McCrery (R-LA)- amendment to clarify language

regarding SSI determination. Provides special language to protect those under 18. Passed on voice vote, although Rangel pointed out that some would have to reapply for benefits under this language and may be turned away.
- Lewis (D-GA)- amendment to provide emergency checks for new SSI recipients who need benefits immediately. No objections; passed on a voice vote.

(Continued from Jeffrey Farkas HRD)
In the final two and a half hours, the Committee completed its work on the bill and reported out favorably by voice vote the Chairman's substitute as amended.

One amendment passed during this time -- a Levin/Matsui proposal ensuring Medicaid coverage for children who receive foster care or adoption assistance maintenance payments -- and two failed: a Rangel amendment to incorporate (I believe) the Administration's deeming proposal on benefits to legal immigrants, and a Kennelly amendment on EITC relating to math error procedures (which may have been an Administration proposal -- she referenced it as something the Administration supports).

Child care created somewhat of a stir yesterday. CBO released a table illustrating the child care levels in the bill compared to the amounts needed to fund child care for those in the H.R. 3507 work program as well as the amounts needed to cover baseline levels for the transitional and at-risk child care programs. CBO broke out the costs needed for work-related child care on a separate line indicating there would be $6.7 billion total left over ($3.9b Federal), not taking into account current law spending on At-Risk and Transitional child care. Members seized on this amount to say the bill would vastly overfund child care. Incorporating the at-risk and transitional baseline levels into the equation, however, CBO's table showed a small Federal surplus over 7-years ($0.16b) but a $700 million deficit in 2002. With some rearranging of the dollar amounts by year, CBO's estimates would indicate the version of H.R. 3507 they analyzed provided just enough child care to cover the costs of those in the work program and the current law baselines for Transitional and At-Risk. The EEO committee made changes to the work requirements yesterday, however, which will probably lead to an increase in the child care costs of the work program and could still leave child care underfunded.

After amendments, the Committee voted on two substitutes -- the Administration's bill, offered by McDermott and Cardin, and a modified version of Castle-Tanner, offered by Levin. Wendell Primus, Deputy Assistant Secretary at HHS, did a walk-through of the Administration's bill, describing TEA and Work first in some

detail. He pointed out that the big difference between the work and child care provisions of the Administration's bill and H.R. 3507 was that the Administration's bill was fully funded while H.R. 3507 was not. A few of the Democrats seemed to echo this sentiment in their remarks about the bill. Clay Shaw took the opportunity to rebut the Administration's criticism of H.R. 4 with a long pasting of Work First based on the "liberal loopholes" piece put out by the subcommittee a few weeks ago. Archer also wanted to know whether the Administration's bill increased spending in the first two years (it does not). The Committee voted down the substitute 24-11, with three Democrats -- Kleczka, Payne, and Stark -- joining all the Republicans in voting against it.

Levin then introduced his substitute, which was a version of Castle-Tanner dropping the immigrant bans and including (I believe) the Administration's deeming provisions, as well a few other changes. (We have the entire text of the bill for further review.) He described the problems in HR 3507 which his substitute corrected: impact on kids in recessions (i.e., contingency fund), linkage with health care, vouchers for time limits shorter than 5 years, no Federal/State partnership, and short funding of work. After some debate, the proposal was voted down on party lines.

Economic & Educational Opportunities Welfare Markup
(From Edwin Lau and Cindy Smith, HRD)

The bill was ordered reported. 5 Minority Members voted for it: Reed, Roemer, Williams, Sawyer, Green.

Amendments
1) Talent -- Raise the number of weekly hours required to meet work requirements (passed: 23Y, 14N) one Majority no vote: Castle; 4 Minority yes votes: Miller, Green, Blumenauer, Reed

1996-98	20hrs/wk
1999	25hrs/wk
2000-01	30hrs/wk
2002 +	35hrs/wk

Talent quoted the President as saying that welfare shouldn't be more attractive than work. Democratic members mostly countered by citing lack of jobs and displacement of minimum wage workers, but in the end, several supported the amendment.

2) Goodling -- Drop out most of the non-budgetary Child Nutrition technical and administrative changes in H.R. 4 (passed by unanimous consent).

3) Talent -- Reduce the limit on counting job search towards work requirements from 12 weeks to 4 weeks (passed as amended) amended by Martinez to increase to 12 weeks in cases where unemployment is above national average.

4) Roemer -- require Castle/Tanner-type Individual Responsibility Plan (passed as amended). State plan assesses skills, work history & employability of each applicant. Gunderson raised three concerns: 1) that the federal government might issue overly prescriptive regs; 2) that the Plan was burdensome as part of intake process; and 3) that the Plan could be used as a new excuse for maintaining eligibility (ie "my plan was faulty", "my plan was not honored"). Gunderson amended provision by requiring a plan for recipients rather than applicants, and prohibiting the federal government from dictating how States implement this provision.

5) Three Mink amendments which would have authorized additional money for health care. (failed)

6) Scott -- count post-secondary education as meeting work requirements (failed: 16Y, 20N)

7) Castle -- Supplemental Jobs Funding (passed on voice vote). This issue was linked to Talent's amendment to increase mandatory compliance rates (#9). A $9 billion authorization was discussed, but the text of the amendment only authorizes $3 billion in 1999.

8) Castle -- Castle/Tanner provision that would keep "leavers" (those who find an unsubsidized private sector job) on the rolls for 6 months as an additional incentive to work (withdrawn).Castle said that they were working up a compromise in Ways and Means.

9) Talent -- Increase mandatory work participation rate (passed on voice vote):

1996	20%
1997	25%
1998	30%
1999	35%
2000	40%
2001	45%
2002	50%

Talent argued that because the mandatory participation rates in H.R. 4 are so low in the first two years (15%), States wouldn't have to do anything. He also argued that exemption of single moms with infant children lowered the 15% participation rate in the bill to an effective 10%. Roemer noted that by CBO estimates,

this amendment would result in childcare funding shortfalls in the outyears. Passed.

10) Scott -- Allow post-secondary education to count as work provided that the participant is already in school, is within 2 years of graduation and shows satisfactory attendance (failed: 18Y, 20N).

11) Scott -- Remove age limit for counting secondary school or GED as alternative to work (failed: 17Y, 22N). In the current bill, participant is only eligible if under 20 y.o.

12) Becerra -- Require minimum wage compensation for work performed under work requirements (failed: 18Y, 22N). A lot of debate over what exactly this amendment would do and what types of work it covered, value of entire welfare package v. cash wages alone.

13) Payne -- Amend repeal of Abandoned Infants Assistance Act to grandfather current grant recipients through the end of current grant cycle. (passed) Since block grant funds can be used to serve the same purposes, Republican members argued that there was no need to maintain the authorization.

14) Mink -- Sense of the Congress that the Bill shouldn't increase Child Poverty (passed). Same language as in the Budget Resolution.

15) Woolsey -- "Home Alone" amendment: under H.R. 4, States could, at their option, exempt parents of children up to age 6 from work requirements if they cannot find child care. Amendment raises allowable age from 6 to 11. (passed)

16) Miller -- Increase child care quality set-aside from 3 to 5%. Goodling then amended from 5 to 4% (passed as amended). This will allow a child care quality set aside of about $119 million.

17) Castle -- Require 100% maintenance of 1995 State contribution to child care funding. (passed) In the current bill, States could maintain 1994 or 1995 levels.

18) Goodling -- Keep current law health and safety standards for child care. (passed)

19) Becerra -- Retain Child Nutrition current law requirement that nutrition education drug abuse education be in languages other than English (failed: 16Y, 17N) This is an option in the chairman's mark.

Distribution:

TO: Gordon Adams
TO: Barry B. Anderson
TO: Kenneth S. Apfel

Jennifer

A Democrat's Guide to Medicaid

(Draft 5/30/96)

Medicaid is one of the main battlegrounds in the fight to stop the Republican agenda in the 104th Congress. The Republican Medicaid agenda could not be more extreme. They want to repeal the program altogether; eliminate its entitlement of basic health care coverage for over 36 million elderly, disabled, and women and children; and establish a new block grant to the States under which State spending will decline precipitously while State authority over Federal funds increases dramatically.

Medicaid is central to several different political debates:

- With Federal spending projected at $105 billion in FY 1997, and with average annual growth rates over the 6 year period FY 1997 - FY 2002 projected at 9.7 percent, Medicaid is a key issue in the balanced budget debate.

- Federal Medicaid matching payments to States represent over 40 percent of all grants-in-aid from the Federal government to the States. State general fund spending on Medicaid represents on average about 13 percent of all general fund State spending. In FY 1997, the State share of Medicaid costs is projected at $79 billion. Thus, Medicaid is central to the debate over "devolution."

- Because Medicaid covers basic hospital, physician, clinic, and preventive health care services for over 36 million Americans, more than half of whom are children, it figures prominently in any debate over the increase in the number of uninsured Americans (currently estimated at over 41 million).

- Medicaid covers nursing home, home health, and prescription drugs for some 4 million elderly and 6 million disabled Americans, and it is central to the policy debate over long-term care.

- Medicaid payments are a major revenue stream for tens of thousands of hospitals, nursing homes, community clinics, and other providers, so Medicaid coverage and reimbursement policies have critical implications for these employers and the jobs they provide in their communities.

Democrats need to think carefully about the radical structural changes that Republicans are trying to make in Medicaid. The repeal of the individual entitlement, combined with the grant of complete discretion over which providers may participate, will have dramatic implications for Democratic constituencies and for Democratic Members, as well as Democratic officeholders at the State and local level. Once enacted, the Republican changes will be virtually impossible to reverse.

Additional information is available from Andy Schneider at the House Democratic Policy Committee (226-4162).

Contents

MEDICAID AT A GLANCE

Medicaid is a means-tested, Federal-State entitlement program that covers basic health and long-term care services for low-income elderly, disabled, and women and children. Enacted in 1965, Medicaid makes Federal matching funds available to States for covered services provided to eligible individuals. The Federal share of the cost varies from 50 to 83 percent, depending on a State's per capita income; on average, the Federal government finances 57 percent of total program costs. State participation in the program is voluntary, but all States participate (the last State to join the program, Arizona, did so in 1982). About half of all Medicaid spending is for populations and services that States are not, as a condition of participating in the program, required to cover, but for which they may receive Federal matching funds.

Medicaid is America's 2nd largest health care program, covering almost as many Americans as Medicare. According to CBO, Medicaid will cover 36.8 million Americans this fiscal year at a total cost of $168 billion ($80.8 billion Federal, $72.2 billion State). By way of comparison, CBO estimates that Medicare will cover 37.5 million Americans in FY 1996 at a total cost to the Federal government of $199 billion. By 1998, if current enrollment trends continue, Medicaid will surpass Medicare as America's largest health care program.

Medicaid is America's largest single purchaser of nursing home services and other long-term care. The Federal government, through Medicaid, will spend an estimated $30 billion on long-term care this fiscal year, the States another $22.7 billion. Most of the long-term care paid for by Medicaid is delivered in nursing homes; Medicaid pays for over half of all the nursing home care provided in this country. Of the 1.5 million nursing home residents nationwide, about two thirds, or 1.0 million, are covered by Medicaid, mostly at State option.

Medicaid is a critical source of revenue for teaching hospitals, public hospitals, children's hospitals, rural and urban clinics, and family planning programs. About one fourth of all inpatients at teaching hospitals are covered by Medicaid. Medicaid accounts for roughly 46 percent of the net revenues of public hospitals, 42 percent of the gross revenues of children's hospitals, 33 percent of the revenues of community and migrant health centers, and 50 percent of the revenues of family planning providers.

Medicaid covers about one fourth of the children in America. Of the 70 million children in America, 18.1 million, or about one fourth, are covered by Medicaid. Under current law, by the year 2001, all American children under 18 who live in families with incomes below the Federal poverty line will be eligible for Medicaid coverage.

Medicaid is America's largest single purchaser of maternity care. Medicaid pays for about one third of the births in the country (1.4 million deliveries in 1993), including prenatal care, delivery, and post-partum care.

WHO GETS MEDICAID?

Three basic groups of people are eligible for Medicaid:

- **Elderly.** More than 4 million adults 65 and over are eligible for Medicaid this fiscal year. About one third of these are eligible because they are receiving cash assistance through the Supplemental Security Income (SSI) program. Others have too much income or resources to qualify for SSI, but have "spent down" to Medicaid eligibility by incurring high medical or long-term care expenses. Finally, an estimated 1.9 million are eligible as "Qualified Medicare Beneficiaries," or QMBs: their incomes are below 120 percent of the poverty level and they receive Medicaid assistance with their Medicare premiums, co-insurance, and deductibles (but not for nursing home care or prescription drugs).

- **Disabled.** About 6 million disabled individuals are eligible for Medicaid in FY 1996. Most of these are eligible because they are receiving cash assistance through the SSI program. The remainder have "spent down" to qualify by incurring large hospital, prescription drug, nursing home, or other medical bills.

- **Mothers and Children.** Over 18.6 million low-income children and about 7.4 million low-income women will be eligible for Medicaid in FY 1996. The majority of these are eligible because they are receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program.

There are some eligibility groups that all States must cover, such as mothers and children reciving cash assistance under the AFDC program, and pregnant women and infants with incomes at or below 133 percent of the Federal poverty level. There are also 13 statutory categories of individuals that States may elect to cover and receive Federal Medicaid matching funds for the cost of providing services to.

All Medicaid eligibles must have incomes and resources (i.e., savings and other assets) below specified levels. These levels are determined by the States within broad Federal guidelines, and they vary from State to State. Current law denies eligibility to individuals who transfer assets to their children or to individuals other than their spouses in order to qualify for nursing home coverage.

There are some Americans who cannot qualify for Medicaid no matter how poor they are because they do not meet the program's categorical requirements. These include childless couples who are not aged or disabled and single adults who are not aged or disabled.

To qualify for Medicaid, individuals must be American citizens or be permanently residing in the U.S. under color of law (legal aliens). Illegal aliens cannot qualify for Medicaid coverage except with respect to emergency care (including emergency labor and delivery).

WHAT DOES MEDICAID COVER?

States that choose to participate in Medicaid must cover a minimum set of benefits for certain populations. However, benefit packages vary from State to State due to the different ways in which States exercise their discretion under current law..

Services that States must cover. Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary:

-- hospital care (inpatient and outpatient)
-- nursing home care
-- physician services (including abortion, but only when necessary to save the life of the mother or in cases of rape or incest)
-- laboratory and x-ray services
-- immunizations and other preventive screening, diagnostic, and treatment (EPSDT) services for children
-- family planning services
-- health center and rural health clinic services
-- nurse midwife and nurse practitioner services

Services that States may cover. States have the option of covering additional services and receiving Federal matching funds for those services, which include:

-- prescription drugs
-- institutional care and community care for individuals with mental retardation
-- home- and community-based care for the frail elderly
-- dental care and vision care for adults

Services must be adequate in amount, duration, and scope. States have discretion to vary the amount, duration, or scope of the services that they cover, but in all cases the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." For example, a State may not limit coverage for inpatient hospital care or nursing home care to 1 day per year.

Services must be comparable throughout the State. States may not very the amount, duration, or scope of services based on the individual's residence. For example, a State may not offer coverage for 30 hospital days per year to residents of urban areas but only 20 hospital days per year to residents of rural counties.

States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, type of illness, or condition." For example, States may not exclude individuals with AIDS from coverage for hospital care, or individuals with Alzheimer's from coverage for nursing home or home health care.

States may impose nominal copayments on some services. States may impose nominal copayments on prescription drugs and certain other non-emergency services, except with respect to children, pregnant women, and nursing home residents.

THE COST OF THE MEDICAID PROGRAM

Federal Medicaid spending this fiscal year will total an estimated $95.7 billion. According to CBO, the Federal government will spend $80.8 billion matching State spending on services, $10.7 billion matching State payments to disproportionate share hospitals, and $4.3 billion -- or just 4.5 percent of total spending -- matching State spending on program administration. Over the 6 years FY 1997 through FY 2002, CBO projects that Federal spending on Medicaid will total $802.7 billion.

Overall Federal Medicaid spending increased 7.5 percent this year. CBO projects that Federal Medicaid spending will rise from $89.1 billion in FY 1995 to $95.7 billion in FY 1996, or 7.5 percent. Between FY 1996 and FY 2002, CBO estimates that Federal Medicaid spending will increase at an average annual growth rate of 9.7 percent, from $95.7 billion to $166.4 billion.

On a per capita basis, Federal Medicaid spending is projected to increase 6.3 percent this year. According to CBO, Federal Medicaid spending in FY 1996 was $2200 per beneficiary. Broken down by beneficiary category, Federal Medicaid spending in FY 1996 is estimated by CBO to be:

- for non-disabled children, $820 per child, an increase of 4.8 percent over FY 95
- for non-disabled adults (including pregnant women), $1350 per adult, an increase of 7.7 percent over FY 95
- for disabled adults, $4850 per individual, an increase of 5.7 percent over FY 95
- for the elderly, $5930 per individual, an increase of 4.9 percent over FY 95.

Most -- about 70 percent -- of the growth in Federal Medicaid spending is caused by an increase in the number of eligible Americans and inflation in the price of medical and long-term care services that Medicaid buys. According to CBO, in 1995 there were four causes for the increase in Federal Medicaid spending:

- an increase in the number of low-income Americans eligible for the program
- inflation in the price of the hospital, nursing home, physician, and other services that Medicaid buys
- State payments to disproportionate share (DSH) hospitals
- other factors, such as the use of covered services by eligible beneficiaries, and State decisions as to whether to cover optional benefits or services.

The first two causes, CBO estimated, explained about 41 and 31 percent, respectively, of the growth in Federal Medicaid spending in 1995. State payments to DSH hospitals accounted for only about 3.5 percent; all other factors explained the other 24 percent.

Medicaid will no longer experience double-digit cost increases. Republicans cite the experience between 1988 and 1993, when, according to CBO, Federal Medicaid spending grew at an average annual rate of 19.6 percent. Reforms enacted by Congress in 1991 and 1993 curbed the principal source of these increases: the abuse of the DSH program and provider-based financing schemes by some States. (The Republican Medicaid "reform" proposal would repeal these curbs).

THE REPUBLICAN MEDICAID AGENDA

The Republicans have a number of ideological, budgetary, and political goals with respect to Medicaid. In no particular order, these objectives are:

(1) to allow the States virtually unlimited discretion in spending the over $700 billion in Federal funds they would be allocated over the next 6 years, including the discretion to decide which population groups to cover and what benefits to offer them;

(2) to lower the amount of their own funds that States must spend on Medicaid in order to receive Federal Medicaid matching funds;

(3) to protect States whose Medicaid caseloads decline -- whether due to net population loss or to aggressive cutbacks in eligibility, or both -- from any reduction in Federal Medicaid matching funds;

(4) to eliminate the legal entitlement to a basic package of health and long-term care services that individual Americans now have under Medicaid;

(5) to limit Federal spending on Medicaid, and to apply the "savings" either to deficit reduction or tax cut offsets or both;

(6) to impose statutory controls on Federal Medicaid spending that can easily be adjusted in the future to enable the Federal government to take further funds out of the program in order to achieve more deficit reduction or to offset additional tax cuts;

(7) to reduce the size and authority of the Federal bureaucracy in general, and of the Health Care Financing Administration (HCFA) in particular;

(8) to allow the Governors to pick and choose which hospitals, nursing homes, physicians, and managed care plans participate in the program, and how much (and how quickly) those participating in the program will be paid for their services to Medicaid beneficiaries; and

(9) to shield the Governors (and their States) from any accountability in Federal court to beneficiaries or providers or taxpayers for compliance with program rules.

These last two goals are of particular relevance to Members representing districts in the 32 States currently controlled by Republican Governors. Part of the Republican agenda is clearly to give their Governors the opportunity to use -- indirectly, of course -- Federal Medicaid funds to leverage political contributions to the election campaigns of Republican office-holders at the local, State, and even Federal level. For instance, Governors (or State legislators) might let it be known that hospitals whose management contributes to Republican incumbents might be allowed to participate, while those whose management does not, might not.

THE REPUBLICAN MEDICAID MESSAGE

Republican rhetoric: We need to "restructure" the Medicaid program.

- **Code for**: We want to create the largest block grant in the history of the Republic, entitling them to over $700 billion Federal dollars over the next 6 years and giving them virtually total discretion over these funds.

- **Reality Check**: The Republican bill would repeal the individual entitlement that 36 million vulnerable elderly, disabled, and women and children now have to basic health and long-term care coverage under Medicaid.

Republican rhetoric: Our proposal is "founded on" the "unanimous" "bipartisan principles" of the National Governors Association.

- **Code for**: We need cover for a bill designed by and for the 31 Republican Governors, so we'll use the NGA's 6-page February 6 outline

- **Reality check**: The nation's Democratic Governors have not been involved in the drafting of the Republican bill and have not endorsed it.

Republican rhetoric: our plan ensures "guaranteed" coverage for low-income pregnant women, young children, disabled, and elderly individuals, and "guarantees" them a "generous" package of benefits.

- **Code for**: We are repealing the individual entitlement to a basic benefit package, but we want people to think they still have protection against the cost of hospital, physician, or nursing home care

- **Reality check**: The Republican bill repeals the current Medicaid program and repeals its entitlement to eligible individuals, replacing current law with an entitlement of Federal funds, on a block grant basis, to the States. States will be able to vary the benefits they offer from county to county, and they could limit or deny benefits based on diagnosis or medical condition.

Republican rhetoric: our plan gives States "enhanced operational flexibility" so that they can "better meet the health needs of their low-income residents."

- **Code for**: Since we're cutting Federal Medicaid funds by 9 percent over the next 6 years and allowing States to cut their own contributions by 29 percent over the same period, we need to give the States the ability to ration care to the poor.

- **Reality check:** The Republican plan repeals the current individual entitlement to a basic package of benefits; it repeals the current minimum reimbursement requirements for hospital, nursing home, clinic, and physician services to children and pregnant women; it allows States to reduce the number of eligible individuals without incurring a loss of Federal matching funds; and it prohibits both beneficiaries and providers from going to Federal court to enforce their rights against the State. The reductions in Federal and State Medicaid funding gives States every incentive to race to the bottom; the "enhanced operational flexibility" gives them the ability to do so, by cutting eligibility and benefits so as to export the sickest and most costly residents to other States.

Republican rhetoric: "centralized bureaucratic micromanagement" by the Federal government has prevented States from running efficient programs.

- **Code for**: States want billions in Federal Medicaid funds without Federal oversight on the use of those funds

- **Reality check:** The States, not the Federal government, administer the Medicaid program on a day-to-day basis. The Health Care Financing Administration (HCFA) has less than 500 employees nationwide to oversee the States' expenditure of nearly 100 billion Federal Medicaid dollars this year; the State of California alone uses nearly 1800 employees to run its own Medicaid program.

Republican rhetoric: the current Medicaid program is a target of "waste, fraud, and abuse" due largely to an "unwieldy centralized bureaucracy."

- **Code for**: HCFA is allowing Medicaid to be ripped off.

- **Reality check:** Medicaid is administered by the States under Federal guidelines Considering Medicaid's complexity (it is a means-tested program, requiring periodic determinations of individuals' incomes and assets), it is a remarkably efficient program: only 4.5 percent of all Federal Medicaid funds are spent on administration. From the Federal government's standpoint, by far the most costly abuse of the program has been the use of what GAO calls "illusory" financing schemes by many States. The Republican bill would repeal the provisions in current law that were enacted to curb these State abuses.

THE REPUBLICAN MEDICAID CUTS:
THE FY 97 BUDGET RESOLUTION
(May 13, 1996)

The Republicans' FY 1997 Budget Resolution calls for cuts in Federal Medicaid spending of $72 billion over the 6-year period FY 1997 through FY 2002. The Resolution also contains reconciliation instructions to the authorizing Committees in the House and Senate directing them to report changes in the Medicaid law to achieve these cuts. The text of these changes is not yet available; however, the following points are clear:

- **The Republican resolution cuts Federal Medicaid spending by $72 billion over the next 6 years, with about 80 percent of the cuts coming in the last 3 years.**

  -- In the last year (FY 2002) alone, Federal Medicaid spending would be cut $26 billion, or one sixth.

- **If the Republicans do what they proposed last year -- to raise the minimum Federal matching rate from 50 to 60 percent -- then the reduction in State spending would be about $176 billion, or 29 percent, more than 3 times (in percentage terms) the reduction in Federal spending (9 percent) over the 6-year period.**

  -- Under this policy, total Federal and State Medicaid reductions would be nearly $250 billion, or about 18 percent below the levels of spending CBO estimates are needed to maintain current services over the next 6 years.

- **The amount of Federal Medicaid matching funds available to the States under the Republican resolution is actually $12 billion less over the next 6 years than the amount that would have been available to the States under the Republicans' January offer to the President**.

  -- Under the CBO baseline, the Federal government will spend an estimated $803 billion over the next 6 years to help the States maintain current levels of services. Under the Republicans' January offer to the President, the Federal government would spend $742 billion; under the Republican FY 1997 resolution, the Federal government would spend $731 billion.

- **Under the Republican FY 1997 resolution, average annual Medicaid spending growth over the next 6 years on a per capita basis would be slashed to 2.0 percent, compared to 6.8 percent under current law.**

THE REPUBLICAN MEDICAID REPEAL (H.R. 3507; S. 1795)
EXTREMIST GUTTING OF A 30-YEAR-OLD AMERICAN GUARANTEE
(May 22, 1996)

For the past 30 years, the Medicaid program has guaranteed coverage for vulnerable Americans for physician, hospital, nursing home, and other basic health care. The bill introduced today by Senator Roth and Representatives Archer and Bliley would end that guarantee and drastically reduce Federal and State funding for the coverage it now provides. Last December, President Clinton vetoed a Republican Medicaid plan that was just as radical, and just as partisan. The title has changed -- the Republicans now claim to be "restructuring" Medicaid rather than "transforming" -- this bill is the same Medicaid repeal as last year's version. It deserves the same fate.

Immediate Repeal of Guaranteed Coverage. The Republican bill terminates current health care coverage guarantees for 36 million Americans, repealing Medicaid's individual entitlement and replacing it with an entitlement of Federal block grant funds to the States. Under the bill, effective October 1 -- a little over four months from now --

- Over 4 million elderly Americans will lose their guaranteed coverage for needed nursing home care;

- Over 18 million children and about 8 million women will lose their guaranteed coverage for preventive and primary care as well as needed hospital care.

- About 6 million disabled Americans will lose their guaranteed coverage for needed physician, hospital, and other specialized services.

Drastic Cuts in Federal Funding. The Republican bill cuts Federal payments to the States by $72 billion over the next 6 years -- a 16 percent reduction in the year 2002 alone. This means that, by the year 2002, States would have 16 percent less in Federal funds than the Congressional Budget Office (CBO) estimates will be necessary to maintain current eligibility and services and provider payment levels.

Drastic Cuts in State Funding. The Republican Federal funding cuts are less than half of the story. Under the Republican bill, States will be able to reduce their own funding of the program by about $178 billion over the next 6 years -- more than twice the amount of the Federal reduction. This huge reduction in State funding comes largely from the bill's reduction -- from 50 to 40 percent -- in the maximum share that any State must pay of the program's cost.

Drastic Cuts in Total Medicaid Funding. Cuts in Federal funding, combined with even more dramatic cuts in State funding, would mean a total cut in Medicaid spending under the Republican bill over the next 6 years of $250 billion, or 18 percent. In the year 2002, the total Federal and State spending cut would be 24 percent below the amount CBO estimates is needed to maintain the program at its current level.

Race to the Bottom: Cutbacks in Eligibility, Benefits, and Provider Payments. As a practical matter, States will not be able to offset the loss of Federal funds of the magnitude sought by the Republican budget through the use of managed care or other delivery reforms. They will have 3 choices: cut back on eligibility and benefits; cut back on payments to providers; or increase the amount of State funds going into the program. Most if not all States will choose the first two. If they choose the third option and use additional State funds to maintain current coverage, they run the risk of losing the "race to the bottom" and becoming a "magnet" for low-income Americans in need of health care moving from other States that have cut back on eligibility or benefits.

- To enable States to cut back on eligibility, the Republican bill (among other things) allows the States to establish their own definitions of disability, which could be far more restrictive than those under the Supplemental Security Income (SSI) program or current Medicaid law (according to CBO, average Federal Medicaid spending per disabled beneficiary ($4850 per year) is far higher than that for Medicaid beneficiaries generally ($2200 per year).

- To enable States to cut back on benefits, the Republican bill (among other things) gives States unlimited discretion to impose deductibles, copayments, and other cost-sharing in any amount on elderly and disabled beneficiaries (i.e., $25 per day for nursing home care). It also gives each State total discretion to determine the amount, duration, and scope of benefits, and to vary coverage from person to person and among different areas of the State. The current requirement that benefits be "sufficient to reasonably achieve their purpose" is repealed, allowing States to limit nursing home coverage to 2 weeks per month and shifting the remaining cost onto the beneficiary's spouse or adult children.

- To enable States to cut back on payments to providers, the Republican bill repeals that current requirement that States must pay "reasonable and adequate" rates to hospitals and nursing homes for serving Medicaid patients. Under the Republican plan, States would be able to pay inadequate amounts, leaving the providers -- both rural and urban -- with three choices: shifting the costs of caring for Medicaid patients to other patients; denying care to Medicaid patients; or downsizing their staffs or services.

Illusory Financing: Reopening the Door to the Federal Treasury. In 1991, and again in 1993, the Congress enacted provisions to curb State use of provider "tax" and "donation" schemes to substitute Federla dollars for their State Medicaid matching obligation. Although the Republican FY 1997 Budget Resolution recently passed by the House expressly calls on the Congress to "reject any illusory financing schemes" in Medicaid, the Republican bill repeals the current law prohibitions against the use of such schemes, reopening the door for abuse of the Federal treasury by the States. Under the Republican plan, States that choose to use these schemes can, as a practical matter, reduce their State matching obligation to zero. This in effect converts Medicaid from a health insurance program into a Federal revenue-sharing program.

SOME QUESTIONS DEMOCRATS SHOULD ASK ABOUT THE REPUBLICAN MEDICAID REPEAL

1.) **Impact on frail elderly and their families**. How many people in my State are now in nursing homes or receiving home health care, or are at risk for nursing home care? What is the likely trend over the next 6 years? If the Republican Medicaid repeal passes, and both Federal and State funding for Medicaid declines by 18 percent over the next 6 years, will my State be able to continue paying for nursing home and home health care at rates that will enable providers to deliver care of adequate quality? Or will the spouses and adult children of nursing home residents have to pick up the tab?

2.) **Impact on Community Providers.** What will happen to hospitals, nursing homes, and community clinics in my State or district that now treat large numbers of Medicaid patients and rely on Medicaid reimbursements for financial viability? Under the Republican bill, will they be allowed to continue to participate in the program, or will the State (or a managed care plan) be able to exclude them for any reason? If they are allowed to participate, is there any assurance that they will be paid -- either by the State or by managed care plans -- at rates that are sufficient to enable them to deliver care of reasonable quality? If not, what effect will the loss of Medicaid revenues by these providers have on employment and on access to care in those communities?

3.) **High-growth States**. Is my State one with high population growth, or is it likely to experience high growth over the next 5 to 10 years? If so, does the Republican bill assure that the Federal government will continue to share in all the costs of covering a rapidly expanding caseload, or will it leave my State holding the bag for the costs of caring for growing numbers of low-income families, disabled, or frail elderly residents?

4.) **Equity**. How much does the Federal government now spend on Medicaid on a per capita basis in my State? How does that per beneficiary Medicaid spending compare with the national average? If my State is lower, does the Republican bill lock in this inequity? If not, what does the Republican bill do to make Federal Medicaid payments to my State more equitable, and how many years is it likely to take to achieve parity with other States? Are States with Republican Governors treated more favorably in the distribution of Federal Medicaid funds than those headed by Democrats, as in the case of Louisiana and New Hampshire in the FY 1996 Omnibus Appropriations bill?

5.) **Race to the Bottom**. If the Republican bill passes, what are States bordering on mine likely to do? Will they use their new "flexibility" to cut back on eligibility and benefits in order to encourage their sicker, costlier residents to leave, and discourage high-risk individuals from moving in? If so, will those individuals seek needed care in my State? What effect will this have on my State and on providers in my State?

6.) **Hardball**. Will States be allowed to choose which providers can participate in the program and how much they get paid? If so, what are my Governor and State legislature likely to do with this leverage? Will they use it for partisan purposes?

MEDICAID-RELATED LEGISLATION ENACTED BY THE 104TH CONGRESS
(May 13, 1996)

Abortion. Section 508 of H.R. 3019, the Omnibus FY 1996 Appropriations bill, prohibits the use of Federal Medicaid matching funds for any abortion except when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. H.R. 3019 was signed into law on April 26, 1996 (P.L. 104-134).

FY 1996 and First Quarter FY 1997 Funding. Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to States for the last 3 quarters of FY 1996 was contained in the 7th continuing resolution for FY 1996, H.R. 1358, which was signed into law on January 6, 1996 (P.L. 104-91). Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to the States for the last quarter of FY 1996 for unanticipated costs incurred for FY 1996, and for matching payments for the first quarter of FY 1997, was contained in the Omnibus FY 1996 Appropriations bill, H.R. 3019, signed into law April 26, 1996 (P.L. 104-134).

Line-Item Veto (Enhanced Recission). S. 4, the Line-Item Veto Act, gives the President the authority to "cancel in whole... any item of new direct spending" (including Medicaid expansions). The President's cancellation is effective unless disapproved by the Congress in a disapproval bill signed by the President or enacted over his veto. This new Presidential authority is effective with respect to laws enacted on or after January 1, 1997. S. 4 was signed into law on April 9, 1996 (P.L. 104-130).

Louisiana Enhanced Federal Matching Rate. Section 519 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, raises the Federal Medicaid matching rate for the State of Louisiana. If the State elects, it may receive an effective Federal matching rate higher than its current 71.9 percent: 84.3 percent for the 9-month period ending 6/30/96; 81.6 percent for the 12-month period 7/1/96 through 6/30/97; and, subject to subsequent appropriations acts, 78.2 percent for the 12-month period 7/1/97 through 6/30/98. In order to qualify for these higher matching rates, the State would have to agree to a specified limit on the amount of Federal Medicaid matching funds it could draw down during each of these periods. All existing Federal Medicaid requirements relating to eligibility, benefits, reimbursement, etc., would continue to apply; however, eligible individuals and providers would have an individual entitlement only against the State, not against the Federal government.

Managed Care "75-25" Rule Waivers. Two managed care plans have received statutory waivers of the current 75 percent/25 percent public/commercial enrollment mix requirement for Medicaid managed care contractors: the Dayton Area Health Plan (P.L. 104-87, signed on December 29, 1995), and D.C. Chartered Health Plan, Inc. (Section 517 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134).

New Hampshire (and certain other States). Section 214 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, directs the Secretary of HHS to pay Federal Medicaid matching funds to States, up to a limit of $54 million, in connection with certain reimbursements to State-operated psychiatric hospitals and contracting providers with respect to which the Secretary had notified the State of an intent to defer matching payments. The largest of the claims at issue is that of New Hampshire ($44.7 million).

Termination of Medicaid Coverage for SSI Recipients Due to Alcoholism or Drug Addiction. Section 105(b) of H.R. 3136 terminates Supplemental Security Income (SSI) benefits for individuals who are eligible on the basis of disability and for whom alcoholism or drug addiction is a "contributing factor" material to a determination of disability. For new applicants, policy is effective on enactment; for current beneficiaries, policy is effective 1/1/97. There is no provision for continued Medicaid coverage for individuals terminated from SSI on this basis. CBO estimates that the Federal government will save $650 billion over the next 7 years in Federal Medicaid matching funds as a result of the loss of Medicaid coverage by some 40,000 to 50,000 individuals each year. H.R. 3136 was signed into law (P.L. 104-121) on March 29, 1996.

"Unfunded Mandates." The Unfunded Mandates Reform Act of 1995, P.L. 104-4, signed into law on March 22, 1995, establishes points of order against in both the House and the Senate against legislation that would increase the direct costs of "Federal intergovernmental mandates" by an amount in excess of certain thresholds, unless the legislation provides full Federal funding for the excess costs. Although participation in the Medicaid program is voluntary with the States, and although the Federal government pays about 57 percent of the program costs, P.L. 104-4 defines as a "Federal intergovernmental mandate" any amendment to the Medicaid program that would either "increase the stringency of conditions of assistance to State governments" or "place caps upon or otherwise decrease" the Federal government's responsibility for funding the program, except where the States have the authority to "amend their financial or programmatic responsibilities to continue providing required services."

CENTER ON BUDGET AND POLICY PRIORITIES

May 23, 1996

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

by Cindy Mann

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **The bill undercuts the "set aside" for disabled people.** The governors agreed to let states determine who was eligible as a "disabled" person but to require states to spend a certain portion of their Medicaid funds on disabled people. While the requirement that states spend a certain portion of their Medicaid funds on the disabled is in the bill, it adds a provision not agreed to by the governors. The new provision allows states to use federal Medicaid payments to fund state mental health facilities; under current law, states *cannot* use Medicaid payments for facilities that treat persons ages 21 - 64. If a state funded its state psychiatric facilities through Medicaid, the cost could consume much, if not most, of the state's expenditure requirement for the disabled. States thus could use federal Medicaid funds to replace some of the state funds now used for those facilities while restricting coverage or cutting Medicaid services sharply for the non-institutionalized disabled individuals.

- **States could allow counties or cities to determine benefits and to deny payment for needed services that are not available locally.** States could turn their Medicaid program into local block grants, as Governor Pataki has already proposed to do. Benefits could be set by counties or other local jurisdictions since rules requiring a statewide benefit package are eliminated.

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

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

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

There Would Be No Legally Enforceable Assurance of Coverage

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

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

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

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

Conclusion

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

CENTER ON BUDGET AND POLICY PRIORITIES

May 23, 1996

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

by Richard Kogan

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

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

Current Matching Requirements

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

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

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

The New Republican Proposal

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

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

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Robert Greenstein, Executive Director

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

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

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

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

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

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

How Much Might Total Medicaid Funding Be Reduced?

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

- Over the next six years, states would be able to cut their own Medicaid funding $178 billion. Under this scenario, the total federal and state six-year cut would be $250 billion. The cut would grow each year, reaching 24 percent in 2002. States would be able to reduce state funding more than twice as much as federal funding would be cut.

- It also is possible to examine the effect of the bill over 10 years. The Congressional Budget Office has published projections of Medicaid spending over the next 10 years, and the new bill includes a formula for determining federal Medicaid payments in years after 2002.

  Over the 10 years from fiscal year 1997 through fiscal year 2006, federal Medicaid funding would be reduced $265 billion below projected levels. In addition, states would be able to reduce state matching contributions by $426 billion without that reduction affecting the level of federal Medicaid funding they would receive. Total federal and state reductions thus could reach $691 billion over 10 years. The potential reduction in overall Medicaid funding would reach 32 percent in 2006, relative to current expenditure projections. (See Tables 1 and 2.)

Table 1

Potential Effect of Reducing State Matching Requirement
(Reductions from CBO's baseline, in billions of dollars)

	6 Years 1997-2002	10 Years 1997-2006
Federal Reduction	-72	-265
State Reduction	(-178)	(-426)
• because of federal cuts	-56	-203
• because of reduced matching requirement	-122	-223
Total Reduction	**-250**	**-691**

Table 2

Depth of Reductions in Republican Medicaid Bill

	Percentage Reduction 1997-2006	Percentage Reduction in 2006
Federal	-16%	-26%
State	-34%	-41%
Total	-24%	-32%

Using Sham Financing Schemes to Produce State Matching Funds

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

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

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

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

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

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

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

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

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

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

Jen Klein — Pauline

Comments on the Center's Analysis by Chairman William Roth

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

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

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

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

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

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

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

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

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.
May 24, 1996

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

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

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

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

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

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

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

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

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

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

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE
May 24, 1996

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

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

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

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

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

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

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

CENTER ON BUDGET AND POLICY PRIORITIES

MEMO

To: Chris Jennings
Gene Sperling & Pauline Abernathy
Nancy Ann Min
John Hilley

From: Ellen Nissenbaum

Subject: Repubs' Medicaid umbrella fund -- new problems

Date: May 30, 1996

I wanted to send you all this ***preliminary and confidential*** memo describing some serious problems with the proposed umbrella fund in the Republicans' Medicaid (and welfare) bill. As you'll see, we believe that there are additional reasons why the fund really won't work as often portrayed and will leave many states "holding the bag."

We plan to follow this up with a detailed analysis early next week but wanted to make you aware of these concerns now before the Administration makes any further statements or plans regarding the upcoming Medicaid Reconciliation mark-ups.

We've alerted key health and Democratic leadership staff to these new concerns.

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Robert Greenstein, Executive Director

To: Interested parties

From: Cindy Mann and Richard Kogan

Re: Preliminary analysis of Medicaid umbrella fund

Date: May 30, 1996

The new Republican Medicaid bill includes an umbrella fund that purports to protect states from "unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters." The fund that is proposed in the bill, however, falls far short of this goal. There appear to be a number of serious problems with the design of the umbrella, including three fundamental issues that run contrary to the principle that federal dollars should "follow beneficiaries".

Umbrella Funds Would Not Be Based on the Number of People Actually Served

Although the bill is subject to differing interpretations, our reading is that umbrella payments would be based on increases in the number of people in the eligible population groups covered by the umbrella fund, *without regard to whether any of these people are actually enrolled.* By contrast, the governors' resolution specifically called for funds to be guaranteed on a *per-beneficiary* basis, meaning that if more people were served under the program than were anticipated to be served, additional per-beneficiary payments would be made to the state. If our reading of the bill is correct, the fund would pay states that have more poor children or more poor pregnant women than anticipated, but it would not necessarily reimburse states that *serve* more poor children or more pregnant women. Enrollment does not appear to be a factor in the equation.

Suppose the number of poor children enrolled in a state's Medicaid program rises because an increasing number of employers in the state do not offer health insurance coverage for dependents (as is the trend). Under the bill, this state would not be able access umbrella payments -- the number of poor children did not increase, just the number of poor *uninsured* children. Without umbrella funds, a state would either bear the full cost of covering the additional children or restrict eligibility and deny coverage to these children — an action it would be free to take under various provisions in the bill.

On the other hand, if the number of poor children in a state increases due to a downturn in the economy, the state could receive an umbrella fund payment *even if it did not enroll any more children.* Indeed, because umbrella payments would be made without regard to the number of people actually served, states could receive additional federal

funds above their basic block grant payments without having incurred any additional costs. This could occur whenever a state was spending state funds above the minimum level required to receive its block grant payment. In addition, while there is a requirement that states match federal umbrella funds, the lack of any rules on provider taxes, intergovernmental transfers, and other financing schemes means that no real state dollars would have to be spent. Thus, the fund would not only fail to protect states against added costs incurred if enrollment increases above expected levels, it would provide states with opportunities to draw down additional federal funds without having to provide health care coverage or incur additional state costs.

The Umbrella Fund Covers Only a Fraction of the Cost of Higher Levels of Enrollment

Even if umbrella payments were based on the number of people actually served, states would not receive the payments they would need to cover the cost of higher-than-anticipated levels of enrollment because of another fundamental flaw in the design of the umbrella fund. Under the bill, payments from the fund are based on a determination that the growth in enrollees *relative to the prior year* is higher than anticipated. Thus, a state that experiences enrollment growth due to a sharp downturn in the economy — whose effect on unemployment lasts for several years — would be reimbursed each year for only a fraction of the cost of increased enrollment. The following table shows the extent to which reimbursement under the fund could fall far short of need.

REPUBLICAN MEDICAID BILL
The Umbrella May Not Provide Full Protection
(Hypothetical Example)

	1996	1997	1998	1999	2000	2001	2002
Projected (3% per year)	100	103	106	109	113	116	119
Actual (4% per year)	100	104	108	112	117	122	126
A) Needed Umbrella		1	2	3	4	6	7
B) Actual Umbrella		1	1	1	1	1	1

This simplified example shows what would happen if the number of individuals in a population group in a particular state started at 100 and then grew faster than expected by one percent in each of the six years beginning in 1997. By 2002, a substantial shortfall

would occur because the formula only considers growth relative to the prior year. Thus, in this example, in 1999, the state would be reimbursed for only one additional person instead of three additional persons because the formula only considers the growth that occurred between 1998 and 1999 and ignores the growth that occurred between 1996 and 1998. Over time, this problem could cost states a very large amount of funds; in this example, in 2002 the state would receive payments on behalf of one individual even though its population group exceeded expectations by seven people. In short, the bill fails to cover the cumulative effect of unanticipated growth.

This same kind of shortfall also could occur if inflation were higher than anticipated. The formula for determining umbrella fund payments takes inflation into account and allows for payments to be made if inflation is above projected levels. However, as in the example above, the payments would not take into account the *cumulative* impact of inflation. Thus, if inflation were one percent higher than anticipated for four years in a row, by the fourth year, prices would have increased by four percent above forecast levels. But the state would only receive a payment covering the rise in inflation as compared to the year before a one percent payment. The preceding three years of extra inflation would not be reflected in the umbrella payment or in a state's base payment.

The Formula for Determining Umbrella Fund Payments Can Be Expected to Lead to an Inequitable Distribution of Payments Among States

Under the formula, states receive umbrella fund payments if the number of individuals in a covered population group is higher than the "anticipated" number of individuals in the population group.[1] The growth rate used to calculate the anticipated number of individuals is based on the rate by which the state's block grant base payment rises.[2] However, state block grant payments increase at varying rates, partly determined by the floors and ceilings set forth in the bill. Some states are squeezed harder than others — after fiscal year 1997, growth rates range from a low of 2.00 percent to a high of 7.22 percent (not including Louisiana).

These differential growth rates can be expected to lead to an inequitable distribution of federal umbrella funds. For example, in 2002 New York's allowable growth rate is 2.00 percent. As long as inflation is higher than 2.00 percent, any amount of increase in the number of people in a covered population group could result in an umbrella payment for New York. By contrast, Florida's growth rate in 2002 is 7.22

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[1] There would be an offset if population in another covered group were below anticipated levels.

[2] The anticipated number of individuals in a group is based on the amount by which the states' outlay allotment (block grant base payment) grows faster than the consumer price index.

percent. If inflation is 3 percent, Florida would have to see its covered Medicaid population grow by more than 4 percent before it would be able to qualify for an umbrella payment.

The allowable growth rates in states seem to have little or no relationship to expected caseload growth. Rather, they reflect a conscious attempt to squeeze high-cost states harder. As a result, under the design of this umbrella fund, high-cost states will have much better access to umbrella payments.

Other Problems with the Umbrella Fund

Other problems with the umbrella fund include the following:

- **People with disabilities may not be covered by the umbrella fund.** Under the governors' proposal, states would be allowed to develop their own definitions of disability, and disabled people would be covered by the umbrella fund. By contrast, under the bill, states can choose to use the SSI definition of disability or to develop their own disability definition, and if a state uses its own definition of disability the fund would *not* cover disabled people. While this change might encourage some states to use the SSI definition of disability, disabled people in states that choose to develop their own definition of disability would be particularly disadvantaged. If the size of that group increased, these states would not receive any additional federal payments but would be able to restrict sharply their definition of disability or the level of services provided to disabled persons.[3]

- **States would receive inadequate payments for Qualified Medicare Beneficiaries ("QMBs").** Under current law, states must cover under their Medicaid program the cost of premiums, copayments and deductibles incurred by low-income Medicare beneficiaries. While states would be under no obligation under the new Republican proposal to cover all of these cost-sharing obligations for QMBs, if a state did attempt to provide benefits consistent with current law, it would not receive adequate protection under

[3] The bill does include a set-aside provision for payments on behalf of disabled people as called for in the governors' resolution. (The set aside covers 60 percent - 70 percent of the projected costs of the disabled by 2002.) However, the bill adds a provision not included in the governors' resolution that allows states to use federal Medicaid payments to cover the cost of state psychiatric residential facilities (under current law federal payments cannot be used to cover facilities serving people ages 21 - 64). This provision means that states could meet their set-aside requirement, or most of it, simply by using federal Medicaid payments to cover the cost of facilities now paid for with state funds. Thus, the set-aside requirement might not provide much protection for people who are not receiving mental health services in a state residential facility.

the umbrella fund. Under the bill, the amount of the umbrella payment states would receive if the number of QMBs in the state were higher than anticipated would be based only on the cost of providing coverage for premiums and not for other cost-sharing obligations. Premiums are less than 30 percent of QMB costs, according to CBO.

Conclusion

This preliminary review of the umbrella fund provisions in the new Republican proposal suggests that the fund may be little more than a relatively minor adjuster for general population and poverty rate changes and only for high-cost states. It does not fully reimburse states for the federal share of higher-than-anticipated enrollment, it does not respond to the real costs that states experience enrolling and serving real people, and it could give rise to new state financing schemes. Accordingly, it is fundamentally different from the governors' concept of a fund that truly protects states from increased costs due to factors beyond their control.

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE

May 28, 1996

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

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

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

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

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

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

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

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

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

These principles include:

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

THE REAL GUARANTEE OF COVERAGE

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

Eligibility

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

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal poverty level.**

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

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

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

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

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefits packages.

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

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

- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries).

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

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

- **The Vaccines for Children Program is repealed,** and states are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.

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

- **Family planning services are limited to "pre-pregnancy" family planning services only.** States would be able to restrict which family planning methods would be available.

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

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

- Medicaid would become the sole federal statute conferring benefits on individuals with no possibility of federal enforcement for its intended beneficiaries.

FINANCING

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

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

The funding provides very limited risk protection for enrollment growth.

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

Not all groups trigger umbrella

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

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

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to significantly decrease the state contribution and increase federal dollars spent on Medicaid. Given the block grant structure of the financing proposal, this change would shift funding from poorer states with higher current FMAPs to the 23 wealthier states that currently have 50 percent FMAPs.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

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

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

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

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

Leave current law nursing home quality stds.

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

- **The Republican bill contains no standards for cost sharing other than some limits related to primary and preventive care for children and pregnant women.** Beneficiaries and their families who are protected by current law against excessive cost sharing could face new obligations to pay for their care or that of a family member. Without cost sharing standards, benefit packages could be essentially meaningless for other services for children and pregnant women, and for all services for the elderly and disabled.

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

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

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

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

- **Under the Republican bill, states would have both a financial incentive and the opportunity to receive federal matching payments for the costs of services that are currently supported with state funds only (e.g., state psychiatric hospitals).** This cost shift is possible because states would have flexibility in defining eligibility (e.g., for the disabled), and benefit levels (amount, duration, and scope), and the elimination of the IMD exclusion.

ELIGIBILITY OF CHILDREN

Summary: The 5/21 Republican bill would stop the phase-in of coverage for "Waxman kids" at its 1996 level, which is age 12.

- **"Waxman kids" -- children between ages 13 and 18 in families with incomes below 100% of poverty will not be guaranteed eligibility for Medicaid coverage under the Republican bill.**
- **In addition, children who are now covered would lose Medicaid eligibility once they turn 13 unless States decide to cover this population as an optional group.**

Current Law

In 1990, Congress expanded Medicaid eligibility for children under 100 percent of the federal poverty line. All children born after September 30, 1983 would have Medicaid coverage phased-in year by year, so that by 2002 all poor children under the age 19 would be eligible for Medicaid coverage.

In 1996, low-income children age 12 were phased-in for Medicaid coverage.

5/21 Republican Proposal

Guaranteed Medicaid eligibility for children ages 13-18 with family incomes below 100% FPL is eliminated. States will not be required to provide Medicaid coverage to this population. States could chose to cover these children as an optional eligibility group.

If the Republican proposal is enacted up to 2.5 million children ages 13-18 will lose the guarantee of Medicaid eligibility and perhaps their coverage, depending on state decisions.

Covering Children is a Wise Investment

Medicaid coverage for 13 to 18 year olds is important to ensure that this population carries its good health status into adulthood. Medicaid services for this population are predominately preventive health services provided through the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) under Medicaid. Periodic health exams and screens under EPSDT assist in the early detection and treatment of disease.

Medicaid expenditures for periodic screening and diagnosis of this population are small in comparison to service expenditures for other Medicaid populations -- however, they are an investment in the health of this population as they enter adulthood.

To protect the health of poor children, the phase-in of coverage should be maintained.

POTENTIAL ELIGIBILITY REDUCTIONS UNDER MAY 21 REPUBLICAN BILL

Summary: The 5/21 Republican bill eliminates guaranteed eligibility for two major categories of individuals who currently are guaranteed coverage:

- **children over 12 who would have their mandatory eligibility gradually phased in, and**
- **individuals with disabilities under current law SSI definitions of "disability."**

As a result of these provisions:

- **1.5 to 2.5 million children over 12 who would be covered by Medicaid could lose guaranteed eligibility by 2002; and**

- **7.8 million individuals with disabilities who will be covered by Medicaid could lose guaranteed eligibility by 2002.**

The 5/21 Republican bill Compared to Current Law

The 5/21 Republican bill continues the mandatory eligibility for the following groups:

- poor pregnant women and children through age 12 under current law,
- elderly recipients of SSI, and
- adults and children receiving AFDC (in its revised format).

However, the 5/21 Republican bill eliminates mandatory eligibility for two major categories:

- children over 12 who would have their mandatory eligibility gradually phased in, and
- individuals with disabilities under current law SSI definitions of "disability."

Potential Eligibility Reductions Among Children:

o 1.5 to 2.5 million children over 12 who would be covered by Medicaid would lose guaranteed eligibility by 2002.

Under current Medicaid law, children under 19 born after 9/30/83 with income below 100 percent of poverty are eligible for Medicaid as a mandatory group. As a result, all children through age 12 (under age 13) are currently guaranteed coverage. Each year an additional age group of children is added, so that by 9/30/2001 all children through age 18 (up to age 19) would be guaranteed coverage. By 2002, HCFA estimates that there will be 1.5 million children added due to this provision. In addition, approximately 1 million children age 13 to 19 are currently covered in optional eligibility categories. All of these children would be guaranteed covered as this provision is phased in by 2002.

The 5/21 Republican proposal would only provide mandatory eligibility to children through age

12. Thus, States would have the option to cover the 1.5 million older children added by the phased in guarantee, but that coverage would no longer become mandatory.

In addition, one million children who are estimated to be covered by Medicaid on the basis of optional eligibility rules would remain optional, and would not become eligible based on the mandatory eligibility rules. These HCFA estimates are based on projected enrollment for all children age 13 to 18 less those that are covered based on current welfare rules. The 1.5 to 2.5 million children who would lose their eligibility guarantee by 2002, would not necessarily loss their Medicaid coverage. Coverage loss would depend on state decisions.

Note: Children's Defense Fund estimates based on an analysis of Census data that there would 3 million children who would lose this guarantee. This estimate included poor children who are uninsured and insured privately.

Potential Eligibility Reductions Among the Disabled:

o 7.8 million individuals with disabilities who will be covered by Medicaid would lose guaranteed eligibility by 2002.

Under current Medicaid law, children and adults, who are determined by SSA to be disabled and whose income qualifies them for SSI, are eligible for Medicaid as a mandatory group. All of these individuals are guaranteed eligibility to Medicaid by this provision. HCFA estimates that 7.8 million individuals with disabilities will be covered by Medicaid based on receiving SSI.

The 5/21 Republican bill would allow the states to determine the definition of disability. Thus, all of the 7.8 million people with disabilities would loss their guarantee to Medicaid eligibility, but, depending on state actions, they may or may not loss their Medicaid coverage.

MEDICAID AND CHILDREN

Summary: Medicaid is a critical source of health insurance coverage for children. Approximately 18 million Americans under age 21, including between a third and a half of all babies under 1 year old, are covered under Medicaid. Medicaid is also the primary source of payment for medical services for children with disabilities.

The 5/21 Republican bill restricts the guarantee of coverage and benefits for millions of current and future Medicaid eligible children.

5/21 Republican Bill

Under the 5/21 Republican bill, millions of children will lose their federal guarantee of Medicaid eligibility. Under current law, Medicaid coverage of children ages 13-18 is being phased in -- by year 2002 all children ages 13 to 18 under 100% FPL will receive Medicaid.
The 5/21 Republican bill eliminates this guaranteed coverage. This change in Medicaid eligibility could affect up to 2.5 million children.

Those who do remain eligible will still lose the following guarantees which exists under current law:

- the guarantee that states will not discriminate in the amount, duration, and scope of services which they provide based on individuals' eligibility groups or diagnoses;
- the right to enforce in federal courts over state benefit and eligibility decisions;
- the guarantee that they will receive all medically necessary services to treat their diagnosed health problems.

Background

- Forty- nine percent of Medicaid beneficiaries (approx. 18 million) are low-income children under age 21.
  - Medicaid pays for about one-third of all births in the United States each year.
  - Between one-third to one-half of all babies under 1 year old and one-third of children ages 1 to 5 receive Medicaid.

Eligibility

- Under current Medicaid law, children under 19 born after 9/30/83 with income below 100 percent of poverty are being phased in for Medicaid coverage as a mandatory group.

- The 5/21 Republican bill language proposal would only provide mandatory eligibility to children up to age 13 (through age 12).

  - States would have the option to cover children over ages 13-18, but that coverage would no longer be mandatory.

  - HCFA estimates based on projected enrollment that 2.5 million children would lose their eligibility guarantee by 2002, but depending on State actions, not necessarily their coverage

Services

- Complete state flexibility with respect to the determination of amount, duration, and scope of services provides no protection against beneficiary discrimination within or across eligibility groups -- including children.

- No uniform, guaranteed adequate level of care would be required.

- Lack of comparability or statewideness requirements -- no guarantee of uniformity of benefits under a given State Plan.

- Redefining treatment under EPSDT -- there is no guarantee that states will provide any and all medically necessary services needed to treat detected health problems in Medicaid children.

- No federal right of action for individuals prohibits beneficiaries from challenging state decisions regarding ADS, comparability and statewideness.

- Repealing the Vaccine for Children program eliminates the cost-effective means for States to provide the childhood immunizations. This will result in reductions in the number of children vaccinated.

  - States and providers will have to purchase vaccine at private prices rather than at the government discount price.

State Definition of Disability

- State discretion to define disability will affect Medicaid children with disabilities - children with cerebral palsy, spina bifida, AIDS and other life-long debilitating diseases.

  - Medicaid is the primary source of payment for medical services for children with disabilities.

  - Medicaid covers 90 percent of all children with HIV and AIDS.

- As states are forced to provide medical care under a fixed block grant, coverage for the most expensive beneficiaries and services could be reduced.

- Families may be forced to give up one income in order for a parent to stay home and provide care to a disabled child.

- The required set-aside is insufficient to continue current level of services to all current disabled beneficiaries.

VACCINES FOR CHILDREN PROGRAM

Summary: The 5/21 Republican bill language repeals the Vaccines For Children Program. The Vaccines for Children Program was established in OBRA '90 to eliminate cost and delivery system barriers low income parents encounter when immunizing their children. It is widely supported by the Nation's Governors, the American Academy of Pediatrics, and State officials.

Background

The Vaccines for Children program (VFC) is an integral part of the Administration's comprehensive immunization initiative involving both public and private providers to increase vaccination levels for two-year-old children.

- The Administration's year 2000 immunization objective is to fully immunize at least 90 percent of two-year-old children with the recommended series of vaccine.

- Immunization rates are at the highest level ever recorded for the recommended series of vaccines including measles, mumps, rubella, diphtheria, pertussis, tetanus, and polio at 75% for two year olds.

The VFC program eliminates a cost barrier faced by Medicaid providers and low-income parents by supplying participating providers with vaccine purchased at a reduced federal price.

- Before VFC, Medicaid had to pay private sector vaccine prices (approximately $280 for the total series of vaccines) instead of the reduced federal contract price (approximately $130.)

- The high cost of vaccine coupled with the limited Medicaid reimbursement rates for immunization provided an economic disincentive for Medicaid providers to provide vaccines. As a result, the continuum of care for beneficiaries was disrupted as providers referred Medicaid beneficiaries to public health clinics for vaccines.

The shift from private prices to the reduced federal vaccine price saves millions of taxpayer dollars.

- California estimates that purchasing vaccines at the reduced federal price saves $40 million a year.

Impact of 5/21 Republican bill:

Repealing the Vaccines for Children program will remove an effective State tool for acquiring and distributing childhood vaccine.

- The VFC program operates in all states and has significant provider enrollment -- well over 39,000 provider sites.

- Through the VFC program all states are providing vaccine to public providers enrolled in the program, and all but a few states are distributing VFC vaccine to private providers.

- States have used the savings affiliated with the VFC program to extend the immunization program to uninsured groups.

The Republican bill would eliminate vaccine purchase contract authority for the Federal government and the States under Section 1928(d)

- The Centers for Disease Control and Prevention currently uses the VFC contract authority for all its vaccine purchases; elimination of this authority would stop the availability of vaccine in doctors' offices and public health clinics.

- States could no longer purchase additional vaccine with state funds for groups not otherwise VFC eligible; State costs would increase significantly or fewer children would be immunized.

Repeal of the VFC program would threaten our continued achievement of high immunization rates.

- The VFC program ensures that children have access to the newest disease preventing vaccines when they are approved and recommended.

- The VFC program was established to improve vaccine rates among two-year-olds: Almost 1.4 million children (25%) 19-35 months of age -- lack one or more of the recommended immunization doses.

IMPACT OF REPUBLICAN PROPOSAL ON CHILDREN

Total Medicaid cuts could reach $265 billion by 2002 if States spend only the minimum required to receive their full grant allocation. States may be forced to restrict the scope of coverage or cut back on essential benefits for children.

REDUCED COVERAGE

The Republican plan would deny the guarantee of coverage for up to 2.5 million children aged 13-18.

Over 800,000 disabled children may also lose coverage because the plan allows States to define disability criteria.

Since the funding formula does not guarantee that additional funds are available for new enrolless or when inflation is increased, states may be forced to deny coverage to certain groups.

A large number of children could lose coverage because states may define income and resources more restrictive than current law. For example, homeowners could be found ineligible because the value of a home could be used to determine eligibility. Under current law, a home of any value does not affect a child's eligibility.

GUARANTEE OF MEANINGFUL BENEFITS NO LONGER SECURE

The plan gives states complete flexibility to define the adequacy of required benefits (the amount, duration, and scope of benefits). Coupled with the cuts of up to $265 billion, states could be forced to:

- cover inpatient hospital care for children for just 1 day;
- cut treatment for a medical condition a doctor discovers through a health exam such as drugs or inhalers for asthma;
- cut home care for disabled children;

States could arbitrarily offer different benefits in different parts of the state, so that children in rural areas may lose vital services such as home visits from a nurse or clinical services from a doctor.

States could reduce benefits for certain populations such as disabled children. For example, disabled children may go without assitive devices such as wheelchairs or rehabillitation services.

The Vaccines for Children program is repealed and states are given flexibility to set their own vaccination schedules. Fewer vaccinations for children would result.

States can charge copays, making health services unaffordable -- Families with children could face copays for physician visits and deductibles for hospital stays.

Studies show that imposing copayments on low-income families results in lower use of necessary health care services.

FY 1993 - Average on $5,936
disabled children
- All children $1,065

Impact on Children

1 in 5 children

The Republican Medicaid Plan may affect the health benefits of up to 18 million children:

No Guarantee of Coverage:

- No entitlement for certain groups of children.

  - Under current law, Medicaid coverage for children age 12-18 under 100% FL is being phased in. Under the Republican proposal coverage of this population is optional for the States -- if States decide to cover these children they only receive coverage for mandatory services.

- Medicaid populations will have to compete for Medicaid dollars -- children will lose to lobbyists, interest groups and advocates representing the elderly and the disabled.

  - Children represent over 49% of current Medicaid beneficiaries, however, 83% of Medicaid dollars are spent on services for adults, the elderly and the disabled.

Cuts up to $250 billion by 2002

- The Republican cut in Federal Medicaid spending is $72 billion, however, the total (Federal and State) reduction in spending could reach $250 billion over six years.

- Under Republican proposals, State matching requirements are reduced, therefore, the amount a State would have to spend in order to receive its full Federal allotment is less than what they currently have to spend.

- States would be allowed to spend less on children than they currently do.

  - The reduction in state spending may mean the elimination of coverage of optional groups of children. States may choose to only cover the mandatory eligible groups.

  - The reduction in State spending may mean a reduction in services for children -- most likely a reduction in optional services such as speech, hearing and language services

Less income in 2002 -- national basis (not in states with match below 40%)

Minimal Benefits Package

treatment under EPSDT
reduction in cov. for FQHCs and RHCs - mand. only for 8 quarters

- Mandatory benefits are reduced under the Republican proposal.

- The Vaccines for Children program is eliminated under the Republican proposal. Low income parents are going to have to overcome cost and delivery system barriers in order to get their children immunized.

state by state # of uninsured This will reduce the # even further.

TODAY - enough for it to meet its purpose. Must be reasonable

- States define the amount and frequency of medical services and benefits children receive.

- There is no requirement on States to treat illnesses and conditions discovered during preventive health screens and exams.

- Follow-up treatment is mandated only for vision, hearing, and dental services. Right now children are guaranteed coverage for services medically necessary to treat an illness or condition discovered during health screens and exams.

Cuts in Optional Benefits

- There are no defined optional benefits under the Republican proposal.

- Current optional benefits used extensively by Medicaid eligible children include personal care services that allow children to stay at home with their families rather than in institutions; speech, hearing and language disorder services which assist with child development and education; physical therapy services which aids mobility; etc.

- The elimination of the current treatment requirement coupled with the lack of defined optional benefits means that some children may not receive comprehensive health benefits.

Redefining Disability may Result in Cuts to Disabled Children

- States have the option to define disability - this could result in fifty different definitions of disability.

- This discretion allows States to deny benefits to certain disabled populations currently receiving Medicaid benefits. Over 4 percent of the children on Medicaid are disabled.

- Medicaid is the primary source of payment for medical services for children with disabilities.

  - These children and their families stand the most to lose under the Republican proposal. Their conditions demand intensive health care services - usually the most expensive to provide.

  - If states are forced to provide medical care under a block grant, coverage for the most expensive services, particularly services provided in a home setting, would be reduced.

  - Medicaid covers 90 percent of all children with HIV and AIDS.

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

May 28, 1996

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

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

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

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

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

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

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

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

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

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

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May 10, 1996

HEALTH CARE GROUPS URGE RECONSIDERATION OF MEDICARE/MEDICAID REDUCTIONS IN BUDGET RESOLUTION

Ten health care groups today urged the chairmen of the three primary budget-writing committees in Congress to reconsider Medicare and Medicaid reductions in the FY 1997 House and Senate Budget Committee proposals.

In a letter to the three chairmen, the organizations point out that "the Budget Committees have significantly changed the allocation of reductions within the (Medicare) program." As a result of larger Medicare Part A reductions in the proposal, "hospitals are likely to experience actual reductions in payment rates," not just reductions in the rate of Medicare revenue growth.

The groups also raise concerns about proposed Medicaid reductions. "If combined with corresponding state reductions through lower state matching requirement or new provider assessments, these reductions could be quite significant," the letter states. The 10 groups repeated their support for "maintaining the entitlement nature of the Medicaid program to ensure that those who have coverage today will continue to have coverage tomorrow." The groups also support maintaining provider assessment restrictions and Boren amendment payment safeguards contained in current law.

A copy of the letter is attached.

Letter also sent to Chairman Archer
and Chairman Bliley

May 10, 1996

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

Dear Chairman Roth:

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

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

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

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

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

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

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

E X E C U T I V E O F F I C E O F T H E P R E S I D E

15-May-1996 05:39pm

TO: (See Below)

FROM: Lisa Kountoupes
Office of Mgmt and Budget, LA

SUBJECT: URGENT CLEARANCE OF HOUSE LETTER - NO ATTACHMENT AT

This letter is virtually identical to the Senate letter cleared earlier today with slight modifications to reflect differences in the two resolutions (ANWR, higher defense numbers, terminations) The House is conducting general debate now and we need to cut it loose. Please return any comments to me in the next half hour. 54790 thanks (It does not contain an attachment at this time, although one has been drafted, we will likely be sending an attachment around later this evening, but we really want to get this up to the hill)

DRAFT HOUSE LETTER -- NOT FOR DISTRIBUTION

The Honorable John R. Kasich
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to transmit the Administration's views on H.Con.Res. 178, the House Budget Committee's concurrent resolution on the budget for fiscal years 1997-2002.

Last week, the House Budget Committee crafted a resolution that was designed to appear more moderate than budget policies that the Republican majority pursued last year. But in some ways, the resolution has even more extreme policies than those in the reconciliation bill that the President vetoed.

For instance, the Republican plan calls for Medicare cuts of $161 billion -- almost $45 billion higher than the savings in the President's budget, according to CBO. Since the Budget Committee has claimed its proposed Medicare Part B savings are identical to the President's proposals, the full difference must come from Medicare Part A. Cuts of this size could limit beneficiary access to hospital health services and lead to lower payments to hospitals even in nominal terms -- not just cuts in the rate of growth. In addition, the structural changes proposed in recent Republican plans would seriously threaten the health of Medicare.

The resolution also includes $72 billion in Medicaid savings, which goes well beyond the savings in the last Republican Medicaid restructuring proposal (if estimated under CBO's new baseline). These figures do not even address the damaging structural changes contained in recent Republican proposals, including the block granting of Medicaid, that would undermine the guarantee of coverage. If these provisions are retained, the Republican plan would mean, for example, the elimination of coverage for as many as 2.5 million children between the ages of 13 and 18.

With regard to taxes, the resolution continues to raise income taxes on working Americans by cutting the Earned Income

Tax Credit (EITC). The House's cut of $20 billion over 6 years actually makes working Americans worse off than the last Republican budget offer, which called for a cut of $15 billion over seven years.

In addition, the tax cuts -- which purport to be $122 billion -- are understated and misleading. For one thing, the cost of the child tax credit mysteriously falls in the year 2002, meaning the revenue estimate for the credit is too low or part of the credit itself disappears. For another, the level of permitted tax cuts is actually higher; the majority has talked about total tax cuts of about $170-$185 billion. Not only does the resolution omit $36 billion in revenues from extending expiring provisions in last year's vetoed reconciliation bill, it also omits $26 billion in revenues from closing corporate loopholes and other tax measures from the last Republican offer. The resolution appears to reserve these revenues to pay for higher tax cuts. If incorporated in this resolution, these revenues could offset some of the unnecessarily deep cuts in Medicare, Medicaid, and other important priorities.

With regard to discretionary spending, the "savings" in this resolution may appear smaller due to the new baseline. In fact, however, the Republican plan proposes lower discretionary spending over the next six years than in their January offer, making it even harder to finance important priorities in education and training, the environment, science and technology, and law enforcement. In fact, the House resolution is worse than the Senate; it shifts even more resources into defense programs that we simply do not need. And it calls for eliminating such valuable non-defense investments as AmeriCorps, Goals 2000, and the Advanced Technology Program as well as the Energy and Commerce Departments.

As you know, the President has proposed a plan that the Congressional Budget Office said would reach balance in 2002. It targets tax relief to middle-income Americans, makes prudent savings in Medicare and Medicaid, and provides enough in discretionary funds to finance the President's investments in key priorities. Clearly, a balanced budget does not necessitate extreme and excessive cuts in programs on which tens of millions of Americans rely.

In their negotiations last winter, the President and congressional leaders came very close to reaching agreement on a long-term plan to balance the budget. The President wants to finish the job, and he has repeatedly asked the Republican leadership to return to the negotiating table. Although the Republican leadership has not yet accepted his offer, the President continues to reach out to groups of lawmakers who share

his goal.

The President wants to balance the budget, and he urges the Republican leadership to join him in that endeavor -- to give the American people the responsible fiscal policy they deserve.

With regard to the budget resolution at hand, I want to express the Administration's deep reservations about the following elements:

Medicare and Medicaid. The Medicare cuts are too large. The resolution would cut Medicare by $161 billion, which would place huge stress on hospitals, resulting in cost-shifting and declining quality, and threatening the financial viability of hospitals -- particularly rural and inner-city hospitals.

The resolution would cut Medicaid by $72 billion -- far more than necessary to balance the budget in 2002 and, because of the new CBO baseline, higher than the

cuts called for in the last Republican budget offer in January. If the resolution assumes previous Republican proposals that allow for lower State matching contributions, the actual cuts in Medicaid services and coverage could be as much as $250 billion. Moreover, the most recent Republican plans have continued to call for eliminating the guarantee of health coverage for millions of Americans.

Welfare. The resolution would cut low-income assistance programs by $53 billion over six years. Because the funding targets are virtually the same, the welfare reform provisions apparently have not changed from the bill the President vetoed in January, which coupled deep cuts with severe structural changes and bans on immigrants -- policies that would harm children and not transform the system to reward work. The President supports real welfare reform that would move people from welfare to work and protect children.

Student Loans. Like last year's House resolution, this resolution seeks to eliminate the Direct Student Loan Program. If implemented, over 2.8 million students now in the program would lose access to direct loans and income-contingent repayment options, and 1,300 schools now in the program would be forced out.

Tax cuts. While the resolution calls for tax cuts of $122 billion, it permits additional tax cuts of unspecified amounts. Tax cuts of about $170-$185 billion, as the majority has suggested, are simply too expensive; they would force unnecessarily deep cuts in Medicare, Medicaid, education, the environment, and other priorities.

The President has proposed an affordable and targeted tax cut to help middle-income Americans raise their young children, pay for postsecondary education, and save for the future. It is a much better way to help raise American living standards.

Arctic National Wildlife Refuge (ANWR). The resolution again calls for opening ANWR, a national treasure, to oil and gas development -- a policy that the Administration has firmly rejected.

Discretionary Spending. The resolution's non-defense discretionary level is wholly inadequate to fund key investments in education and training, the environment, science and technology, and law enforcement. It provides more than $19 billion less in 1997 than the President's budget. The House provides even less than the Senate for

these programs because of the greater shift of money to defense.

Rather than provide the necessary resources for these investments, the resolution provides $13 billion more in defense budget authority than the President's budget in 1997 -- which commits historically high levels of resources to readiness, as measured in funding per troop. (Further, in the critical years of defense modernization at the turn of the century, the resolution does not provide enough budget authority, compared to the President's defense program.) Moreover, the resolution does not even provide the "freeze" level that it claims. It characterizes the 1997 non-defense funding levels as a freeze from the fiscal 1996 agreement. That level, however, is more than $2 billion less than a true freeze, because it does not fully account for one-time spending cuts that Congress used as "offsets" in the 1996 omnibus spending bill.

In addition, the resolution targets high-priority investments for deep cuts and, in some cases, elimination. For example, discretionary funds for education and training would fall by $4.2 billion in 1997, compared to 1995. Over the next 6 years, the resolution cuts $61 billion from the President's proposed levels for education and training. With this resolution, the House Budget Committee repeats its failed attempt to eliminate Goals 2000, bilingual education, and AmeriCorps. For the environment, the resolution proposes to phase out energy conservation research and fossil energy research and development. It also would cut EPA operations by 14 percent in 1997, and 25 percent by 2002 -- significantly cutting enforcement actions and inspections, and ending efforts to spur new technologies.

Like last year's resolution, this resolution proposes to terminate many of the President's key technology investments, including the Advanced Technology Program. It cuts funds for NASA significantly. Finally, it again proposes to eliminate the Departments of Energy and Commerce. Just moving the components of these agencies elsewhere in the government will not save money, but it would disrupt and damage important national programs including environmental clean-up, technology, and nuclear weapons safety.

While the Administration and Congress share the goal of a balanced budget, we have grave concerns about the approach contained in this resolution. We also hope that Republicans learned from last year's experience, which included two government shutdowns and 13 continuing resolutions, that we need

to work together. We want to work with you, as the process moves forward, to achieve a balanced budget that is acceptable to the President, the Congress, and the American people.

Sincerely,

Alice M. Rivlin
Director

Attachment

IDENTICAL LETTER SENT TO HONORABLE MARTIN O. SABO

Distribution:

TO: John Hilley
TO: Barbara C. Chow
TO: Martha Foley
TO: John C. Angell
TO: Ananias Blocker
TO: Laura D. Tyson
TO: Gene B. Sperling
TO: George Stephanopoulos
TO: Donald A. Baer
TO: Barry J. Toiv
TO: Christopher C. Jennings

CC: Stacey L. Rubin
CC: Dena B. Weinstein
CC: Pauline M. Abernathy
CC: Jennifer L. Klein
CC: Charles E. Kieffer
CC: Charles S. Konigsberg
CC: Lisa Kountoupes
CC: LAWRENCE J. HAAS

E X E C U T I V E O F F I C E O F T H E P R E S I D E

16-May-1996 11:12am

TO: (See Below)

FROM: Lisa Kountoupes
Office of Mgmt and Budget, LA

SUBJECT: URGENT CLEARANCE OF HOUSE ATTACHMENT

Attachment: Additional Concerns with H.Con.Res 178 as Reported by the House Budget Committee

MEDICARE

The Medicare cuts are too large. The resolution would cut Medicare by $161 billion -- almost $45 billion more than the President's budget, according to CBO.

As the President's budget shows, cuts of this magnitude are unnecessary to balance the budget in 2002. The President's budget would reduce projected Medicare costs by a reasonable amount while still achieving a balanced budget in 2002 and extending the life of the Hospital Insurance (Part A) Trust Fund to about 2006.

The resolution drops the proposal to raise the Part B premium to 31.5 percent of program costs. But to achieve $123 billion in Part A savings without a premium increase, the resolution calls for $24 billion more in Part A savings than was in the last Republican offer. Such savings are achievable only by: further cutting hospital payments; cutting disproportionate share payments to hospitals that serve a large indigent population; or cutting payments for home health services, skilled nursing facilities, and hospices. All of these steps would seriously, and adversely, affect beneficiaries. If all additional Part A savings come from hospitals, the cut in hospital payments is 18 percent over the hospital cuts in the vetoed bill. Cuts of this magnitude could place tremendous stress on hospitals and limit beneficiaries's access to hospital-based health services.

The resolution proposes the establishment of medical savings accounts (MSAs) for Medicare beneficiaries. As CBO concluded last fall, MSAs would likely attract healthier Medicare beneficiaries for whom Medicare now spends very little. If so,

MSAs could cost Medicare substantial money, speeding the depletion of the Part A Trust Fund.

Other Republican proposals would permit physicians who participate in a private, fee-for-service plan to charge beneficiaries extra through "balance billing," which would raise out-of-pocket costs for beneficiaries and seriously threaten the viability of the traditional Medicare system.

MEDICAID

The resolution would cut Medicaid by $72 billion -- far more than

needed to balance the budget in 2002. The latest Republican offer called for $85 billion in savings off CBO's December 1995 baseline; but, off CBO's new March 1996 baseline, the same policies would save only $60 billion. The resolution, thus, cuts more from Medicaid because it has more savings off a lower baseline.

Moreover, under the budget resolution, Medicaid cuts could far exceed $72 billion if States spend only the minimum amounts needed to receive their full block grant allocation. Last year's vetoed reconciliation bill called for cutting State matching requirements. Republicans in the House Budget Committee markup defeated efforts to add language to the resolution urging States to retain their current funding levels for Medicaid.

But more than dollars are at stake. The resolution gives no indication that Republicans plan to withdraw their proposal to block grant Medicaid. If a block grant were enacted, funding levels would no longer automatically respond to economic crises, such as recessions; millions of people would lose their guaranteed access to health care, and those who do receive coverage would no longer have a Federal guarantee to a basic level of benefits.

We understand that under the Republican plan, phase-in coverage for poverty-level children aged 13-18 could end. In addition, if Republicans retain their previous disability criteria, millions of people with disabilities would be at risk for losing their current guarantee to coverage.

Nor does the resolution provide any assurance of continued federal enforcement of nursing home quality standards, which have dramatically improved the quality of nursing home care. Although the Committee adopted a non-binding amendment regarding current federal protections, the resolution provides no assurance that current federal nursing home quality standards, spousal impoverishment protections, and provider tax and donation laws will remain in place.

By contrast, the President's budget gives States unprecedented flexibility to manage their programs but preserves the guarantee of health coverage for millions of children, people with disabilities, and older Americans. We can balance the budget without leaving States, and the families they serve, vulnerable to factors beyond their control.

WELFARE

The resolution cuts in welfare programs -- $53 billion, not

counting interactions with Medicaid -- match those in the vetoed welfare bill and are much deeper than in the recent NGA proposal. The resolution cannot both meet the $53 billion savings target and provide child care and other funding to move families from welfare to work unless it cuts Food Stamps, SSI, immigrants, and other programs even more deeply than the vetoed welfare bill. With these cuts, a large majority of disabled children coming on the SSI rolls could have their benefits reduced, the national nutrition safety net could be jeopardized, and legal, tax-paying immigrants could be banned from most means-tested programs.

The plan folds 20 separate child protection programs into two block grants at a time when the General Accounting Office and others report that current resources are not keeping pace with the needs of a national child protection system in crisis. Under this plan, funds could be inadequate to respond to rapidly rising reports of abuse and neglect, and insufficient to protect abused children and find them safe, loving, and permanent adoptive homes. The plan potentially guts accountability for State child protection systems, over 20 of which now operate under court mandates for failing to provide adequate service to abused and neglected children.

STUDENT LOANS

Like last year's House resolution, this resolution calls for eliminating direct lending. Over 2.8 million students now in direct lending would be denied access to direct loans and "pay-as-you-can" repayment options. The 1,300 schools now in the program would be forced out, and the 450 schools planning to enter direct lending on July 1 would be shut out.

ARCTIC NATIONAL WILDLIFE REFUGE (ANWR)

The House resolution again calls for the opening up of the Arctic National Wildlife Refuge (ANWR), a national treasure, to oil and gas development -- a proposal that the Administration has consistently opposed.

TAXES

With this resolution, Republicans continue to raise income taxes on millions of working Americans by cutting the Earned Income Tax Credit (EITC). The EITC helps low-income working families stay off welfare and out of poverty. The resolution calls for $20 billion of cuts. Though scaled back from last year's House proposals, they are $5 billion higher than the last Republican

offer and are still too high.

Over 4 million workers who do not reside with children would lose their entire credit, and see their net income taxes increase, on average, by $174 a year. The resolution appears to impose these tax increases retroactively to January 1, 1996. Millions of families with children might see a cut in their EITC due to, among other things, a more rapid phase-out of the EITC for families in income ranges where they likely would benefit from the child tax credit. At the same time, many of other working families with children would lose part or all of their EITC, but not receive any child tax credit.

In addition, the resolution purportedly contains tax cuts of $122 billion over 6 years -- specifically, a child tax credit that costs $23 billion a year. But the resolution assumes -- without saying why -- that the cost of the credit would mysteriously fall to $16 billion in 2002. Either the revenue estimate for the credit is too low, or part of the credit itself disappears in the last year.

More generally, the resolution conceals the exact nature of the tax cuts; moreover, the statements by House and Senate leaders have exposed sharp differences over how much revenue will be lost. The Committee's markup materials, however, suggest the tax cut could be as high as $185 billion and that the Ways and Means Committee bill will contain capital gains tax relief and other changes. The capital gains proposal in last year's reconciliation bill was too expensive, and was heavily targeted to the most well-to-do. Furthermore, the costs would have exploded in later years, according to Joint Tax Committee estimates.

In the resolution, the revenue line itself is a smoke screen: It allows for another "deficit neutral" tax relief bill, financed through revenues that Republicans apparently have held in reserve. Not only does the resolution omit $36 billion in revenues from extending expiring provisions in last year's vetoed reconciliation bill, it also omits $26 billion in revenues from closing corporate loopholes and other tax measures from the last Republican offer. Rather than use these dollars to mitigate the excessive cuts in Medicare, Medicaid, and welfare, the resolution makes those funds available for more tax cuts. If such tax cuts mirrored last year's vetoed reconciliation bill, they would favor the well-off; that bill devoted about half of its tax cuts to people making over $100,000.

DISCRETIONARY SPENDING

The "savings" in this resolution may appear smaller due to the new baseline. In fact, however, the Republican plan proposes lower discretionary spending over the next six years than in their January offer, making it even harder to finance important priorities in education and training, the environment, science and technology, and law enforcement. In fact, the House resolution is worse than the Senate; it shifts even more resources into defense programs that we simply do not need. And it calls for eliminating such valuable non-defense investments as AmeriCorps, Goals 2000, and the Advanced Technology Program -- and for eliminating the Energy and Commerce Departments.

Although described as a freeze from 1996, the non-defense spending level is actually over $2 billion below that level. The 1996 Omnibus Appropriations bill included one-time savings to finance higher level of spending for education and training, the environment, and anti-crime efforts that cannot be, or are not expected to be, repeated in 1997.

Education and Training. The resolution provides $61 billion less in budget authority for education and training from 1997 to 2002 than the President's budget. In 2002, this would represent a 25 percent cut below the 1995 level, when adjusted for inflation.

The resolution seeks to end AmeriCorps, denying 200,000 youth the chance to serve their communities by 2002 while earning money for college, compared to the President's budget. It eliminates Goals 2000, which supports all States in efforts to establish high standards and innovative reform in every school. It terminates Bilingual Education, eliminating help for nearly 530,000 limited English proficient students in learning English and succeeding in school compared to 1996. And it freezes funds for Title 1, meaning that 400,000 fewer children would receive services in 1997, compared to the President's budget.

The resolution freezes funds for Head Start, eliminating up to 20,000 slots next year for children now receiving services (presuming program quality is maintained). It would deny summer jobs to about 600,000 youths over the next six years, and eliminate job training or related services for over 340,000 low-income adults and 560,000 dislocated workers.

Finally, under the resolution, 2.7 million fewer students would receive Pell grants over the next six years, 191,000 in 1997 alone. Nor does the resolution provide resources to increase the number of students who could participate in

college work study.

Natural Resources and the Environment. The resolution effectively cuts the Environmental Protection Agency's operating budget by 14 percent in 1997 and 25 percent by 2002, compared to the President, impairing EPA's ability to protect public health and the environment -- significantly cutting EPA and state enforcement actions and facility inspection (i.e. taking environmental cops off the beat); preventing the U.S. from meeting its international commitments to cut greenhouse gas emissions that affect global climate change; and ending efforts to spur new technologies to protect public health, cut costs, create jobs, and increase exports. The resolution uses these cuts to let polluters off the hook by financing taxpayer spending for Superfund cleanups, rather than require responsible parties to pay the cost.

The resolution provides far less than the President to improve National Parks. The funding levels likely would force reductions in resources for the Agriculture Department's Forest Service and Natural Resources Conservation Service, thus cutting conservation of our natural resources and forests.

The resolution also cuts (?) the GLOBE program, jeopardizing partnerships involving over 1,500 U.S. schools and 35 other countries and resulting in thousands of student across the U.S. and worldwide losing the opportunity to be a part of this program.

Technology Programs. The resolution would end technology programs that work with industry to promote economic growth. It repeats earlier efforts to end the Advanced Technology Program (ATP), and also would end the Manufacturing Extension Partnership (MEP), the Technology Administration, and the National information Infrastructure (NII) Grants Program. With these eliminations, the resolution would cut $330 million from federal research and development, compared to 1996.

The resolution also would cut NASA's budget by over $300 million, likely falling heavily on important environmental observations provided by NASA's Mission to Planet Earth (MTPE) as well as important aeronautics research and the Space Shuttle in 1997. Cuts in Solar and Renewables and Conservation would eliminate top Administration priorities, such as the Partnership for a New Generation of Vehicles and the Climate Change Action Plan. Virtually all technology transfer and information-sharing activities would end

immediately.

Once again, the resolution proposes to eliminate the Commerce and Energy Departments, which the Administration strongly opposes. Just moving the components of these agencies elsewhere in the government will not save money and could create more government with less efficiency. Termination would disrupt and damage key national services, including environmental clean-up, technology, and nuclear weapons safety.

Anti-Crime Programs. At $22 billion, the resolution provides $2 billion less than the President's request, sharply cutting the President's proposals to fight crime -- including more funds for drug enforcement on the Southwest Border, gang violence investigations and prosecutions, and law enforcement technology.

The resolution provides only $4.1 billion for the Violent Crime Reduction Trust Fund, $900 million less than the President's request, jeopardizing such important anti-crime initiatives as Violence Against Women grants, Violent Offenders and Truth in Sentencing grants, and drug courts. Also, the resolution sharply cuts funds for the Legal Services Corporation in 1997 and eliminates it fully in 1998, thus drastically reducing access to the judicial system for the poorest Americans.

Defense. The resolution provides $13 billion in budget authority and $6 billion in outlays above the President's budget in 1997, and roughly $25 billion in budget authority and $33 billion in outlays more over the next six years. Such increases are unnecessary. The President?s plan for defense provides the funds necessary for readiness and modernization of our forces without these unjustified add-ons.

At the same time, the resolution provides about $6 billion less in budget authority from 2000 to 2002, the critical years for defense recapitalization. Among other problems with the resolution, it calls prematurely for deployment of a U.S.-based system for national missile defense; sets the military retiree COLA date equal to the civilian date from 1997 to 2002; and would terminate the Dual Use Applications Programs that will bring cutting-edge commercial technologies into the defense sector to cut costs, increase performance of defense systems, and strengthen the defense industrial base.

International Affairs. The resolution would cut spending on

international affairs by eight per cent in 1997, and nearly a third by 2002, compared to the President's request. Although supporting materials indicate that USAID and USIA would be "consolidated" into the State Department, the cuts would effectively eliminate the programs, making this resolution even more extreme than earlier Congressional attempts at consolidation that the Administration strongly opposed.

By nearly eliminating USAID programs and ceasing to support concessional lending by the multilateral development banks by 2002, the resolution would end nearly all U.S. development assistance to the world's poorest countries. It would cut the State Department's operating expenses by over a third, forcing a withdrawal from many diplomatic activities of importance to U.S. security and prosperity. Further, it would cut export promotion programs about 40 per cent from the President's request by 2002, just as export competition will be intense. In short, the resolution would place the United States in an isolationist stance in world affairs.

OTHER AREAS OF CONCERN

Among the Administration's other concerns, the resolution would eliminate the National Institute for Occupational Safety and Health; unwisely reform the Food and Drug Administration; consolidate the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) programs into a proposed Native American Block Grant by 2000 while cutting funds for the programs; assume the elimination of grants that increase access to health care services for rural Americans; reduce assistance to rural areas by creating a Rural Development Block Grant Program; repeal the Davis-Bacon and the Service Contract Acts; eliminate the Office of Labor Management Standards; cut funds for Labor Department health and safety agencies; eliminate funds for the Trade Adjustment Assistance Program; terminate funds for the National Endowment for the Arts and National Endowment for the Humanities; reform the Federal Employees' Compensation Act; consolidate the Community Development Block Grant program, HOME program, and Community Development Financial Institutions program into one fund and reduce funds for them; eliminate the Council of Economic Advisers; and effectively dismantle the Office of Personnel Management.

Distribution:

TO: Lisa Kountoupes
TO: John Hilley
TO: Barbara C. Chow
TO: Martha Foley
TO: John C. Angell
TO: Ananias Blocker
TO: Laura D. Tyson

TO: Gene B. Sperling
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