MEDICAID COMPROMISE

NEW GENERAL FLEXIBILITY PROVISIONS FOR STATES, including:

- Eliminate federal waiver process for mandatory enrollment in managed care.
- Eliminate federal waiver process for home and community-based care options.
- Repeal the Boren Amendment.
- Repeal the cost-based reimbursement requirement for health centers/clinics.
- Repeal requirements for federal review of managed care contracts exceeding $100,000.

FINANCING

- Accept and work off the NGA financing formula to achieve CBO scorable savings, (which has no cap and ensures that federal support increases with enrollment), but retain current law with regard to state matching and provider tax rules.

ELIGIBILITY

- Accept NGA definition of eligibility with the exception of two modifications to the kids and disability definitions.
  - -- Retain current law that phases in kids ages 13-18, but repeal requirement that makes it impossible for states to "roll-back" optional coverage of kids and pregnant women to the mandatory poverty/coverage levels.
  - -- Retain federal disability designation authority, but restrict it to the definition agreed to in the welfare bill, (which excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids from mandatory coverage).
- Empower states to use any Medicaid savings to provide coverage of anyone under 150 percent of poverty WITHOUT any federal waiver.

BENEFITS

- Accept the NGA benefits definition, but retain appropriate federal standards to ensure that the benefits are meaningful.

  -- Retain current law's flexibility in defining benefits' "amount, duration, and scope" as long as it is "reasonable to achieve its purpose," is available statewide, and meets the current law's comparability requirements.

  -- Authorize the Secretary to narrow the definition of "treatment" that states must provide for children under the EPSDT benefit.

- Allow states to require nominal copayments for Medicaid HMO coverage.

ENFORCEMENT

- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.

- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.

- Preserve individual federal right of action (through the federal courts) for eligibility disputes, but limit access to federal courts (and substitute state court jurisdiction) over most benefit disputes.

STRUCTURE/SECOND TIER ISSUES

- Repeal outdated managed care quality standards, i.e., the private/public-75/25 enrollment rule, and substitute outcomes oriented quality rules.

- Retain federal nursing home standards and enforcement, but eliminate duplicative nursing home resident reviews and allow for nurse-aide training to take place in rural nursing homes.

- Retain current federal family financial protections, like spousal impoverishment and protections against liens on family property.

- Preserve current law protections by drafting reforms off of Title XIX.

CHANGES INCLUDED IN MEDICAID COMPROMISE B

FINANCING

- Consistent with NGA formula, assure states that their federal allotments can never fall below the previous year's actual federal spending in the state, even if enrollment declines.

BENEFITS

- Exempt optional benefits (with the exception of prescription drugs) from all but the adequacy standard, (i.e., exempt optional benfits from the comparability and statewideness requirements).

- Make services provided by community health centers an optional, rather than a mandatory benefit.

ENFORCEMENT

- Allow eligibility and benefit cases to be heard in state (rather than federal) court if the state makes all federal remedies and processes available.

STRUCTURE

- Accept NGA proposal to draft a new Medicaid title, but use current law as the statutory foundation to ensure that protections are not unintentionally repealed.

MEDICAID COMPROMISE B

NEW GENERAL FLEXIBILITY PROVISIONS FOR STATES, including:

- Eliminate federal waiver process for mandatory enrollment in managed care.
- Eliminate federal waiver process for home and community-based care options.
- Repeal the Boren Amendment.
- Repeal the cost-based reimbursement requirement for health centers/clinics.
- Repeal requirements for federal review of managed care contracts exceeding $100,000.

FINANCING

- Accept and work off the NGA financing formula to achieve CBO scorable savings, (which has no cap and ensures that federal support increases with enrollment), but retain current law with regard to state matching and provider tax rules.
- Consistent with NGA formula, assure states that their federal allotments can never fall below the previous year's actual federal spending in the state, even if enrollment declines.

ELIGIBILITY

- Accept NGA definition of eligibility with the exception of two modifications to the kids and disability definitions.
    - -- Retain current law that phases in kids ages 13-18, but repeal requirement that makes it impossible for states to "roll-back" optional coverage of kids and pregnant women to the mandatory poverty/coverage levels.
    - -- Retain federal disability designation authority, but restrict it to the definition agreed to in the welfare bill, (which excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids from mandatory coverage).
- Empower states to use any Medicaid savings to provide coverage of anyone under 150 percent of poverty WITHOUT any federal waiver.

BENEFITS

- Accept the NGA benefits definition, but retain appropriate federal standards to ensure that the benefits are meaningful.

  -- Retain current law's flexibility in defining mandatory benefits' "amount, duration, and scope" as long as it is "reasonable to achieve its purpose," is available statewide, and meets the current law's comparability requirements. However, exempt optional benefits (with the exception of prescription drugs) from all but the adequacy standard, (i.e., exempt optional benefits from the comparability and statewideness requirements).

  -- Authorize the Secretary to narrow the definition of "treatment" that states must provide for children under the EPSDT benefit.

- Allow states to require nominal copayments for Medicaid HMO coverage.

- Make services provided by community health centers an optional, rather than a mandatory benefit.

ENFORCEMENT

- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.

- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.

- Allow eligibility and benefit cases to be heard in state (rather than federal) court if the state makes all federal remedies and processes available.

STRUCTURE/SECOND TIER ISSUES

- Repeal outdated managed care quality standards, i.e., the private/public-75/25 enrollment rule, and substitute outcomes oriented quality rules.

- Retain federal nursing home standards and enforcement, but eliminate duplicative resident reviews and allow nurse-aide training to take place in rural nursing homes.

- Retain current federal family financial protections, like spousal impoverishment and protections against liens on family property.

- Accept NGA proposal to draft a new Medicaid title, but use current law as the statutory foundation to ensure that protections are not unintentionally repealed.

THE NATIONAL GOVERNORS' ASSOCIATION (NGA) MEDICAID RESOLUTION

- **PLEASED THERE IS A GUARANTEE AND MONEY FOLLOWS PEOPLE:** We are pleased that the Governors have passed a policy resolution that affirms our national commitment to the guarantee under Medicaid. We are also pleased that they have continued the financial partnership between the federal government and the states that allows Medicaid funding to follow increases in enrollment.

- **BUT IT MUST BE A MEANINGFUL GUARANTEE FOR EVERYONE ELIGIBLE UNDER CURRENT LAW.** As Congress considers the NGA resolution and legislation to reform Medicaid, we need to make sure that the guarantee is real:

  1. **There must be national guidelines for eligibility that protect those who are eligible under current law:**

     Children. Current law, which phases in coverage for 1.5 million children between the ages of 13 and 18, should be retained.

     People With Disabilities. People who meet the national definition of disability should be guaranteed coverage.

  2. **There must be a national guarantee to meaningful benefits.**

  3. **We must preserve adequate legal enforcement of this guarantee.**

- **WORKING WITH THE GOVERNORS TO CLARIFY THEIR INTENT:** We are working with the Governors to clarify the intent behind the individual provisions of the NGA resolution. Their recent testimony before the Congress shed some additional light on their proposal, but they have yet to finalize their policy.

- **WILL CONTINUE TO WORK WITH GOVERNORS AND OTHERS:** In the weeks to come, we will continue to work the Governors, the Congress, consumer advocates, health care providers, and other interested parties to assure that any Medicaid reform legislation provides for enhanced flexibility to the states while preserving the program's fundamental guarantee.

NATIONAL GOVERNORS' ASSOCIATION MEDICAID RESOLUTION

The Administration fully supports the significant victory achieved by the Democratic Governors in reaching agreement with the Republicans on a financing mechanism that ensures that "dollars follow people." However, we have concerns about each of the four elements that make up the Medicaid guarantee -- financing, eligibility, benefits and enforcement.

MAINTAINING THE GUARANTEE

(1) Financing. We support the concept behind the umbrella in the NGA resolution because it allows financing to increase as enrollment grows. However: (1) states get guaranteed allotments even if they reduce coverage, contrary to the current system where federal financing rises or fall with changes in coverage; (2) states can reduce their match from 50% to 40%, meaning that either federal spending will rise, or if federal spending is capped, overall cuts in Medicaid will increase by an additional $140 billion; and (3) states could substitute state dollars with provider taxes and donations, effectively reducing states' real Medicaid spending.

Our Position: Clarify that we have some concerns about these provisions, indicating that CBO may have concerns as well.

(2) Eligibility. NGA repeals the phase-in of coverage for 1.5 million children aged 13 to 18 and allows states to define disability.

Our Position: Retain kids phase-in and, as in welfare reform, let states limit disability definition for alcoholics and other substance abusers and tighten definition for children under SSI.

(3) Benefits

- **"Adequacy" Requirements.** NGA eliminates the "adequacy" requirement so states can determine the amount, duration and scope of services without limitation.

  Our Position: Retain adequacy requirement.

- **Statewideness and Comparability:** NGA repeals statewideness and comparability for optional benefits and may repeal these requirements for mandatory benefits.

Our Position: Retain the comparability and statewideness requirements for mandatory benefits. Until now, we have also maintained statewideness and comparability for optional benefits. We could go farther by giving states flexibility on optional benefits, but the President believes that we need more information about the NGA position and would need to discuss how these distinctions would be applied in order to protect against discrimination. For example, we might be open to offering different benefits to broad categories of beneficiaries (e.g., disabled v. children) but not to dividing beneficiaries into very specific groups (e.g., AIDS patients v. stroke patients).

- **EPSDT (Early and Periodic Screening, Diagnosis and Treatment):** NGA redefines EPSDT so states need not cover all optional services for children.

  Our Position: We have clarified that states are not required to provide the benefits they give to children under the "treatment" portion of EPSDT to other populations. In going farther, the President shares Governors' concerns about abuses in the EPSDT program but feels strongly that we need to address them carefully.

(4) **Enforcement.** NGA eliminates the federal private right of action for beneficiaries, providers and health plans.

Our Position: Repeal Boren Amendment and make clear that providers can't sue over payment rates. Reiterate the President's strong support for a federal cause of action in eligibility claims.

We agreed that, if really pushed, we could go farther. We could eliminate any private right of action under the statute for providers (e.g., over qualifications). We could also require that all individuals exhaust administrative remedies and that, while all eligibility claims would be heard in federal court, most benefits disputes (factual disputes not claiming violation of *law*) would be heard in state courts.

OTHER ISSUES

We also have concerns about the repeal of Title XIX and believe that, instead, changes should be made to the existing Medicaid statute. There are also second tier but critical issues apart from the guarantee that we did not discuss (e.g., nursing home standard enforcement, financial protections for families, the Vaccines for Children program) that we need further clarification on from NGA.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

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TO: JENNIFER KLEIN

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MCH Update

STATE MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN: SUMMER 1995

Health Policy Studies Division
NGA Center for Policy Research

Release Date: September 29, 1995

Beginning in 1990, the Health Policy Studies Division of the National Governors' Association, Center for Policy Research has conducted a national survey of state Medicaid coverage of pregnant women and children and innovative maternal and child health initiatives. The **MCH Update** is produced twice a year, reflecting the ongoing progress states have made in expanding Medicaid coverage to pregnant women and children.

The data presented in this issue was collected during the summer of 1995. Surveys were received from 49 states. Topics covered in this issue include: expansions of eligibility for Medicaid for women, infants and children; strategies to streamline eligibility; annualized Medicaid eligibility thresholds for AFDC (Aid to Families with Dependent Children), medically needy, OBRA pregnant women and infants; births paid for by Medicaid; and children insured by Medicaid.

Broadening Eligibility Criteria

Congress first allowed states to delink eligibility for Medicaid from eligibility for cash assistance in 1986. Between 1987 and 1990, a number of legislative options and mandates, have been enacted to expand Medicaid eligibility thresholds for pregnant women and infants, and children. The last two major expansions for Medicaid eligibility occurred as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and OBRA 1990 legislation. The OBRA '89 legislation required that states cover, at 133 percent of the federal poverty level, all pregnant women and children under age six. OBRA '90 legislation mandated that states phase in coverage to those children under the federal poverty level who were born after September 30, 1983, until all children under age nineteen are covered. On October 1, 1995, states will begin covering children living below 100 percent of the federal poverty level who are twelve years old and below.

Beyond Federal Mandates

Legislative changes resulting from amendments to Medicaid included in OBRA '89 and '90 also gave states the opportunity to expand coverage of pregnant women, infants, and children beyond federal mandates. For example, states have the option to expand eligibility for pregnant women and infants up to 185 percent of poverty. Currently, 34 states and the District of Columbia have expanded coverage of pregnant women and infants above the mandated 133 percent of the federal level, as displayed in Table 1. Table 1 summarizes state coverage levels for pregnant women/infants and children as of August 1995. It also provides information on the mechanism used by the state to expand eligibility beyond the federal requirements. Each of these mechanisms is described in greater detail below.

Section 1902(r)(2). In the past few years, an increasing number of states have begun taking advantage of provisions in the Medicaid statute that permit them to broadly expand Medicaid coverage for pregnant women and children above the levels specified in OBRA '86, '87, '89, and '90 legislation. The 1902(r)(2) option of the Social Security Act was added to the Medicaid statute by the Medicare Catastrophic Care Act of 1988, and allows states to use more liberal income and resource criteria than those used for the AFDC program to determine Medicaid financial eligibility. By disregarding the additional amounts of income and resources, states can qualify certain categories of populations for Medicaid eligibility who are not statutorily entitled to benefits. Six states—**California, Minnesota, New Mexico, Vermont, Washington,** and **Wisconsin**—indicated that they have expanded eligibility for pregnant women and infants through the 1902(r)(2) provision. Eight states—**Connecticut, Michigan, Minnesota, New Hampshire, New Mexico, Vermont, Washington,** and **Wisconsin**—reported broadening coverage for children under six and twelve states—**Colorado, Delaware, Kansas, Maine, Michigan, Minnesota, New Hampshire, New Mexico, North Carolina, North Dakota, Vermont,** and **Washington**—reported broadening coverage for children older than six through the 1902(r)(2) option of the Social Security Act.

Section 1115 Waivers. In an effort to expand health care coverage to broader populations, the Health Care Financing Administration (HCFA) has granted research and demonstration waivers that permit states more flexibility in designing their Medicaid programs. Many states have used this as a mechanism to move populations into managed care settings, expand eligibility, and modify benefit packages. Section 1115 waivers are time-limited and subject to evaluation. As of September 1995, six states —**Arizona, Hawaii, Rhode Island, Oregon, Tennessee and Minnesota**—had implemented section 1115 demonstration waivers. In addition, HCFA has approved waivers in seven more states—**Delaware, Florida, Kentucky, Massachusetts, Minnesota, Ohio,** and **Vermont**. Although some states will implement programs next year, other states may delay or already have delayed implementation because of uncertainty about the fiscal impact of Medicaid program changes at the federal level. Ten other states—**Alabama, Georgia, Illinois, Kansas, Missouri, New Hampshire, New York, Oklahoma, Utah,** and **Texas**—have submitted proposals that are currently being reviewed by HCFA. Four additional states—**Connecticut, Maryland, New Jersey,** and **Washington**—have initiated discussions among various state agencies to formulate proposals.[1]

[1] For a description of the approved 1115 waivers see the National Governors' Association StateLine--Update: State Progress in Health Care Reform, September 1995.

is more common. Thirty-three states have enrolled or plan to enroll pregnant women and children in Medicaid managed care under 1915(b) waivers while fifteen states have enrolled or plan to enroll special needs children. (See Map 2.)

Enhanced Services to Pregnant Women

In addition to expanding eligibility thresholds for pregnant women and children, as shown in Table 1, states have expanded the range of services available to Medicaid-eligible pregnant women. The October 1994 issue of the ***MCH Update*** provided state-level information with respect to the types of enhanced prenatal care service covered by Medicaid. These services include case management, risk assessment, nutritional and psychosocial counseling, health education, and home visiting. As of October 1994, thirty-seven states were providing three or more of these enhanced services. In addition, several states have established transportation programs to ensure pregnant women have access to services.

Enhanced Prenatal Care Services and Medicaid Managed Care

With the movement towards placing Medicaid recipients into managed care arrangements, states must address the issue as to whether enhanced prenatal care services will continue to be paid for by the Medicaid program. States can include these services within their managed care package (and therefore in the capitation rate); or states can offer these services as a stand-alone service (and pay for these on a fee-for-service basis through providers other than managed care organizations). Policy decisions about the provision of enhanced prenatal care services within managed care arrangements are currently being made. Anecdotal data collected from the states reveals the following trends:

- A majority of those states that have implemented managed care in selected geographic areas have continued to provide enhanced prenatal care services under the Medicaid managed care package. For example, under **Oregon's** statewide 1115 waiver, Medicaid recipients receive case management, risk assessment, nutritional counseling, home visits and other enhanced services.
- A few states which offered enhanced services under fee-for-service Medicaid, offer enhanced services as stand alone services to Medicaid recipients in managed care. For example, **Wisconsin** has implemented managed care and offers case management and risk assessment as stand alone services.
- A few states which offered enhanced services under fee-for-service, contract with managed care providers for some enhanced services and offer others on a fee-for-service basis. For example, **Maryland** requires that risk assessment, nutritional counseling and enhanced health education are included in the Medicaid managed care package. Other enhanced services such as case management, psychological counseling, and home visiting are available from local health departments and other health care providers as stand alone services.

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*The **MCH Update** is produced regularly by the Health Policy Studies Division of the National Governors' Association and is supported through a cooperative agreement with the federal Maternal and Child Health Bureau, Health Resources and Services Administration. This project, entitled "Partnership for Information and Communication," identifies and shares information on innovative strategies used by states to improve health care programs for pregnant women and children. This issue of the **MCH Update** was written by Frank Ullman, Research Assistant. Thanks are extended to Chyrl Andrews and Stephanie Cook for their assistance in preparation of this issue and to many state officials who contributed their time to this research effort. For more information about this MCH Update please call Frank Ullman at (202) 624-5334. For information about other subjects being explored under NGA's Maternal and Child Health projects, please contact Deborah Perry, Project Manager, at (202) 624-5851.*

facilitate enrollment of infants into Medicaid.

Categorical Eligibility for Medicaid

There are several categories of individuals that under current law are eligible for Medicaid. These include families receiving cash assistance under the AFDC program and individuals who are eligible under medically needy programs. Table 3 compares the income limits that determine Medicaid eligibility through AFDC and medically needy programs with the income eligibility levels which result from expansions through OBRA legislation for pregnant women, infants, and children. The range of allowable income for an AFDC family of three ranges from $1,968 to $12,024. For a medically needy family of three, **Vermont** has the highest level for an allowable income, up to 100 percent of the federal poverty line. Among OBRA pregnant women and infants, **Hawaii** has the highest level of coverage, up to 300 percent of poverty level.

Births Paid For By Medicaid

Recent research suggests that the number of Medicaid financed births has increased as a result of Medicaid expansions. Estimates on the number and percent of births paid for by Medicaid in 1993 were provided by states and are listed in Table 4. Blanks indicate that data were not available. The percent of births within a state paid for by Medicaid range from 11 to 54 percent; these data generate a national estimate that is consistent with the common assertion that approximately one-third of all births in the United States are paid for by Medicaid.

Children Insured by Medicaid

One purpose of the Medicaid expansions was to increase the number of children insured by Medicaid. Table 4 presents state responses for the number of children insured by Medicaid in 1993. Children enrolled in Medicaid ranged from 10 to 44 percent of all children within a state. On average, children with Medicaid coverage represent approximately one-fifth to one-fourth of all children within a state. Overall, children represent approximately half of all Medicaid beneficiaries in the United States. However, children represent approximately one-fifth of total expenditures. (See Figures 1 and 2.)

Medicaid Managed Care and Maternal and Child Health

Under current law, if states wish to enroll Medicaid recipients into managed care arrangements, they must seek a waiver from the Department of Health and Human Services. States have the option to apply for two different types of waivers, a Section 1915(b) waiver or Section 1115 waiver.

Section 1915(b) waivers are "programmatic waivers" that were specifically designed to enable states to enroll Medicaid recipients into managed care arrangements by waiving the Medicaid requirement for freedom of choice of providers for recipients. By contrast, Section 1115 waivers allow states broader flexibility than 1915(b) waivers. Section 1115 waivers, if approved, allow states to engage in "experimental, pilot, or demonstration" projects. Under the 1115 waivers, states have enrolled a variety of populations. Many states are enrolling or have proposed to enroll pregnant women and children, children with special needs and other populations through their statewide 1115 waivers. (See Map 1.) Six states—**Arizona, Hawaii, Minnesota, Oregon, Rhode Island,** and **Tennessee**—have enrolled pregnant women and children. Seven states—**Delaware, Florida, Kentucky, Massachusetts, Ohio, South Carolina, and Vermont**—plan to enroll pregnant women and children under statewide 1115 waivers. Three states—**Arizona, Oregon, and Tennessee**—have enrolled children with special health care needs, and two states—**Illinois** and **Massachusetts**—plan to enroll children with special health care needs through statewide 1115 waivers. In addition, many states have enrolled pregnant women and children and children with special health care needs in managed care arrangements through 1115 demonstration waivers that are not statewide. The use of 1915(b) waivers

Streamlining the Eligibility Process

States have not relied exclusively on increasing income eligibility thresholds to improve access to health care. Strategies to simplify and streamline the application process have been incorporated into states' Medicaid programs. These strategies include dropping the assets test, adopting presumptive eligibility, shortening application forms, expediting eligibility determinations, allowing applications to be processed through the mail, and providing continuous eligibility for newborns. (See Table 2.) The information provided reveals that a majority of states have chosen to drop assets tests and shorten application forms for pregnant women, infants and children in an effort to streamline eligibility.

Dropping the Assets Test. As of August 1995, forty-five states and the District of Columbia have adopted the option to disregard assets when determining Medicaid eligibility for pregnant women/infants and/or children.

Adopting Presumptive Eligibility. OBRA '86 gave states the option to allow health care providers to grant pregnant women with immediate, short-term Medicaid eligibility at the provider site while formal determination is made. Called presumptive eligibility, this option is intended to provide immediate access to prenatal care services. Currently, thirty states and the District of Columbia have adopted presumptive eligibility for pregnant women.

Shortening Application Forms. By removing assets restrictions when determining Medicaid eligibility, states have been able to greatly reduce the length and complexity of the Medicaid application form. As indicated in Table 2, forty-two states and the District of Columbia have shortened their Medicaid application forms for pregnant women, infants and children. Similarly, as indicated, many have decided to streamline their application forms for the entire Medicaid population.

Expediting Eligibility Determinations. In an effort to ensure that pregnant women receive early prenatal care, states have developed policies to ensure that the applications of pregnant women are given priority and that their Medicaid eligibility determination is established as quickly as possible. As indicated in Table 2, twenty-nine states and the District of Columbia have programs of expedited eligibility. In some states, informal guidance has been provided to expedite eligibility of pregnant women's applications to their local services offices, but a formal policy has not been implemented.

Allowing Mail-In Eligibility. Allowing applications for Medicaid to be processed through the mail is another strategy used by states to simplify the eligibility process for pregnant women and children. Twenty-five states and the District of Columbia have implemented programs allowing pregnant women and children to mail in their Medicaid applications, waiving the customary face-to-face interview. Mail-in applications reduce transportation and other barriers that may restrict access to care for this group.

Providing Continuous Eligibility for Newborns. With the passage of OBRA '90, states are required to provide continuous eligibility of newborns through the infant's first year of life as long as the infant remains in his or her mother's household. Once Medicaid eligibility is granted to either a pregnant woman or infant, this eligibility cannot be rescinded due to an increase in family income or resources. In order to ensure that infants will be enrolled into the program and receive continuous coverage throughout the first year, many states have developed a referral form that is filled out by the hospital at the time of the birth of an infant to a Medicaid-eligible woman. In most cases, the hospital sends this form to the state or local eligibility office, and a Medicaid identification number is assigned to the infant. As displayed in Table 2, thirty states and the District of Columbia use a referral form to

Table 1
Expanded Medicaid Coverage
for Women, Infants, and Children
August 1995

State	Pregnant Women & Infants		Children Under 6		Children Six and Older		
	Percent of federal poverty level	Mechanism	Percent of federal poverty level	Mechanism	Percent of federal poverty level	Under	Mechanism
Alabama	133%		133%		133%	12[a]	
Alaska	133%		133%		100%	12[a]	
Arizona	140%	1115	133%		100%	14	OBRA '90
Arkansas	133%		133%		100%	12[a]	
California	200%	1902(r)(2)	133%		100%	19	OBRA '89
Colorado	133%		133%		100%	12	1902(r)(2)
Connecticut	185%	OBRA '89	185%	1902(r)(2)	185%	12[a]	
Delaware	185%	OBRA '89	133%		100%	19	1902(r)(2)
D.C.	185%		133%		100%	12[a]	
Florida	185%	OBRA '89	133%		100%	20	OBRA '89
Georgia	185%	OBRA '89	133%		100%	19	OBRA '89
Hawaii	300%	1115	133%	1115	133%	19	1115
Idaho	133%		133%		100%	12[a]	
Illinois	133%		133%		100%	12[a]	
Indiana	150%		133%		100%	12[a]	
Iowa	185%	OBRA '89	133%		100%	12[a]	
Kansas	150%	OBRA '89	133%		100%	15	1902(r)(2)
Kentucky	185%	OBRA '89	133%		100%	19	
Louisiana	133%		133%		100%	12[a]	
Maine	185%	OBRA '89	133%		125%	19	1902(r)(2)
Maryland	185%	OBRA '89	185%	1115	185%	12[a]	1115
Massachusetts	185%		133%		100%	12[a]	
Michigan	185%	OBRA '89	150%	1902(r)(2)	150%	15[a]	1902(r)(2)
Minnesota	275%	1902(r)(2)	133%	1902(r)(2)	100%	12[a]	1902(r)(2)
Mississippi	185%	OBRA '87	133%		100%	12[a]	
Missouri	185%	OBRA '89	133%		100%	19	OBRA '89[b]
Montana	133%		133%		100%	12[a]	
Nebraska	150%	OBRA '89	133%		100%	12[a]	
Nevada	133%		133%		100%	12[a]	
New Hampshire	185%	OBRA '89	185%	1902(r)(2)	185%	19	1902(r)(2)
New Jersey	185%	OBRA '89	133%		100%	12[a]	
New Mexico	185%	1902(r)(2)	185%	1902(r)(2)	185%	19	1902(r)(2)

Table 1
Expanded Medicaid Coverage
for Women, Infants, and Children
August 1995

State	Pregnant Women & Infants		Children Under 6		Children Six and Older		
	Percent of federal poverty level	Mechanism	Percent of federal poverty level	Mechanism	Percent of federal poverty level	Under	Mechanism
New York	185%	OBRA '89	133%		100%	12[a]	
North Carolina	185%	OBRA '89	133%		100%	12[a]	1902(r)(2)
North Dakota	133%		133%		100%	18	1902(r)(2)
Ohio	133%		133%		100%	12[a]	
Oklahoma	150%		133%		100%	12[a]	
Oregon	133%		133%		100%	19	1115
Pennsylvania	185%	OBRA '87	133%		100%	12[a]	
Rhode Island	250%	1115	250%	1115	100%	12[a]	
South Carolina	185%	OBRA '89	133%		100%	12[a]	
South Dakota	133%		133%		100%	12[c]	
Tennessee	185%	OBRA '89	133%		100%	12[a]	
Texas	185%	OBRA '89	133%		100%	12[a]	
Utah	133%		133%		100%	18	OBRA '89
Vermont	225%	1902(r)(2)	225%	1902(r)(2)	225%	18	1902(r)(2)
Virginia	133%		133%		100%	19	
Washington	200%	1902(r)(2)	200%	1902(r)(2)	200%	19	1902(r)(2)
West Virginia	150%	OBRA '89	133%		100%	19	OBRA '89
Wisconsin	185%	1902(r)(2)	185%	1902(r)(2)	100%	12[a]	
Wyoming	133%		133%		100%	12[a]	

Definitions:

1902(r)(2)-Section of the Social Security Act allowing states to use more liberal criteria than those used for the Aid to Families With Dependent Children program to determine Medicaid financial eligibility.

OBRA '89 & '90-Omnibus Budget Reconciliation Acts of 1989 and 1989 mandated/permitted states to expand Medicaid coverage.

1115-Research and demonstration waivers granted by the Health Care Financing Administration that permit states more flexibility in designing their Medicaid programs.

Notes:

[a]Under OBRA '90, states are required to provide Medicaid coverage to children aged 6 or older born after September 30, 1983, with income below the federal poverty level.

[b]Born after June 30, 1979

[b]Children born prior to 10/1/83 are covered through 1902(r)(2)

[c]Born after June 30, 1983

SOURCE: National Governors' Association, 1995

Table 2
Strategies to Streamline Eligibility
August 1995

STATE	DROPPED ASSETS TEST	PRESUMPTIVE ELIGIBILITY	SHORTENED APPLICATION	EXPEDITED ELIGIBILITY	MAIL-IN ELIGIBILITY	NEWBORN REFERRAL FORM
Alabama	X		X	X	X	X
Alaska	X		X	X		
Arizona	X			X		
Arkansas		X				X
California	X	X	X	X		
Colorado	X	X	X		X	
Connecticut	X	X	X	X	X	X
Delaware	X		X	X	X	X
D.C.	X	X		X	X	X
Florida	X	X	X*			X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X		X
Idaho	X	X				X
Illinois	X	X	X		X	X
Indiana	X		X*			X
Iowa		X	X*			X
Kansas	X		X*	X		
Kentucky	X		X			X
Louisiana	X	X	X			X
Maine	X	X	X*		X	
Maryland	X	X	X*		X	X
Massachusetts	X	X	X	X	X	X
Michigan	X		X		X	
Minnesota	X		X	X		
Mississippi	X		X		X	
Missouri	X	X	X	X		X
Montana	X	X		X		
Nebraska	X	X			X	
Nevada					X	
New Hampshire	X	X	X	X	X	X
New Jersey	X	X	X*	X		X
New Mexico	X	X	X	X	X	X
New York	X	X	X			
North Carolina	X	X	X	X	X	X
North Dakota						
Ohio	X	X	X	X	X	X
Oklahoma		X	X*	X		X
Oregon	X		X	X	X	
Pennsylvania	X	X	X	X		X
Rhode Island	X		X	X		X
South Carolina	X		X		X	X
South Dakota	X		X	X		
Tennessee	X	X	X*	X		X
Texas	X	X	X*			X
Utah	X	X	X		X	
Vermont	X		X	X	X	
Virginia	X		X	X	X	
Washington	X		X*	X	X	X
West Virginia	X		X	X	X	X
Wisconsin	X	X	X			X
Wyoming	X	X	X*	X	X	
TOTAL	**46**	**31**	**43**	**30**	**26**	**31**

Note: *States that have developed shortened Medicaid application forms for their entire Medicaid population.

SOURCE: National Governors' Association, 1995

Table 3
Annualized Medicaid Eligibility Thresholds [a]
AFDC, Medically Needy, OBRA Pregnant Women and Infants
August 1995

	AFDC FAMILY OF 3		MEDICALLY NEEDY FAMILY OF 3		OBRA PREGNANT WOMEN AND INFANTS FAMILY OF 3	
STATE	Allowable Income	Percent of Poverty* $12,590	Allowable Income	Percent of Poverty* $12,590	Allowable Income	Percent of Poverty* $12,590
Alabama	$1,968	15.6%	n/a		$16,745	133%
Alaska [b]	12,024	76.4%	n/a		20,934	133%
Arizona	4,184	33.1%			17,626	140%
Arkansas	2,448	19.4%	$3,300	26.2%	16,745	133%
California [c]	7,284	57.9%	$11,208	89.0%	25,180	200%
Colorado	5,052	40.1%	n/a		16,745	133%
Connecticut	6,972	55.4%	9,276	73.7%	23,292	185%
Delaware	4,056	32.2%	n/a		23,292	185%
D.C.	5,040	40.0%	6,720	53.4%	23,292	185%
Florida	3,636	28.9%	3,636	28.9%	23,292	185%
Georgia	5,088	40.4%	4,500	35.7%	23,292	185%
Hawaii [b]	9,056	62.5%	8,544	62.5%	43,470	300%
Idaho	3,804	30.2%	n/a		16,745	133%
Illinois	4,404	35.0%	5,904	46.9%	16,745	133%
Indiana	3,456	27.5%	n/a		18,885	150%
Iowa	5,112	40.6%	6,792	53.9%	23,292	185%
Kansas	5,148	40.9%	5,760	45.8%	18,885	150%
Kentucky	6,312	50.1%	3,696	29.4%	23,292	185%
Louisiana	2,280	18.1%	3,096	24.6%	16,745	133%
Maine	6,636	52.7%	5,496	43.7%	23,292	185%
Maryland	4,392	34.9%	5,100	40.5%	23,292	185%
Massachusetts	6,948	55.2%	12,590	100.0%	23,292	185%
Michigan	6,612	52.5%	6,804	54.0%	23,292	185%
Minnesota	6,384	50.7%	8,508	67.6%	34,623	275% [d]
Mississippi	4,416	35.1%	n/a		23,292	185%
Missouri	3,504	27.8%	n/a		23,292	185%
Montana	6,360	50.5%	5,700	45.3%	16,745	133%
Nebraska	4,368	34.7%	5,904	46.9%	18,885	150%
Nevada	4,176	33.2%	n/a		16,745	133%
New Hampshire	6,600	52.4%	7,824	62.1%	21,403	170%
New Jersey	5,316	42.2%	7,092	56.3%	23,292	185%
New Mexico	4,572	36.3%	n/a		23,292	185%
New York	6,924	55.0%	9,600	76.3%	23,292	185%
North Carolina	6,528	51.9%	4,404	35.0%	23,292	185%
North Dakota	5,172	41.1%	6,060	48.1%	16,745	133%
Ohio	4,092	32.5%	n/a		16,745	133%
Oklahoma	5,652	44.9%	5,500	43.7%	18,885	150%
Oregon	5,520	43.8%	7,356	58.4%	16,745	133%
Pennsylvania	5,052	40.1%	5,604	44.5%	23,292	185%
Rhode Island [e]	6,648	52.8%	8,900	70.7%	31,475	250%
South Carolina	5,280	41.9%	n/a		23,292	185%
South Dakota	6,084	48.3%	n/a		16,745	133%
Tennessee	6,996	55.6%	3,000	23.8%	23,292	185%
Texas	2,208	17.5%	3,204	25.4%	23,292	185%
Utah	6,816	54.1%	6,816	54.1%	16,745	133%
Vermont	7,872	62.5%	10,500	83.4%	25,180	200% [f]
Virginia	3,492	27.7%	4,300	34.2%	16,745	133%
Washington	6,552	52.0%	8,004	63.6%	23,292	185%
West Virginia	2,988	23.7%	3,480	27.6%	18,885	150%
Wisconsin	6,216	49.4%	8,268	65.7%	23,292	185%
Wyoming	4,320	34.3%	n/a		16,745	133%
Average	**$5,333**	**41.8%**	**$6,457**	**51.1%**	**$21,592**	**170.0%**

* The poverty guideline indicated is current for 1995.

SOURCE: National Governors' Association, 1995.

Table 3
Annualized Medicaid Eligibility Thresholds [a]
AFDC, Medically Needy, OBRA Pregnant Women and Infants
August 1995

Notes for Table 3:

a. AFDC and medically needy thresholds are current through August 1995. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the payment standard. In Colorado, Georgia, Kentucky, Maine, Michigan, Mississippi, Montana, North Carolina, Oklahoma, South Carolina, Tennessee, and Utah, the threshold is the state's need standard. Please note, in these thirteen states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' payment standards are actually significantly lower than the eligibility threshold.
b. Poverty guidelines for Hawaii and Alaska differ from other states: Alaska (family of three) = $15,740; Hawaii (family of three) = $14,490.
c. California's Annualized Medicaid Eligibility Threshold for OBRA Pregnant Women and Infants, for a family of three, $25,180 is the amount before income deduction is applied.
d. Minnesota covers pregnant women and infants at 275 percent of the federal poverty guideline (275 percent = $34,623).
e. Rhode Island covers pregnant women and children under 6 yrs. with incomes up to 250% of federal poverty guideline (250 percent = $31,475).
f. Vermont covers pregnant women at 200 percent and children under 18 years old at 225 percent of the federal poverty guideline (225 percent = $28,327.50).

Table 4

Number and Percentage of Births and Children Covered by Medicaid, 1993

State	Births Paid For By Medicaid 1993		Children under age 21 Insured by Medicaid, 1993	
	Number	Percent of Total Births	Number	Percent of all Children
Alabama	28,817	47%	279,138	23%
Alaska	4,200	38%	47,417	23%
Arizona	28,903	42%	291,515	25%
Arkansas	16,464	47%	197,585	27%
California	232,101	40%	2,665,603	27%
Colorado	18,588	34%	240,749	10%
Connecticut	10,710	23%*	190,576	
Delaware	3,231	30%	38,000	
D.C.				
Florida	83,539	44%	1,202,831	27%
Georgia	57,000	51%	643,424	
Hawaii	3,949	20%	68,000	
Idaho	7,225	41%	71,078	20%
Illinois	68,504	36%	1,027,303	29%
Indiana	31,760	39%	357,353	21%
Iowa	11,032	30%	135,634	16%
Kansas	11,702	31%*	160,411	
Kentucky	21,413	40%*	331,629	
Louisiana			366,049**	
Maine	3,536	23%	95,853	27%
Maryland	24,000	32%	279,745	19%
Massachusetts	19,890	24%	498,554	26%
Michigan	56,408	40%	797,050	
Minnesota	19,200	30%	232,000	
Mississippi	23,433	42%	320,201	37%
Missouri	24,200	39%	354,743	23%
Montana	4,271	38%	72,961	29%
Nebraska	7,979	34%	103,720	21%
Nevada	5,984	25%	49,864	
New Hampshire	1,700	11%	45,936	
New Jersey	35,058	29%	447,272	21%
New Mexico	15,181	54%	158,800	32%
New York	108,791	38%	1,717,353	30%
North Carolina	46,251	45%	550,094	27%
North Dakota	2,639	30%	30,950	14%
Ohio	53,714	34%	932,816	33%
Oklahoma	21,297	46%*	188,691**	
Oregon			167,864**	
Pennsylvania	42,939	26%	902,629	
Rhode Island	4,000	28%	70,000	29%
South Carolina	25,981	46%	286,749	25%
South Dakota	3,375	34%	47,702	21%
Tennessee	37,215	48%	529,331	36%
Texas	154,717	48%	1,700,084	28%
Utah	11,933	33%	123,966	16%
Vermont	2,486	33%	43,411	29%
Virginia			284,210**	
Washington	30,965	39%	297,000	20%
West Virginia	11,593	54%	234,304	44%
Wisconsin	24,759	35%	331,196	21%
Wyoming	3,065	47%	34,976	21%

Notes: These are state self-reported estimates based on their own data and methodology.

Blanks indicate data not available.

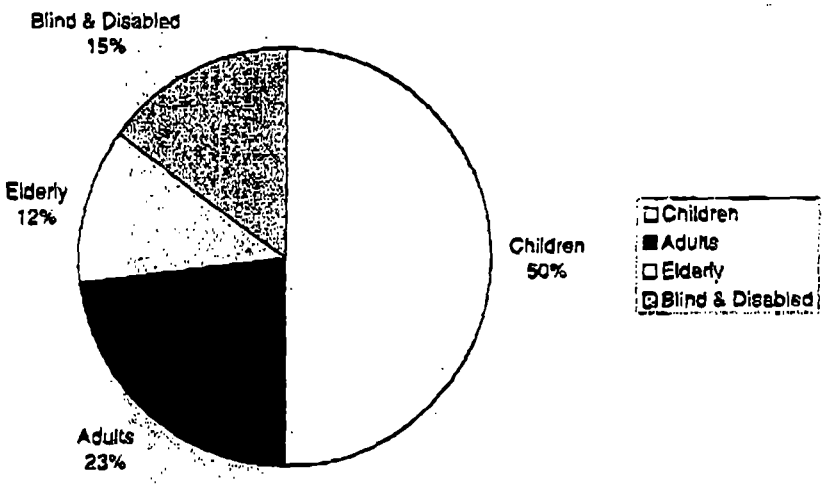
*Percentage calculated by the National Governors' Association based on 1993 natality statistics compiled by the National Center for Health Statistics.

**Numbers derived from HCFA 2082 data.

SOURCE: National Governors' Association, 1995

Figure 1

Medicaid Beneficiaries, 1993

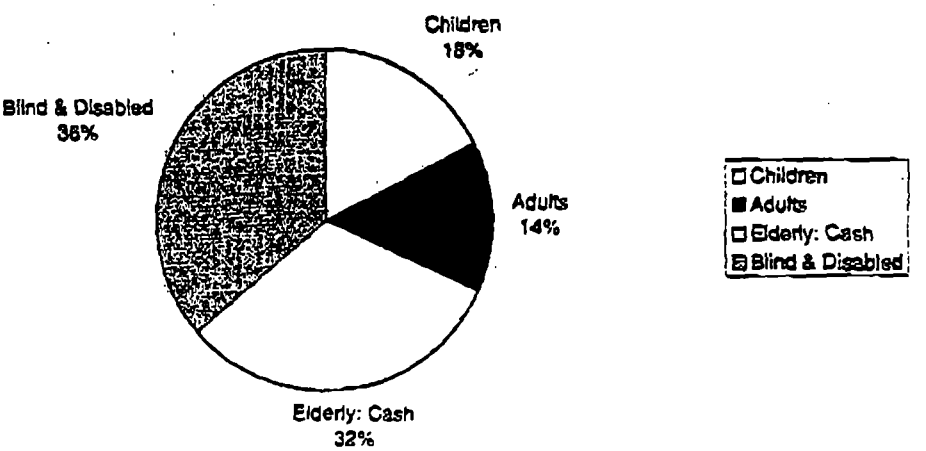


Source: Urban Institute analysis of HCFA data, 1994

The Kaiser Commission on the Future of Medicaid

Figure 2

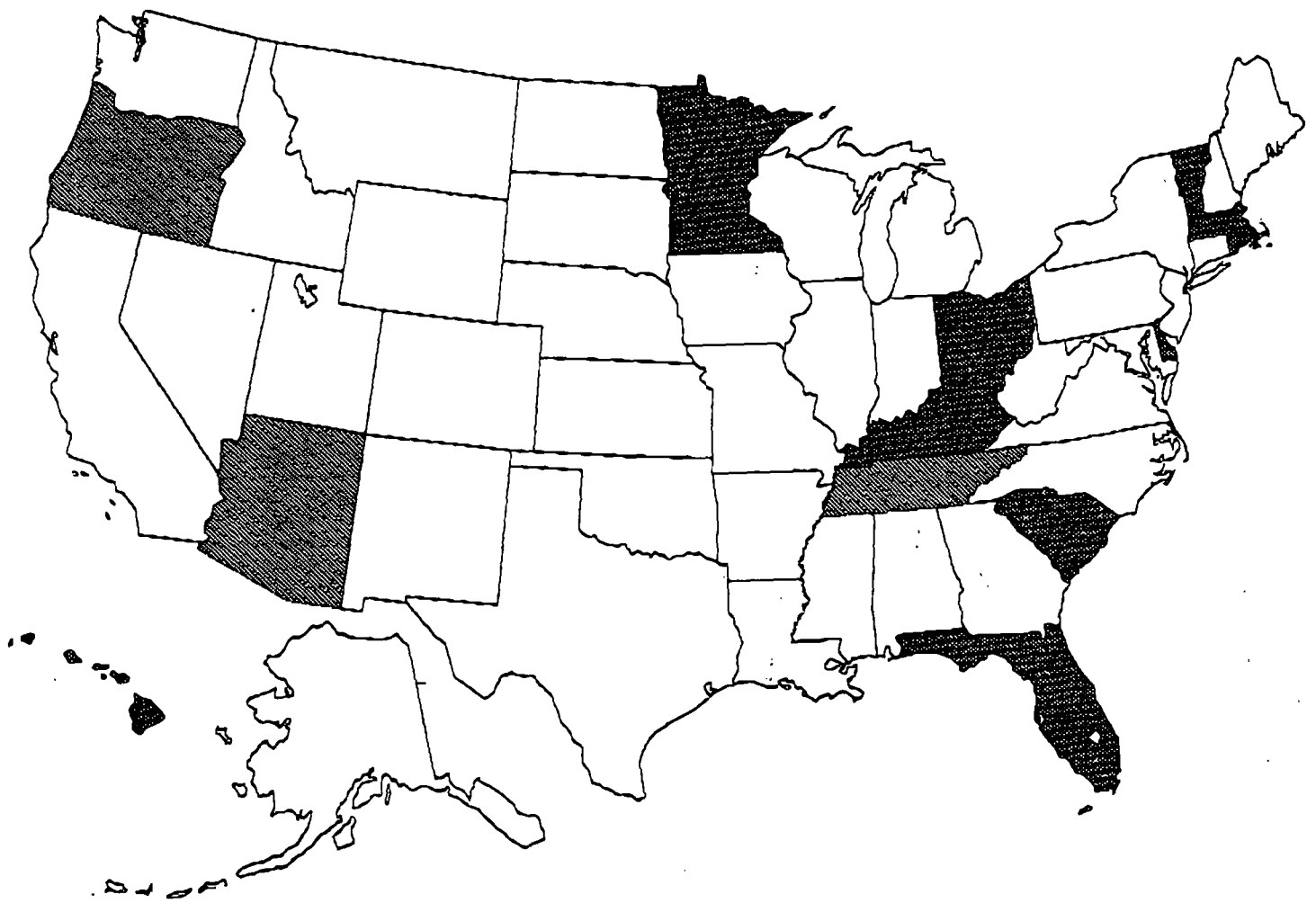
Medicaid Expenditures*: By Beneficiary Group, 1993



*Expenditures do not include special payments to disproportionate share hospitals.
Source: Urban Institute analysis of HCFA data, 1994.

The Kaiser Commission on The Future of Medicaid

MAP 1: Selected 1115 Waivers Affecting MCH Populations



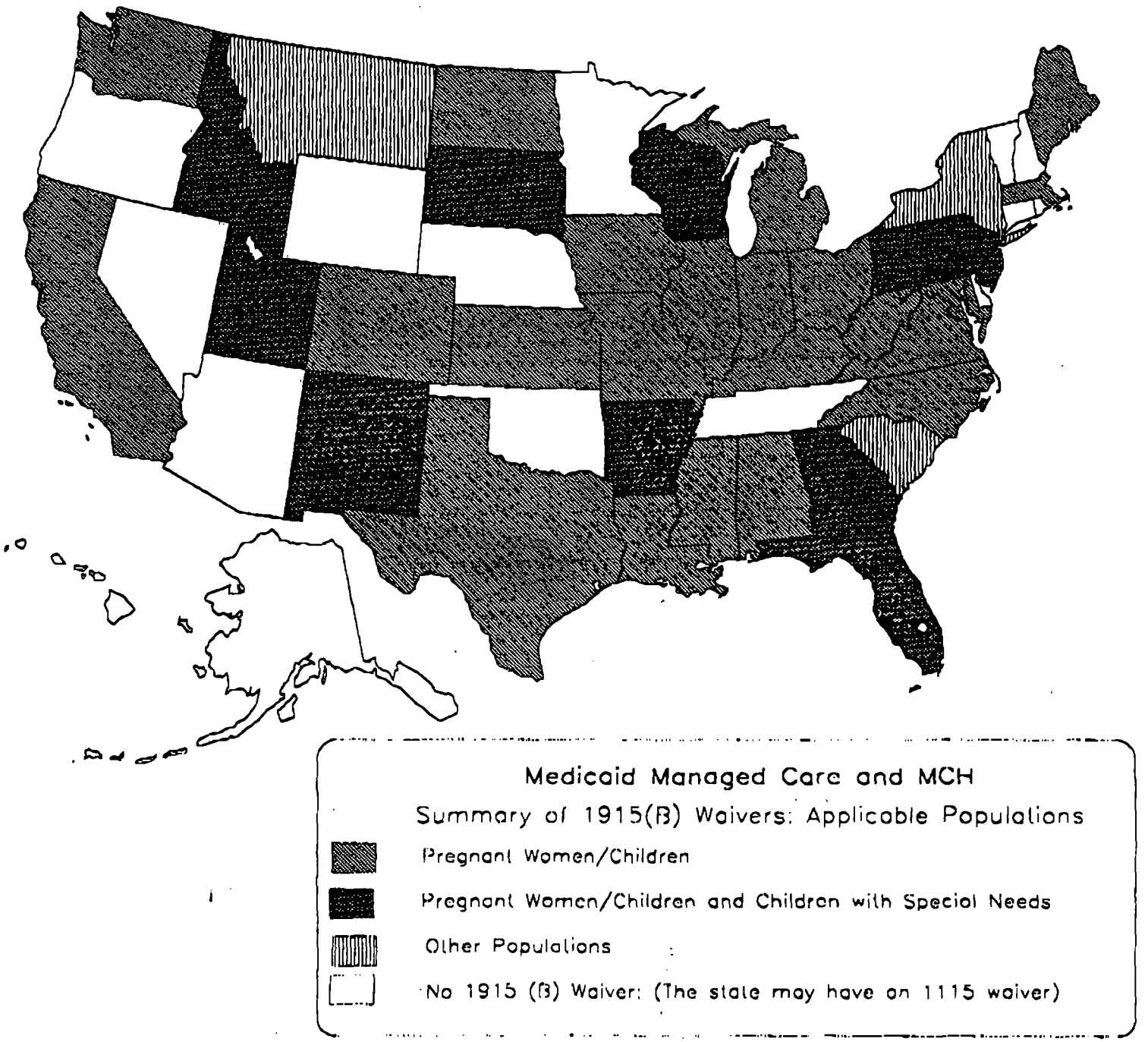
Medicaid Managed Care and MCH
Summary of Selected 1115 Waivers Affecting MCH Populations

- Pregnant Women/Children
- Pregnant Women/Children and Children with Special Needs

Note: AZ, HI, MN, OR, RI, TN are implementing their 1115 waivers; DE, IL, KY, MA, OH, SC, and VI have approved waivers that have not yet been implemented.

Source: Information was adopted from Medicaid Managed Care: A Guide for States produced by the NATIONAL ACADEMY for STATE HEALTH POLICY (February 1995) and materials provided by HCFA current 9/19/95.

MAP 2: 1915(B) Waivers Affecting MCH Populations



Note: All waivers except New Jersey's had been approved as of February 1995.

Source: Information was adapted from Medicaid Managed Care: A Guide for States produced by the NATIONAL ACADEMY for STATE HEALTH POLICY (February 1995)

The Governors' Medicaid Proposal

CENTER ON BUDGET AND POLICY PRIORITIES

March 1996

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Richard Kogan
Cindy Mann

CENTER ON BUDGET AND POLICY PRIORITIES
Washington, D.C.

The **Center on Budget and Policy Priorities**, located in Washington, D.C., is a non-profit, tax-exempt organization that studies government spending and the programs and public policy issues that have an impact on low-income Americans. The Center is supported by foundations, individual contributors, and publications sales.

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March 1996

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ISBN 1-57291-012-7

Contents

Tables

Acknowledgments

The authors wish to thank their colleagues at the Center on Budget and Policy Priorities who contributed to this report. Robert Greenstein and Isaac Shapiro offered analytical and editorial advice. Betty Hitchcock and Wendy Burnette prepared the document for publication.

The Center on Budget and Policy Priorities thanks the Carnegie Foundation for making this work possible.

The authors claim sole responsibility for the contents of the report.

I. Overview

The Medicaid proposal adopted by the National Governors' Association makes some improvements in the Medicaid block grant approved by Congress but also has many troubling elements. By creating incentives for states to withdraw large amounts of state funding, the plan could result in total program reductions at least *three times as deep* as the federal reductions by themselves. In addition, the plan leaves some groups of poor children and adults without a guarantee of coverage and grants states sweeping discretion to scale back the health services that Medicaid covers. In combination, the increased incentive for states to withdraw Medicaid funding and the broad discretion granted to states over eligibility and benefits is likely to lead both to a substantial reduction in the number of people insured and to erosion in the health services covered for many of those who remain insured.

To begin with, the governors' plan would eliminate the federal guarantee of coverage to substantial numbers of people now protected by the program. Most of the basic decisions concerning coverage for poor children over age 12, low-income parents, and disabled people would be left to state discretion.

States also would decide the amount, duration, and scope of the health services covered for persons insured under the program, without any meaningful federal standards or guidelines. State discretion over the health services covered would be so vast as to allow states, for example, to deny vision and hearing care to children or to restrict coverage of hospital care for people with chronic illnesses to only a few days per month. In other examples, a state could decline to cover all necessary laboratory tests for an elderly individual who has suffered a stroke or to pay for the cost of medical equipment such as a walker.

The removal of federal standards in these areas is especially significant in light of other parts of the governors' plan that would allow states to reduce state Medicaid

funding sharply. States would be able to withdraw $182 billion to $214 billion in state funds over seven years without affecting the level of federal Medicaid funding they receive. By contrast, under current law states cannot withdraw state funding without triggering at least a dollar-for-dollar reduction in federal funds. The ability of states to scale back Medicaid eligibility and benefits and reap 100 percent of the savings makes state actions to reduce the health insurance that Medicaid provides more likely.

Aggravating this situation are aspects of the governors' proposal that would make legal the types of sham financing schemes that a growing number of states were using until Congress and the Bush and Clinton Administrations outlawed them in the early 1990s. These financing mechanisms would enable states to meet state matching requirements without actually providing the requisite amount of state funds. States taking advantage of these financing gimmicks in coming years could reduce state Medicaid contributions still further without jeopardizing federal funds. As a consequence, the potential reduction in state funding under the governors' proposal could be even greater than $182 billion to $214 billion.

The funding structure the governors' plan would establish also has other shortcomings. Under the plan, if enrollment of certain groups of beneficiaries increased above projected levels because of such factors as population growth or an economic downturn, states could receive additional federal payments from an "umbrella" fund. This fund reflects the laudable goal of creating a financing system in which federal dollars "follow the people." But there are problems with the fund's design. For example, the umbrella payments, as well as the basic block grant payments, would not respond to increases in inflation that cause state health care costs to be higher than anticipated.

In addition, the governors' proposal is structured in a manner that would allow states to "game" the system and access federal umbrella funds in unwarranted circumstances. This feature of the governors' proposal is likely to reduce federal savings; partly because of it, the level of federal savings that would result from the proposal is likely to be lower than the level of savings that either the Administration's proposal or the current Republican budget proposal would generate.

Another problem with the governors' plan is that it ends basic legal protections which now are part of Medicaid. The plan would repeal current Medicaid law without providing any assurance that provisions of current law banning providers from billing Medicaid patients, protecting beneficiaries from unaffordable cost-sharing requirements, and prohibiting discrimination against certain groups of beneficiaries based on their medical condition would be maintained. In addition, the plan makes clear that neither beneficiaries nor providers could turn to federal courts to enforce any rights the new federal law might provide.

Medicaid is a complex program under which financing provisions and coverage and benefit rules interact in ways that determine whether vulnerable people are assured adequate health care coverage. It is possible to broaden state flexibility substantially and achieve significant savings without weakening the health care safety net if care is taken to balance various interests and goals. But the governors' plan does not achieve such a balance. It primarily serves the interests of state governments by guaranteeing states a certain level of federal payments, allowing states to withdraw large amounts of state funds without losing any of this federal money, letting states scale back Medicaid eligibility and benefits, and denying recipients and providers access to federal court.

The likelihood that a substantial number of states would take advantage of opportunities to withdraw state funds, coupled with the great latitude states would have to scale back Medicaid benefit packages and to end coverage for certain groups of beneficiaries, creates a large risk that health insurance for vulnerable populations would be materially weakened. Under the plan, millions of poor children, parents, and disabled and elderly people are likely either to become uninsured or inadequately insured.

II. The Limits of the Coverage Guarantees

The following groups of people would be guaranteed coverage for some health care services under the governors' plan:

- Pregnant women and children under age six with incomes below 133 percent of the federal poverty line;
- Children aged six through 12 with incomes below 100 percent of the federal poverty line;
- Elderly people with incomes and assets below the Supplemental Security Income standards; and
- Medicare beneficiaries with incomes below 100 percent of the federal poverty line. These beneficiaries would receive coverage for payment of Medicare copayments, deductibles and premiums.

Several other groups of people now guaranteed coverage under Medicaid, however, would lose that guarantee.

Poor Children over Age 12

Under changes enacted in 1990 with bipartisan support and signed into law by President Bush, Medicaid coverage for older poor children is being phased in so that by 2002, all poor children under age 19 will be covered. The governors' proposal would repeal the coverage guarantee being phased in for poor children over age 12.

Coverage of older poor children would be optional with the states (except for some children with ties to the welfare system; see the next section). As a result, states could deny coverage to large numbers of poor children over age 12. For example, they

could limit coverage to children below a certain age (such as 14) or to children with incomes below some fraction of the poverty line.

The principal group that would lose assurance of coverage consists of poor children over 12 whose parents work at low-wage jobs that do not offer health insurance for dependents. Three million poor children over age 12 in non-welfare families could be denied coverage because of this repeal.

Another feature of the governors' plan makes it likely that many states will think twice before extending coverage to poor children over age 12. Under the plan, an umbrella fund would be created to provide additional federal payments to a state when the number of Medicaid beneficiaries in the state exceeds the number forecast at the time of the legislation's enactment. But the umbrella fund has a gap — children over 12 whom a state opted to cover would not be counted when a state's umbrella funding level is determined.

This means that whether or not a state elects to cover children over 12 in working poor families *has no effect on the level of federal Medicaid a state receives.* Both the "basic grant" the state would receive and umbrella funding it would get would be unaffected by whether a state chooses to cover none, some, or all of these poor children.

Moreover, if a state decided to cover working poor children and enrollment of these children then exceeded expectations — perhaps because child poverty rose in the state — the umbrella fund would offer no help. States that chose to enroll poor children over age 12 consequently would assume *all* of the risk of higher-than-anticipated enrollment themselves. This would likely discourage states from picking up this option.

The exclusion of these children from the umbrella funding mechanism stands in contrast to the treatment of other groups. The umbrella fund would cover beneficiary growth among groups of elderly and disabled people that states elected to cover, as well as among groups of elderly and disabled people that states were required to cover. For children and pregnant women, however, the umbrella fund would cover only those whom states were mandated to cover. Groups such as children over age 12 in working poor families would be left out.

Children and Parents Who Receive AFDC

The problem caused by eliminating the coverage guarantee being phased in for poor children over age 12 is compounded by the changes proposed for families that qualify for Medicaid based on their receipt of AFDC benefits. Under current law, all children and parents who receive AFDC are automatically eligible for Medicaid. Under the governors' plan, however, states could disenroll many of these children and parents. While a state could opt to continue covering children and parents whose

income and assets are below the state's current AFDC standards, the state could instead elect either of the following two options:

- to restrict Medicaid eligibility in states in which the AFDC eligibility criteria are above the national average by lowering the state's Medicaid income and asset limits to the current national average limits in AFDC. The current national average AFDC income limit for a family of three is $399 per month, or just 38 percent of the poverty line. More than half of the children over age 12 who receive Medicaid based on AFDC eligibility — 53 percent — live in states with AFDC income limits above the national average; or

- to cover only those parents and children who qualify for the new program a state creates under its welfare block grant. These programs are likely to have much more restrictive criteria than the current AFDC program in many states. Under the welfare block grant, states would have unlimited discretion to restrict eligibility, and no federal minimum eligibility standards would apply.

If most states adopted either of these latter two options, millions of children and parents would lose Medicaid coverage. For example, in a state choosing the last option, those parents and older children who would be ineligible for welfare due to time limits or other restrictive welfare rules that a state adopted would lose Medicaid coverage.

Currently, four million parents and 1.5 million children receive Medicaid on the basis of their eligibility for AFDC. (These 1.5 million children are in addition to the three million children over age 12 in *non*-AFDC families who will be eligible for Medicaid under current law when coverage guarantees for poor children are phased in fully.)

People With Disabilities

Under the governors' proposal, there would be no federal definition of disability and no minimum income or asset standards for persons with disabilities. A state could limit coverage for disabled people in whatever way it saw fit.

For example, a state could limit coverage to people who reside in state institutions or whose disabilities are life-threatening. States also could restrict eligibility to disabled individuals with incomes well below the poverty line. States thus could eliminate the current link for the disabled between Medicaid coverage and eligibility for the Supplemental Security Income program. In some states, significant numbers of low-income individuals sufficiently disabled to receive SSI could lose Medicaid coverage.

States would have strong incentives to restrict eligibility for disabled people since they are a rapidly growing and high-cost group to insure. The Congressional Budget Office projects that under current law, the increase in disabled beneficiaries will account for about 45 percent of the projected growth in overall Medicaid costs between 1995 and 2005.[1] Six million people are now enrolled in Medicaid because of their disabilities.

The governors' proposal does contain a "set-aside" requirement that would direct states to spend a certain percentage of their Medicaid funds on the disabled.[2] But if states reduce overall Medicaid expenditures as the governors' proposal would allow (see Chapter III), Medicaid resources devoted to the disabled in 2002 could be 38 percent to 43 percent below what is projected under current law.[3] States could reduce coverage for the disabled sharply and still meet the set-aside requirement.

A Guarantee of What?

While the governors' proposal guarantees coverage for certain categories of people, it repeals virtually all federal standards relating to the health services that states must cover under their Medicaid programs. Under the proposal, a state would have to offer *some* hospital care, physician services, home health care, laboratory services, and other specified benefits to people the state is required to cover.[4] But all current rules on the *amount, duration, and scope* of the health care services that must be covered would be dropped.[5]

---

[1] Statement of Joseph R. Antos, Assistant Director for Health and Human Resources, Congressional Budget Office, before the U.S. House of Representatives Committee on Commerce, June 21, 1995.

[2] The set-aside requirement equals "90 percent of the percentage of total medical assistance funds paid in fiscal year 1995 for persons with disabilities." For example, if 28 percent of total Medicaid spending in a state in fiscal year 1995 was devoted to the disabled, then in future years at least 25 percent (90 percent of 28 percent) of Medicaid spending in that state would have to be earmarked for the disabled. (This example is used because in fiscal year 1995, some 28 percent of Medicaid dollars nationwide were spent on services for the disabled.)

[3] These percentages are consistent with reductions in overall state Medicaid funding of $182 billion to $214 billion over seven years, as discussed in the state funding section.

[4] Under current law, certain benefits are considered mandatory while others are optional. States currently must provide *all* categories of persons covered under the program with all mandatory benefits. By contrast, under the governors' plan, states would only have to provide the categories of people they are required to enroll with the mandatory categories of services (i.e., some hospital care, physician services, etc.) There would be *no* federal benefit rules applied to optional categories of people, such as poor children over age 12.

[5] States already have considerable flexibility in defining benefit coverage as long as "Each service (is)

(continued...)

People guaranteed coverage under the plan thus may find the guarantee a hollow one. All of the rules regarding what hospital care, physician services or other services must be covered would be left up to the states, with no minimum federal standards. A state could choose to offer only a skeletal benefit package to any or all groups of beneficiaries.

A state seeking to reduce state expenditures for Medicaid could impose annual or lifetime limits on hospital utilization or limit coverage for hospital care to only a few days per month. In an extreme case, a state could guarantee only several days of hospital care in the event of a heart attack. A state also could limit expenditures for prescription medications to a level below what a significant number of chronically ill or disabled people need.[6]

If mid-year fiscal pressures arise, a state could scale back the health services it covers for new applicants as compared to the services covered for the people already enrolled in the program.[7] Large differences among states in Medicaid benefit packages almost certainly would emerge in the absence of federal minimum standards.

This, in turn, would increase the risks of the "race to the bottom" about which many analysts have warned. Without federal standards, policymakers in a state may become concerned that having a more generous benefit package than neighboring states will attract people from those states. As a result, major reductions in Medicaid services by one state could trigger reductions by others, setting in motion a downward spiral in the adequacy of the health care coverage that Medicaid provides.

The governors' proposal also would substantially modify current federal requirements concerning the treatment services that must be made available to poor children; it would restrict the rules governing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) component of Medicaid. Under current law, children found to be suffering from a medical problem detected during a routine screening must be provided with the treatment necessary to address the problem. The governors' proposal would greatly scale back this treatment guarantee for children by

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[5] (...continued)
sufficient in amount, duration, and scope to reasonably achieve its purpose," 42 C.F.R. sec. 440.230(b). Thus, under current law, services do not have be sufficient to meet every person's needs, but services must be of sufficient amount, duration and scope to assure that most of the eligible people receive the amount of services they need. State-imposed limits on services have been approved by HCFA and upheld by the courts.

[6] Currently, prescription medications are an optional service, although all states cover prescriptions for most of their Medicaid beneficiaries. Even though the service is optional under current law, states electing to provide this service must follow federal amount, scope and duration rules.

[7] Maryland Governor Parris Glendening has already stated that this approach might be taken in Maryland, projecting that managed care savings will not be sufficient to offset anticipated reductions in federal Medicaid payments under a block grant. *Maryland FY97 Budget, Budget Priorities, p. 20.*

allowing states to provide only whatever level of treatment is otherwise available under the state's Medicaid plan. Since there would no longer be any meaningful federal rules governing the benefits provided under a state's plan, this proposed change in EPSDT rules would leave poor children with serious medical problems without assurance they would receive the treatment their physician recommends. Without a guarantee of treatment, the EPSDT screening requirements that would be retained in the governors' plan are likely to be of little value.

In addition, the plan could weaken the benefit coverage provided to poor Medicare beneficiaries. Under current law, Medicaid pays the *Medicare* copayments, premiums, and deductibles for those Medicare beneficiaries whose income is below the poverty line.[8] The governors' plan would weaken this coverage for low-income Medicare beneficiaries by allowing states to limit payments for Medicare copayments to the rates the state pays under Medicaid. For example, if a Medicare beneficiary were required to pay a 20 percent copayment on physician charges set at $5,000 based on Medicare rates, and under *Medicaid* rates the physician charges were limited to $4,000, Medicaid would cover only $800 of the $1,000 copayment (i.e., Medicaid would pay 20 percent of $4,000 rather than 20 percent of $5,000). It is unclear whether poor Medicare beneficiaries would have to pay the difference between the state's Medicaid payment and the Medicare charges (in this example, $200) or whether providers would be expected to absorb the uncovered portion of their fees.

The Effects of Repealing Current Medicaid Law

The governors' plan calls for repealing the existing Medicaid statute (Title XIX of the Social Security Act) without specifying those portions of current law that would be retained. A wholesale repeal of Title XIX could have far-reaching consequences. Provisions protecting beneficiaries from copayment and other cost-sharing requirements they cannot afford could disappear. So could rules prohibiting providers from billing Medicaid patients. A better course of action would be to review Title XIX and eliminate, revise and simplify those provisions of the law that do not comport with the changes that Congress wishes to make to accord states more flexibility.

Ban on Access to Federal Court

Finally, neither beneficiaries nor providers would be able to sue in federal court to enforce any rights the new federal Medicaid law supposedly guarantees them.[9] The

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[8] Medicaid also pays the premium costs, but *not* the copayment and deductible costs, for Medicare beneficiaries between 100 percent and 120 percent of the poverty line.

[9] The plan is silent as to whether it also would prohibit beneficiaries from relying on other federal laws, such as the Americans with Disabilities Act or civil rights laws, to bring certain Medicaid claims into

(continued...)

elimination of the right to seek legal redress in federal court would be unprecedented; no federally established program supported by billions of federal dollars is now immune from suit in federal court. Without access to federal courts, the meaning of federal law would be subject to the differing views of the courts of 50 states, and important remedies that may not be available in state court could be lost.[10]

As a result, there are two reasons why the coverage guarantees in the governors' proposal have less meaning than may initially appear to be the case. Those who are guaranteed coverage are not guaranteed any type of minimum benefit package, and they also are prohibited from bringing suit in federal court if a state violates the federal coverage guarantee.

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[9] (...continued)
federal court.

[10] If Medicaid law is revised to eliminate or substantially limit federal standards regarding provider reimbursement rates, there will be much less litigation under federal Medicaid law in the future. In those limited areas where federal rights would be maintained, access to federal courts should be maintained as well.

III. Effects of the Governors' Funding Mechanisms

This chapter examines the funding structure of the governors' proposal. One important aspect of the governors' proposal is its inclusion of additional federal Medicaid payments to states with larger-than-anticipated Medicaid caseloads. This is a significant improvement over the Medicaid bill Congress passed last fall, which would have established fixed federal block grants that would not have been responsive to unexpected changes in the location, number, or mix of Medicaid beneficiaries.

Nevertheless, there are a number of serious flaws with the governors' funding structure.

1) It could lead to very large reductions in state Medicaid funding, producing substantial cutbacks in the Medicaid benefit package, payments to providers, and/or Medicaid coverage. Reductions in state Medicaid funding could be nearly three times as large as the reduction in federal funding.

   Such large reductions could result in decreased coverage for low-income individuals. They also could result in shifts in costs to local governments that operate city or county hospitals or clinics and to employers and employees who pay premiums for private health insurance policies.

2) States would again be permitted to use discredited — and currently illegal — financing schemes to lessen state contributions to Medicaid.

3) If Medicaid caseloads exceeded expectations in a state or nationally, the federal government would bear a fair share of the added Medicaid costs. But if caseloads fell below expectations, states would collect much or all

of the savings, with the federal government failing to receive a fair share of the reduction in cost.

4) States would be able to "game the system," limiting the efficacy of the proposed caps on federal Medicaid expenditures and enriching their treasuries at federal expense.

These four deficiencies suggest that the funding structure of the governors' proposal is designed to serve state fiscal needs more than federal fiscal needs and also to protect states against unexpected fiscal problems more than to protect poor children, parents, and elderly and disabled people against unexpected health problems. There also is a fifth shortcoming with the financing aspects of the governors' proposal:

5) The caps it would place on federal Medicaid funding would not respond to unexpected changes in the general inflation rate. As a result, the caps would squeeze states too hard if the general inflation rate turned out to be higher than is currently forecast and would treat states too generously (and cost the federal government too much) if inflation was lower than forecast.

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 FMAP is based on state per-capita income; the poorer a state, the higher the federal share of Medicaid costs and the lower the state share. The state shares of Medicaid costs range from 21 percent in the poorest state (Mississippi) to 50 percent in the 12 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 the rates paid to health care providers increase — the federal government pays its share (at least 50 percent) of the additional costs. Similarly, if states reduce Medicaid expenditures, the federal government receives its share (again, at least 50 percent) of the resulting savings.

The Governors' Proposal

The governors' proposal would change current law in three fundamental ways.

- The proposal would set a ceiling or "cap" on federal Medicaid payments for each state. (See box at bottom of the page.) Once federal payments reached the ceiling, the federal government would cease providing funds, and a state would bear in full any additional costs incurred. The federal cap would be set at a level below what federal Medicaid expenditures are projected to be under current law. Therefore, the amount of matching funds that a state would have to put up to secure its maximum federal funding allotment also would be less than the amount the state would be expected to contribute under current law. As a consequence, states could reduce projected state Medicaid contributions without affecting the amount of federal funds they receive.

- In addition — and of particular importance — the NGA proposal would reduce state matching percentages for at least 25 states. All states that currently pay *more than* 40 percent of Medicaid costs would have to pay at most 40 percent of such costs.

  For example, a state now bearing 50 percent of Medicaid costs would instead have to pay 40 percent of such costs. This means a state that has a 50 percent matching rate and now provides $3 in state funds for each $3 in federal Medicaid payments it receives would instead have a 40 percent match rate and be required to provide just $2 in state funds for each $3 in federal funds.

The Cap on Federal Medicaid Payments

The proposed cap on federal payments to a state would equal the sum of: a) the "basic grant" to the state (which would equal federal Medicaid expenditures in the state in a base year, increased in accordance with a growth formula written into the statute); and b) "umbrella" payments made to a state to cover unanticipated caseload growth (that is, caseload growth that was not anticipated and not built into the growth formula used to determine the state's basic grant).

The federal umbrella payments would be paid to states on a per beneficiary basis. They would be open-ended in that no limit would be placed on the number of additional beneficiaries for whom umbrella payments would be made. But in another sense, the umbrella payments would be capped — the *amount* of the umbrella payment for each additional beneficiary served would be determined by a formula written into the statute, not by the state's actual costs in serving the beneficiary. The umbrella payments would not cover unlimited costs for the additional beneficiaries.

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. (The NGA proposal is unclear on whether matching rates also would be reduced for states whose *current* matching rates are below 40 percent. The Medicaid part of the budget reconciliation bill that Congress passed last fall would have lowered the matching rate requirement for many of those states as well.)[11]

- Third, the governors' proposal 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 mechanisms 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 $50 million in federal matching funds. Making such financing schemes legal again would enable states to *appear* to meet state matching requirements without really spending the requisite amount of state money on Medicaid benefits.[12]

Potential Reductions in State Medicaid Funding

How deep could reductions in Medicaid funding be under the governors' proposal? Several factors are at work here.

First, consider the effect of capping federal Medicaid payments. If federal payments are capped, a state would have to decide whether to contribute more than the

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[11] The Administration's Medicaid proposal does not include a reduction in state matching requirements. Neither did the Budget Resolution that Congress approved in June. The reconciliation bill Congress passed did, however, reduce state matching requirements. It lowered the maximum state matching percentage to 40 percent, as the NGA proposal would. This change by itself would lower the *average* state share of Medicaid costs from its current level of 43 percent to 38 percent. The reconciliation bill also changed some factors used in calculating state matching percentages to reduce below 40 percent the matching percentage for some states whose current matching rates exceed 40 percent, and to reduce to still lower levels the matching rates for 12 states whose current rates already fall below 40 percent. Overall, the reconciliation bill would lower the average state share of Medicaid costs from 43 percent to 37 percent.

[12] The budget reconciliation bill that Congress passed also would have repealed the prohibitions against these financing schemes. The Medicaid proposal in the Administration's budget would not repeal current prohibitions on the use of such schemes.

amount needed to draw down its full federal payment. If it did so, a state would be contributing state dollars for which it received no matching federal payments.

Since there would be no requirement for a state to contribute unmatched dollars, many states likely would reduce their state contributions to the minimum level that would secure their full federal payment. This would result in state funding reductions relative to what states are projected to spend under current law, on top of the federal funding reductions.

A second factor driving potential reductions in state Medicaid funding is the proposed reduction in state matching percentages. Suppose a state whose current matching rate is 50 percent receives federal Medicaid payments of $6 billion. Under current law, the total size of the state's Medicaid program would be $12 billion — the $6 billion provided by the federal government plus $6 billion provided by the state. Suppose, however, the federal payment was capped at $6 billion and the state matching share was reduced from 50 percent to 40 percent, as NGA proposes. State contributions could drop to $4 billion. Total Medicaid funding could decrease from $12 billion to $10 billion.

Table 1

The Effect of Reducing the State Matching Rate

	Existing law	NGA proposal
Federal share	$6 billion (50%)	$6 billion (60%) (amount capped)
State share	$6 billion (50%)	$4 billion (40%)
Total funding level	$12 billion	$10 billion

Now, combine the effects of these two factors. Suppose a particular state would secure $7 billion in federal Medicaid funds under current law, matched by $7 billion in state funds. Suppose also that NGA's new federal cap would reduce federal funding for the state from $7 billion to $6 billion. And suppose the state's matching rate was reduced from 50 percent to 40 percent, allowing the state to reduce its contribution to $4 billion without losing any federal funds. The total resources available to the Medicaid program in the state could shrink from $14 billion to $10 billion, producing an overall reduction in funding for the state's Medicaid program of 29 percent.

Table 2

Capping and Cutting Federal Payments; Cutting the State Share

	Existing law	NGA proposal
Federal share	$7 billion (50%)	$6 billion (60%) (amount capped)
State share	$7 billion (50%)	$4 billion (40%)
Total funding level	$14 billion	$10 billion

In short, the combined effect of the federal caps and the reductions in state matching rates contained in the governors' proposal would be to facilitate very deep reductions in state Medicaid funding. This, in turn, raises a related question. To reduce state funding this much, states must be able to reduce substantially the cost of their Medicaid programs. Could they do so?

Under the governors' proposal, the answer is "yes." The proposal allows states to take an array of actions to shrink Medicaid coverage and reduce costs. States would be able to scale back the health services their Medicaid program covers to whatever degree they wish. They also could define "disability" narrowly and reduce the costs of insuring the disabled population. Furthermore, states would be free to narrow Medicaid coverage both for poor children over age 12 and for parents in welfare families. States also would be able to reduce the fees paid to medical care providers to the extent politically feasible.

In other words, states would have the ability to reduce Medicaid expenditures

Using the "Savings" to Expand Coverage

Some governors have suggested the proposed reduction in state matching requirements is desirable because states could "use the savings to expand Medicaid coverage for uninsured workers." This is not the case; reducing state matching requirements cannot assist states in covering uninsured workers. To the contrary, it would make such coverage expansions less likely and reductions in coverage more likely.

Reducing state matching requirements, as the governors propose, would enable states to reduce their contributions for Medicaid without causing federal contributions to increase. The result would be to lower the total amount of resources available to Medicaid.

A reduction in resources would necessitate reductions in the number of people covered, reductions in the health services for which beneficiaries are insured, reductions in the amount that providers are paid for their services, or some combination of such actions. By definition, a reduction in total Medicaid resources does not provide new resources to cover more people.

quite sharply, enabling a state to provide no state funding beyond the amount needed to secure its full federal Medicaid contribution. In assessing whether states would pursue such a course, it should be noted that state treasuries would get 100 percent of the savings from such Medicaid cutbacks; the federal government would get none. This differs dramatically from the situation under current law, where a state keeps between 20 cents and 50 cents of each dollar saved from Medicaid cuts, depending on the state.

How Much Might Total Medicaid Funding Be Reduced?

The governors' proposal does not specify the precise amount of federal Medicaid savings it seeks to achieve. Several governors have suggested that total federal cuts over seven years should fall between $59 billion — the amount in the President's 1997 budget — and $85 billion, the amount in the Republican Congressional leadership's January budget offer.

On this basis, it is possible to calculate the amount of federal, state, and total reductions in Medicaid funding that could occur under the NGA proposal. 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:

- If the seven-year federal funding reduction were $59 billion and state matching requirements were reduced only for states with current matching rates above 40 percent, states could cut their Medicaid contributions $182 billion over seven years. Under this scenario, the total reduction in federal and state funding combined would be $241 billion over seven years. The reduction would grow in depth with each year, reaching 19 percent in 2002.

- If the seven-year federal cut were $85 billion and state matching requirements were reduced in the same manner as under the Congressional reconciliation bill (see footnote 11), states could reduce state funding by $214 billion over seven years. In this case, the total seven-year cut — including both federal and state reductions — would equal $299 billion, reaching 26 percent by 2002. (See Table 3.)

- In both cases, states would be able to reduce state funding more than twice as much as federal funding would be cut. Between 72 percent and 76 percent of the potential Medicaid funding reductions would consist of reductions in state contributions.

It is instructive to contrast the potential funding reductions under the governors' proposal with the funding cuts envisioned last spring in the Congressional budget resolution. The budget resolution called for $182 billion in federal Medicaid cuts and explicitly rejected any changes in the federal/state matching percentages. The federal

Table 3

Potential Reductions in Medicaid Funding
(In billions)

	Minimum		Maximum	
	7-year	In 2002	7-year	In 2002
Federal reductions (net)[13]	$ 59	11%	$ 85	18%
State reductions:*				
-- because of federal cap	$ 48		$ 69	
-- because of FMAP change	$134		$145	
Total state reductions	$182	30%	$214	37%
Grand total reductions*	$241	19%	$299	26%

* Assuming states contribute only the amount needed to draw down the maximum federal payment to which they are entitled.

[13] The exact level of a new "special" grant for undocumented aliens, which is part of the governors' proposal, makes a small difference in the size of the potential state and total funding reductions because the aliens grant would be exempt from state matching requirements. If the *net* federal cut is $59 billion and the new aliens grant is $3.5 billion, the *gross* federal cut is $62.5 billion. It is the gross cut that determines the size of the potential reductions in state matching payments.

The NGA did not specify the size of the aliens grant. An aliens grant of $3.5 billion is assumed here as part of the $59 billion net federal reduction. An aliens grant of $6 billion is assumed as part of the $85 billion net federal cut. The $3.5 billion figure reflects the size of the aliens grant in the reconciliation bill. The $6 billion figure is the size of the aliens grant in the "Medigrant II" proposal, which House Commerce Committee staff circulated on the eve of the NGA meeting as part of a proposal to achieve $85 billion in federal Medicaid savings and which formed part of the basis of the NGA plan.

reductions of $182 billion proposed at that time would have produced a potential total funding reduction of $320 billion over seven years, taking state reductions into account. This means that, while proposed federal funding reductions would be less than half as deep as they were last spring, the total Medicaid funding reductions that would result from the governors' plan is nearly as large as the total cut that could have occurred under the original Congressional plan. (See Table 4; also see Appendix B for a

Table 4

Potential Reductions in Medicaid Funding — Then and Now
(1996 - 2002, in billions)

	Federal Reductions	Potential State Reductions	Potential Total Reductions
Congressional budget plan (June 1995)	$182	$138	$320
Governors' plan, maximum (Feb. 1996)	$85	$214	$299

description of the data and methodology that underlies the calculations and Appendix C for a listing of current and proposed state matching rates.)

Governors' Plan Likely to Lead to Substantial Cost-Shifting

The Medicaid funding reductions that would occur as a result of the NGA plan would likely lead to substantial cost-shifting. Since the governors' plan could result in as much as $299 billion in federal and state funding reductions over seven years, the degree of cost-shifting could be quite large.

Funding reductions of this magnitude greatly exceed what most experts believe can be achieved through efficiencies and service delivery reforms, such as the greater use of managed care. Such reductions in funding would lead to some combination of: greater numbers of people going without needed care; greater reliance on emergency rooms at city and county hospitals and on other locally operated public health facilities; increases in private-sector health insurance premiums as medical providers who are undercompensated by Medicaid spread their costs; and reduced income for medical providers. The second and third of these scenarios entail cost-shifting to local taxpayers and to those who pay for private-sector health insurance policies, principally employers and employees.

Cost-shifting would occur both because providers would be paid less for the services they perform and because some individuals would lose coverage entirely or for some needed health care services. Some people would go without needed care or pay for care from their own limited resources. Others, however, would use emergency rooms or other "free" providers. As a result, the number of people receiving uncompensated care would increase. (Moreover, in many cases, care likely would be delayed until medical problems became more serious, causing the cost of uncompensated care that ultimately was provided to rise further.)

In the past, when provider payments were squeezed or uncompensated care increased, doctors and hospitals routinely increased the fees they charged to those with private-sector (e.g., employer-based) health insurance. This increase was one reason that health care premiums rose so rapidly in recent decades — individuals with private-sector health insurance paid "too much" to cover shortfalls in Medicare, Medicaid, and uncompensated care. Cost-shifting was one of the factors that prompted some businesses to drop health insurance coverage as premium costs climbed.

In the current environment, providers have less ability to increase charges to the private sector because a growing portion of physician and hospital care is financed through managed care companies. The market power of managed care enterprises makes them able to resist attempts by individual hospitals and doctors to raise prices. Consequently, only a portion of the Medicaid funding reductions that would occur under the governors' plan would likely be cost-shifted to businesses and insured workers.[14]

The increasing difficulty of shifting costs to private-sector insurance plans has two implications. First, if uncompensated care becomes scarcer, a greater number of sick, poor, uninsured people will have difficulty receiving medical assistance. Second, city and county hospitals and other providers of uncompensated care are likely to face a noticeably increased caseload. The cost of that increased caseload will be borne largely by local taxpayers in the form of either tax increases or reductions in other services.

[14] Cost-shifting to private insurance plans is a hidden tax on businesses, working people, and others with private-sector health insurance. Employees bear the brunt of this cost shift; most economists believe that employer-paid costs for benefits such as health insurance are largely passed on to workers in the form of lower wages than they would otherwise be paid.

Bogus Financing Schemes

In one sense, the figures presented here concerning potential state funding reductions are a worst-case scenario; they show the loss of Medicaid funding that would result if no state contributed unmatched dollars to Medicaid. In another sense, however, these figures understate the extent to which state funding could be withdrawn. Reductions in state Medicaid resources could be even deeper if states begin using sham financing schemes to meet a portion of their Medicaid matching requirements. As noted, the governors' proposal would drop all legal bars to the use of such financing schemes.

In the past, a number of states used creative financing schemes to make payments which they could call "Medicaid contributions" but that really were not. For example, a state might impose a special "tax" on a health care provider and then rebate to that provider the amount collected from it. The provider and the state would each be in the same financial position as if this back-and-forth transfer had not occurred. But the state could call the rebate a "Medicaid expenditure" and claim federal matching funds for it.

Similarly, a state might make a special "intergovernmental transfer" from one state entity — for example, a state hospital — to the state Medicaid program and then promptly rebate to the hospital the amount collected from it. The state and the hospital would each be in the same position as if this transfer had not occurred. But here also the state could call the rebate a "Medicaid expenditure" and claim federal matching funds for it. Provider tax rebates and intergovernmental transfers are two versions of the same shell game. Congress largely banned such sham transactions in the early 1990s. The NGA proposal, however, would make them legal again. (See the box on the next page for a more extensive treatment of this issue.)

Until being outlawed in the early 1990s, sham financing was used by some states to extract extra federal Medicaid payments without providing the requisite amount of additional state matching funds. This increased federal costs. Under the governors' proposal, federal payments would be capped, and sham financing consequently would not generate more federal money. Rather, sham financing would allow a state to withdraw even more of its own funding without losing federal dollars. In effect, legalizing sham financing makes state matching requirements meaningless. The result would be a larger reduction in the total resources available to Medicaid for finance health care services, and hence larger cutbacks in the categories of people insured, the types of health services covered, or the payment rates for providers.

"Heads I Win, Tails You Lose"

As described above, under the governors' proposal, the level of federal Medicaid payments to states would be capped. For any state, the cap would equal the state's

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 it has made to the hospitals.

The result is that the hospitals gain $10 million ($50 million in DSH payments less the $40 million in provider taxes), while the state gains $15 million (it receives $25 million in federal matching funds plus $40 million in provider taxes while disbursing $50 million in DSH payments). Thus, 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 cited here because the following example has been documented by GAO and provides a good illustration of how this practice works.

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 was 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 state funds having been expended.

When provider donations were limited by Congress through legislation enacted in 1991 that became effective in January 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. 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 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 is now limited through additional tightening provisions that were enacted in 1993 and took effect in 1994.

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

basic grant (i.e., the level of federal Medicaid expenditures in the state during the base year, increased to reflect a growth factor built into the statute), plus the federal

umbrella payments the state would receive if the actual number of Medicaid beneficiaries in the state exceeded the number reflected in the state's growth factor when the legislation was enacted.[15]

If the actual number of Medicaid enrollees in a state exceeded the number reflected in the growth factor, the cap on federal Medicaid payments to that state would increase accordingly. But if the actual number of enrollees in the state fell below the level assumed in the state's growth factor, the federal cap on payments to the state would *not* decrease. States consequently would be in an enviable position — they would receive more federal funds if beneficiary growth exceeded expectations, but would not receive less funding if beneficiary growth fell short of expectations. The plan thus provides states with an incentive to restrict coverage, since they would lose no federal funds by doing so and all of the savings would accrue to state treasuries.

Moreover, the federal government would have to be able to predict beneficiary growth with perfect accuracy *on a state-by-state basis* to avoid incurring unintended federal costs. If the federal government's prediction of *national* beneficiary growth were perfect, but some state caseloads grew faster than expected while others grew more slowly, the federal government would end up spending more than forecast. In addition, federal payments to states with slower-than-anticipated caseload growth would be more generous than anticipated, raising issues of equity among states. (See box on next page.)

DSH and Bogus Financing Schemes

In recent Congressional hearings, one governor said that repealing the current prohibitions on sham financing should not be a concern. Disproportionate Share Hospital (DSH) payments probably would not exist under the governors' Medicaid proposal, he indicated, and as a result the opportunity for state financing games would disappear.

This conclusion is not correct. In the past, states characterized their rebates of provider taxes or intergovernmental transfers as "Disproportionate Share Hospital payments" to draw down federal matching funds. Under the governors' proposal, this would be not necessary. In fact, there would be a wider, not a narrower, field for such financing scams.

For example, states could impose special "taxes" on HMOs or other large managed care providers covering Medicaid enrollees. States then could rebate those "taxes" to HMOs and characterize the rebates as state Medicaid payments. It would not be necessary to label these rebates as DSH payments to employ these schemes; under the governors' plan, states could make such rebates by using the discretion the plan would give them to establish special rates for certain groups of providers. (Note: rebating "taxes" or "contributions" is easier when the state can deal with a few big entities, such as a few large urban hospitals. Large HMOs could be the vehicles for such financing maneuvers in the future.)

[15] An alternative way of interpreting how the caps would work is provided in Appendix A.

This raises a related issue. If budget estimators at the Office of Management and Budget and the Congressional Budget Office take into account the extent to which state-by-state caseloads may differ from expectations, their estimate of the savings from this one-sided approach to setting federal caps is likely to be small.

This will present Congress with a choice. Congress could settle for lower savings in the Medicaid area. The result would be weakened health care coverage for millions of low-income Americans and very small federal savings. Alternatively, Congress could reduce the basic grants and federal spending caps for *all* states to make up for the lost savings. Such an approach, however, would penalize states whose caseload levels equaled or exceeded the anticipated level — and would likely require sharper cutbacks in Medicaid services in such states — while still according favorable

How the Governors' Proposal Would Treat States Inequitably

A hypothetical example helps to illustrate how the NGA funding structure would likely result in some states' receiving windfalls while harming other states or the federal treasury. Imagine two states that each receive $5 billion in federal Medicaid payments in the base year, and in each of which caseload growth is forecast to be two percent per year. Suppose also that the portion of the growth factor that is intended to help cover increases in the cost of *providing medical services* to beneficiaries (as distinguished from cost increases due to increases in the *number* of beneficiaries) has been set at about three percent. Under the governors' proposal, the two states would both receive an overall federal funding increase of five percent over the base-year level — three percent for increases in the cost of delivering medical care and two percent for caseload growth. The basic grants these two states would receive consequently would each equal $5.25 billion ($5 billion plus five percent).

Suppose, however, that the Medicaid caseload actually grew only one percent in one of these states while growing three percent in the other state, instead of growing two percent in both states. Total caseload growth in the two states combined would equal expectations. But the state experiencing one percent caseload growth would get a $50 million windfall; it would get federal funds for one percent more beneficiaries than it actually served. The second state would not receive a windfall but would not be hurt, as it would receive an extra $50 million from the federal umbrella fund to cover its higher-than-anticipated caseload growth.

The Congressional Budget Office might anticipate this problem and lower its savings estimate as a result. If that occurs, Congress may decide to offset the loss in savings by reducing, for *all* states, the growth factor allowed for increases in the cost of delivering medical services. In this example, that growth factor might be reduced from three percent to 2.5 percent; that reduction would offset the $50 million federal loss that would otherwise occur as a result of the first state's receiving the $50 million windfall described above. But such an attempt to avoid federal losses would not prevent the inequitable treatment of some states and would create other difficulties. If the cost of delivering medical care services grew more rapidly than 2.5 percent, the state whose caseload growth exceeded expectations would be shortchanged; it would receive insufficient federal funds to deal with increases both in the cost of medical services and in the number of beneficiaries.

treatment to states whose caseloads turned out to be smaller than predicted.

These problems are not difficult to correct. The remedy is to allow the federal caps to adjust upward *or downward* if a state's caseload turns out to be higher *or lower* than anticipated.

Gaming the System

A number of states may contribute just enough state funds to Medicaid to draw down the maximum federal payments to which they are entitled. But some states may, as a matter of policy or for other reasons, find themselves contributing more than the minimum. These states, which would be contributing unmatched dollars and might not be overly pleased by that development, would face an enticing prospect — they would be able to "game the system" and secure substantial amounts of additional federal revenue.

Suppose a state finds that caseload growth exceeds the level anticipated in the state's growth factor. In such a case, the federal government would pay additional amounts to the state on behalf of each additional beneficiary beyond the number originally forecast (except for additional children covered at state option). Since the state is providing more state funding than needed to meet its matching requirement, the state will be able to receive the federal umbrella payments without contributing any additional state matching funds.

In this circumstance, the state will be in a position comparable to that of a health maintenance organization (HMO) — it will receive an additional federal payment for each new person it enrolls while incurring costs only to the extent required to pay the actual medical bills of the new enrollees. In effect, the federal payment will be a "capitation" payment.[16] When coupled with other provisions of the governors' plan, this approach provides a strong — perhaps irresistible — temptation for states to engage in "gaming."

States could, under the NGA plan, provide different benefit packages for different groups of beneficiaries, with some benefit packages being adequate and others greatly scaled back. A state that is contributing more state dollars than needed

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[16] The per-capita federal umbrella payments would apparently be based on the average cost of beneficiaries in each of several broad beneficiary categories such as the elderly, the disabled, and children. (The governors' proposal refers to "additional funds for certain populations," which is generally understood to mean that the formula for determining the size of the per-capita umbrella payments will vary for different groups of Medicaid enrollees, such as the elderly, children, the disabled, etc.) The governors did not specify how many such beneficiary groups should be created or how the level of the per-capita payments should be set. One approach would be to have the per-capita payments for each group equal average federal Medicaid costs for that group in the base year, adjusted by the same general growth factor used in the basic grant for the state (excluding that portion of the growth factor intended to cover anticipated caseload increases).

to meet its matching requirement could seek as many additional enrollees as possible in certain beneficiary categories to maximize its federal umbrella payments, while providing the additional enrollees only minimal health benefits at low state cost. The state also could concentrate on enrolling categories of new beneficiaries likely to be healthy in order to keep the costs of covering the beneficiaries low. The state could even drop coverage for new enrollees who had the misfortune to get sick too often, just as insurance companies sometimes drop coverage for those with too many claims. As long as the federal umbrella payment the state received for each additional beneficiary was higher than the average cost of medical care for these new enrollees, which would be easy to arrange, the state treasury would make money on each additional enrollee.

As a result, the federal caps, intended to generate federal Medicaid savings for the federal government, could become rather meaningless. Federal Medicaid expenditures would rise toward the level they would have attained had federal Medicaid law not been changed. Federal savings would dissipate even though the additional Medicaid beneficiaries might not get meaningful health care coverage.

As noted, states will be able to "game the system" in this manner only if they are contributing, or *appearing* to contribute, some unmatched state dollars. Even if bogus financing schemes are not permitted, the design of the governors' funding proposal thus leaves federal policymakers with a dilemma. If all states reduce their state contributions to the maximum extent allowed, the risk to the federal treasury posed by this type of gaming will not materialize. But there will be $182 billion to $214 billion in state funding cuts, and Medicaid beneficiaries are likely to suffer considerably. Alternatively, if states do *not* reduce their funding levels nearly as much as $182 billion, many states will find themselves in a position to exploit federal umbrella payments to the detriment of the federal treasury.[17]

In theory, any Medicaid reform proposal that includes capped per-beneficiary federal payments can present states with the possibility of gaming the system. Other proposals that would provide capped federal payments to states on a per-beneficiary basis, however — such as the Clinton Administration's proposal, the Medicaid legislation designed by the conservative Democratic "Coalition" in the House of Representatives, and the proposal Senate Democrats offered last fall — include features that minimize these risks to the federal government. These features include

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[17] The governors' proposal states: "Appropriate provisions will be established to ensure that states do not have access to the umbrella fund unless there is a demonstrable need." This vague statement appears not to have much meaning, however, given the other features of the governors' plan. For example, suppose it means that states will receive per-capita payments only on behalf of additional enrollees who are sick and receiving meaningful health benefits from the state. This concept would be unenforceable since it is difficult to distinguish "additional" enrollees from "anticipated" enrollees. How can the state tell, for any individual enrollee, whether he or she was one of the anticipated ones or an additional one? Furthermore, if a standard of "demonstrable need" is to be effective in preventing states from gaming the system, enforcement by the Health Care Financing Administration and meaningful federal benefit standards will both be essential. Such measures would, however, run afoul of other aspects of the governors' proposal.

maintaining existing prohibitions of bogus financing schemes, requiring an adequate and fundamentally equal benefit package for every beneficiary in the state, and preserving existing state matching requirements.[18]

Inadequate Adjustments for Inflation

If the general inflation rate in the U.S. economy is higher than expected, medical care will cost more due to no fault of the federal government, the state, or state Medicaid programs. Consequently, any Medicaid proposal should provide states and beneficiaries with protection against higher-than-anticipated inflation, as the current Medicaid program does.

At first blush, the governors' proposal appears to provide such protection. The "basic grant" paid to states is supposed to include "an inflation factor." In fact, however, this turns out to mean only that an inflation factor *based on current inflation forecasts* is built into the basic grant and umbrella payment structure. No adjustment would be made if the actual inflation rate turns out in coming years to be higher or lower than today's forecasts predict.

This is a serious deficiency in the plan. While the governors' proposal provides for an adjustment in federal funding levels if Medicaid caseloads rise beyond expectations (except for optionally covered children), it provides no comparable adjustment if the general inflation rate exceeds expectations. The Medicaid caps included in both the Administration and Coalition Medicaid proposals do contain such an adjustment.

An example helps to show why federal Medicaid payments should be adjusted if inflation is higher or lower than forecast. Suppose the general inflation rate is expected to be three percent per year. Suppose also that Medicaid costs (exclusive of costs due to caseload growth) are projected to grow six percent per year under current law (three percentage points above the general inflation rate), and policymakers are contemplating capping Medicaid cost growth at four percent per year (allowing only a one percent margin above the general inflation rate to reflect more rapid increases in

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[18] Other legislation with per-beneficiary federal caps minimizes the risks of state gaming in several ways. First, states would not be allowed to use bogus financing schemes to meet their matching requirements. Second, states would be far less likely to be contributing unmatched state dollars, since their matching rates would not be reduced. States not contributing unmatched dollars cannot game the system in this fashion, because they would have to contribute additional state matching funds to go along with the federal umbrella payments being received on behalf of additional beneficiaries. Finally, even if states were contributing unmatched state dollars, they would find it difficult to limit enrollment to new beneficiaries whose medical care cost less than the federal per-capita payment. Medical underwriting (that is, selecting only healthier people to enroll), disenrollment of people who become too sick, and skeletal benefit packages all would be prohibited under these other Medicaid proposals. States would have to provide adequate benefits to all enrollees due to federal benefit standards, the continuing federal requirement that benefits be of reasonable amount, duration, and scope, and federal rules requiring comparable benefits and access throughout a state.

health care costs due to the ongoing development of improved medical technologies). Rather than establishing a rigid formula that inflexibly fixes the allowable growth rate at four percent per year, policymakers could set the growth factor at "one percent above actual inflation." If actual inflation turned out to be 3.5 percent instead of 3 percent, the cap would allow 4.5 percent growth in medical costs. Conversely, if general inflation was only 2.5 percent, the cap would allow 3.5 percent medical cost growth.

In both instances, costs would continue to be squeezed by the amount considered appropriate when the legislation was drafted (in this example, by two percentage points, since Medicaid costs were assumed to rise three percentage points more than the general inflation rate in the absence of legislation to overhaul the program). If, instead, the allowable growth rate were inflexibly fixed at four percent — rather than at one percent above the actual inflation rate — costs would be squeezed either too much or not enough, depending on whether the general inflation rate was higher or lower than had been forecast. Adjusting the cap so it increases or decreases if inflation is higher or lower than CBO has forecast thus would produce a more rational result.

This approach also would afford more protection to states. If, over the next seven years, inflation averages one percent per year higher than CBO currently expects, the additional Medicaid costs would total $73 billion under current law, with states bearing $31 billion of these costs. Because the governors' plan lacks an adjustment in the caps to reflect inflation that is higher or lower than expected, however, states either would have to bear themselves *all* of the additional Medicaid costs that would result from higher-than-forecast inflation or else would have to restrict Medicaid eligibility, scale back the health services covered, or reduce payments to providers to achieve cost reductions to offset the effects of higher inflation.

The approach recommended here would not reduce federal Medicaid savings. If inflation proves to be higher than is currently forecast, federal Medicaid costs under current law would be higher than CBO currently projects. If the governors' Medicaid proposal were modified so it changed in cost when the general inflation rate varied from expectations, the amount saved — relative to what Medicaid would have cost the federal government without reform legislation — would remain virtually the same. The amount of federal savings that the Medicaid spending caps generated, and the amount by which the federal deficit would be reduced, would be essentially the same as the amounts that CBO estimated at the time of the legislation's enactment.

Such an approach also would not increase the federal deficit. The Congressional Budget Office, the Office of Management and Budget, and other analysts have long found that inflation has little or no effect on the deficit. If inflation is higher than expected, federal outlays increase, but federal revenues rise by about the same

amount.[19] Therefore, the approach recommended in this paper would also protect the federal government against the possibility that inflation might be lower than currently forecast.

The possibility that the general inflation rate may surpass current forecasts should not be ignored. CBO currently projects that general inflation will average 2.8 percent per year for the foreseeable future. In the 1980s, general inflation averaged 5.2 percent per year, while the average inflation rate was 7.0 percent in the 1970s.[20] (It was 2.7 percent in the 1960s.) Though the underlying inflation rate in the economy is lower today than in the previous two decades, CBO's record on economic forecasting — while as good or better than anyone else's — is far from perfect. In early 1988, for example, CBO overestimated inflation for the year already in progress by a full percentage point. In 1990, CBO underestimated inflation for the year in progress by half a percentage point.

CBO's projections are necessarily more speculative over a longer period of time. For example, CBO's baseline economic assumptions published in January 1995 assume prices in 2002 that are 4.3 percent higher than CBO assumed two years earlier, in its January 1993 assumptions. The assumptions CBO made back in January 1985 of what prices would be in 1992 turned out to err in the other direction; actual prices were 4.5 percent lower than CBO had predicted. High-quality seven-year price forecasts can be off as much as 5 percent in either direction during an era of relative economic stability.

For Medicaid, this means that total program costs in 2002 could be $15 billion higher or lower than CBO now expects solely because of uncertainty about inflation. This underscores why adjusting Medicaid caps up or down to reflect the extent to which inflation is higher or lower than anticipated should be a basic part of any Medicaid proposal that includes a cap.

(Note. The analysis in this chapter assumes a straightforward interpretation of the financing aspects of the NGA proposal. Alternative interpretations produce different problems; see Appendix A.)

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[19] See *The Economic and Budget Outlook: Fiscal Years 1996-2000*, Congressional Budget Office, January 1995, pages 78-79. If inflation is higher than expected, state revenues increase as well. Under current law, higher inflation leads to higher state Medicaid costs and to higher state revenues in the same proportion. Under the governors' proposal, by contrast, higher-than-anticipated inflation would force the state to absorb what under current law is both the state *and the federal* share of the increase in Medicaid costs caused by higher inflation. In such a case, state Medicaid costs would grow much more rapidly than state revenues would.

[20] These figures reflect the average annual percentage change in the GDP implicit price deflator on a calendar-year basis.

IV. Summary and Recommendations

The NGA plan could result in the loss of much of the intended federal savings while placing substantial numbers of low-income children, parents, and elderly and disabled individuals at risk of losing some or all of their health insurance coverage. Although the plan advances a number of important principles, including the basic concept that federal funding should follow enrollees and increase when enrollment rises, it is seriously flawed. In particular, its financing provisions — combined with the sweeping discretion granted to states over coverage and benefits and the lack of federally enforceable legal protections — are likely to lead to an increase in the ranks of the uninsured and to excessively scaled back benefits for many who retain coverage.

Despite their severity, these problems can be remedied within the basic Medicaid structure the governors have proposed. This chapter briefly describes how policymakers can address the major shortcomings of the governors' proposal in the areas of coverage, benefits, financing, and legal protections. The remedies described here would increase federal savings and avoid changes that would greatly weaken the health care safety net, while affording states flexibility to alter their Medicaid programs in a number of important areas.

Coverage

The governors' plan would cause three principal groups to lose the guarantee of health care coverage provided under current law. These coverage gaps can be closed.

The three groups are as follows:

- **Poor children over age 12.** The governors' plan makes coverage of this group of children optional for states; up to three million children could be

affected. *The guarantee of coverage for poor children over age 12 that is part of current law — and is phasing in through 2002 — can be retained.*

- **Large numbers of children and parents who now qualify for Medicaid based on their receipt of AFDC.** The plan would allow states to deny coverage to substantial numbers of poor children over 12 and poor parents who now receive Medicaid based on their receipt of AFDC. Health care coverage for up to four million parents and 1.5 million children over 12 is at risk.

  To prevent erosion in coverage, states can be required to cover children and parents whose income is below current AFDC standards. Such a requirement can be designed in a way to make it simple for states to administer.

- **People with disabilities.** The governors' plan would give states total discretion to define who would qualify based on disability. Being sufficiently disabled and poor to receive SSI would no longer provide an assurance of Medicaid coverage. (As noted in Chapter II, the plan's "set-aside" requirement for the disabled is of limited help. Under the set-aside, Medicaid funding for coverage of the disabled could, by 2002, be as much as 40 percent below the Medicaid funding levels projected for coverage of the disabled under current law.)

  The governors' plan would require states to continue covering elderly people who meet SSI income and asset standards. *States also can be required to cover disabled people who meet SSI disability and financial eligibility standards.*

Benefits

- **No federal benefit standards.** One of the most significant problems with the plan is that it grants states unlimited discretion to define the *amount, duration, and scope* of the services that will be offered. This means that the coverage guarantees the governors propose for poor pregnant women, poor children under 12, and elderly SSI recipients would mean little, since Medicaid coverage for some of these groups could consist of insurance only for a rather skeletal benefits package that fails to include key health care services. The lack of benefit standards also allows for "gaming" by states. *Federal rules requiring states to provide services that are sufficient in amount, duration, and scope can be retained and applied to all groups of beneficiaries.*

- **Changes in "EPSDT."** Under the plan, children would no longer be assured of receiving the treatment they need if a medical problem is discovered during a periodic health examination or screening. This change is particularly troublesome in light of the elimination of basic federal benefit standards. As a result of these two changes, many poor children could fail to receive basic treatments a doctor prescribes. *This problem can be addressed by maintaining EPSDT rules.*

- **Changes in benefit coverage for "QMBs."** Some poor elderly and disabled people who receive Medicare (called "Qualified Medicare Beneficiaries," or "QMBs") may face significant increases in out-of-pocket costs because Medicaid would, in many cases, leave a portion of their Medicare co-payments uncovered. *Medicaid can cover the full cost of Medicare cost-sharing obligations for these poor beneficiaries, as it does under current law.*

Financing

The plan would permit states to withdraw large amounts of state funds from Medicaid; it would allow states to withdraw approximately $200 billion over the next seven years without that affecting the level of federal Medicaid funding they receive. State Medicaid cuts could be nearly three times as deep as the federal reductions. The potential to reduce state funding to this degree is likely to prompt states to take advantage of opportunities allowed under the plan to restrict coverage and to scale back benefits for those who remain insured.

State Matching Requirements

- The NGA plan allows at least 25 states to cut state funding by up to one-third without losing any federal funds; it does this by reducing state "matching requirements." *Current state matching rates can be retained.*

Financing Gimmicks

- The plan allows states to reduce state funding to a still-greater degree by using financing gimmicks that are currently illegal, including the use of selective provider taxes and intergovernmental transfers. *Current prohibitions and limitations on such financing gimmicks can be retained.*

The Basic Payment and the "Umbrella Fund"

The NGA plan includes both basic block grant payments to states and "umbrella" payments to cover additional beneficiaries who enroll. The umbrella fund

is a fundamental part of the NGA plan; it ensures that funding follows people and protects states from the effects of recessions and other unexpected changes in caseload size or caseload mix. But the system of block grant and umbrella funds designed by NGA has four significant flaws that need correction.

- **No adjustment for inflation.** The plan establishes "basic" block grant payments to states, with the calculation of these payments based partly on CBO's current inflation assumptions. The plan fails to adjust these payments if the overall inflation rate in the U.S. economy turns out to be higher or lower than CBO has forecast. States and beneficiaries will be at risk if the general inflation rate is higher than forecast. The federal government will pay too much if inflation is lower than forecast. *This can be remedied by setting the level of growth that Congress wishes to allow in block grant payments at a specified amount above or below the general inflation rate.*

  For example, if the general inflation rate is forecast to be three percent, and on that basis, Congress wishes to allow four percent growth, Congress should set the growth factor at one percentage point above the general inflation rate. (Note: the GDP price deflator can be used here as the inflation measure; the Consumer Price Index need not be involved.) The Medicaid proposals advanced by the Coalition and Senate Democrats have followed this approach to dealing with inflation.

  The federal deficit is not affected by this change. CBO has found that when inflation is higher or lower than forecast, this does not affect the deficit since it results in changes in revenues and outlays that cancel each other out.

- **No adjustment if caseload falls.** States in which caseloads exceed expectations will get additional federal funds. But if a state's caseload falls below expectations, the state gets to pocket federal money that, under the governors' plan, it does not need. This reduces federal savings and means that states whose caseloads fall below anticipated levels will receive windfalls. It also means that states which reduce caseloads by restricting coverage can do so — and lower their costs — without losing any federal funds. *Federal payments should decrease if caseload comes in below expectations, just as the payments would increase if caseload exceeds expectations.*

- **States can game the system.** In some circumstances, states could "game" the umbrella fund, because protections against gaming included in other plans that allow for per-capita payments are missing from the governors' plan. States could increase their caseloads by enrolling new beneficiaries while keeping costs very low by giving the new enrollees a minimal benefit package. The states would claim "per-capita" payments from the

federal government for the new enrollees; since states could arrange matters so that the cost of serving these additional beneficiaries was less than the per-capita federal payments they would receive, states could make a profit from these transactions and deposit the extra funds in their state treasuries.

This problem can be addressed by maintaining federal benefit standards and providing full umbrella payments only to states that provide the full range of basic benefits to enrollees.

- **No umbrella payments for optional children and pregnant women.** The umbrella fund fails to cover increases in the number of those children and pregnant women who are not "mandatory" beneficiaries. This means, for example, that if a state elects to cover working poor children over age 12 and the number of such children increases during a recession, the state will receive no additional federal Medicaid payments to cover the additional caseload. This may strongly discourage states from covering such children.

  The umbrella funding mechanism can be modified so it covers all mandatory and optional categories of beneficiaries. Under the governors' plan, the umbrella fund already applies to caseload increases for all categories of elderly and disabled beneficiaries. It also should apply to all categories of children and pregnant women, rather than just to *mandatory* categories of these groups.

Loss of Legal Protections

- **Repeal of Title XIX.** The plan would repeal the statute that governs Medicaid. Key protections included in the statute — such as the ban against providers billing Medicaid patients, limits on cost-sharing requirements, and quality standards — are at risk. *Title XIX can be retained as the basic law and amended to reflect the changes that policymakers wish to make to produce savings and accord states flexibility.*

- **No access to federal court.** Neither beneficiaries nor providers would be allowed to bring suit in federal court, even if their state was violating federal law and misusing federal funds. No other federal law guarantees a benefit to eligible individuals and provides billions of federal dollars to states to honor that guarantee, while denying eligible individuals access to federal court if a state violates these federal guarantees. *This problem can be addressed by continuing to allow federal Medicaid claims to be brought in federal court.*

Summary of Recommendations

- Retain the guarantee of coverage for poor children age 13-18, which is now being phased in.
- Require states to cover children and parents whose income is below current state AFDC standards as well as individuals who meet SSI disability and financial eligibility standards.
- Retain federal rules requiring states to provide services that are sufficient in amount, duration, and scope; tie a state's receipt of full umbrella payments to its provision of the full range of basic benefits.
- Maintain current EPSDT rules.
- Do not reduce state matching rates.
- Retain current prohibitions and limitations on financing gimmicks such as provider taxes and intergovernmental transfers.
- The basic grant should grow by some designated percentage above or below the actual inflation rate.
- Payments to states should decrease if caseload falls, as well as increasing if caseload rises.
- "Umbrella" payments should cover caseload increases for all beneficiary groups, including both mandatory and optional groups.
- Retain Title XIX as the basic law and amend it as desired to reflect agreed-upon changes.
- Continue to allow federal Medicaid claims to be brought in federal court.
- Continue to cover the full cost of co-payments for Qualified Medicare Beneficiaries.

APPENDIX A: ALTERNATIVE INTERPRETATIONS PRODUCE DIFFERENT PROBLEMS

The analysis in this paper assumes the most straightforward interpretation of federal Medicaid payments under the NGA proposal. We assume that the "basic grant" is intended: a) to fully cover projected caseload growth, including changes in the mix between high-cost and low-cost beneficiary groups; and b) to partially cover increases in the cost of delivering medical care. States would be guaranteed their basic grant. In addition, they would receive "umbrella" payments to fully cover the federal share of additional costs if caseload (or caseload mix) exceeded the initial projections.

Other formulations of the basic grant and umbrella payments also are possible. One such formulation may be significant because of its similarity to the Medigrant II proposal advanced by the staff of the House Commerce Committee in January. Under the alternative formulation:

- Each year, the Department of Health and Human Services (HHS) would alter the distribution of basic grant funds among states. At the beginning of each fiscal year, the distribution used in the prior year would be revised to reflect the most recent state-by-state data on the distribution and case mix of Medicaid enrollees. Thus, if caseloads had grown faster than expected in one state and slower than expected in another, the basic grant to the first state would be adjusted upward while the basic grant to the second was adjusted downward.

- The *total* amount provided in basic grants to the 50 states and the District of Columbia would remain the same as initially set forth in the statute, with one exception. HHS would be required to increase the aggregate amount of the basic grants to cover caseload increases that HHS determined were generated by an economic slowdown. Any such increases in the aggregate amount of the basic grants would be temporary, lasting only as long as the slowdown.

This formulation would have the following effects:

- If some states chose, as a matter of policy, to squeeze providers and benefits harder so they could expand coverage within limited resources, all *other* states would find their basic grants reduced to offset the increase in caseload caused by the states that expanded coverage. This across-the-board reduction in basic grants would penalize states that chose the approach of providing more substantial benefits for those who are most vulnerable.

- The federal umbrella payments would fail to protect against the *cumulative* effect of caseload growth, despite the clear understanding of many governors that these payments should provide such protection. A simple example illustrates the problem. Suppose a state's basic grant includes a growth factor sufficient to cover a beneficiary population that grows at two percent per year. But suppose actual beneficiary growth turns out to be three percent per year. After the first year, the state would be covering one percent more beneficiaries than expected; after the second year, two percent, and so on. By 2002, the seventh year, the state caseload would be seven percent above expectations. But *the umbrella payment in 2002 would only cover one percent higher costs* — the difference between the expected two percent growth from 2001 to 2002 and the actual three percent growth.

  HHS' annual redistribution of basic grant funds might make up for a portion of the six percent shortfall in this case, but almost certainly would not make up for most of this shortfall. To make up for all of this shortfall, the state in question would need to have received a six percent increase in its basic grant by 2002 beyond the basic grant level the statute originally envisioned for the state. For the state to have received a basic grant increase of this magnitude, the *national* Medicaid caseload would need to have remained at or below initial expectations during the 1996-2002 period. If the total amount of funding available for basic grants remained fixed at the levels set in the statute (as would occur in the absence of an economic slowdown), while the national caseload rose beyond expectations, the basic grants to the states experiencing caseload increases would not increase sufficiently to absorb these caseload increases fully into the state's "base."

  Under the governors' plan, national caseload is likely to exceed initial expectations for two reasons. First, public policy in many states seems to favor expanded coverage, paid for by managed care efficiencies and, perhaps, restricted benefit packages. Second, the incentive for states to "game" the umbrella payments by enrolling many new, artificially cheap enrollees would likely lead to greater-than-anticipated caseload growth.

  In short, under this interpretation of the governors' plan, states with unexpected caseload increases are likely to get inadequate fiscal protection, with the protection becoming more inadequate with each passing year.

- HHS would have considerable leeway in deciding the overall, national level of the basic grants as well as the level for each state. HHS would be

required to estimate what portion of caseload growth resulted from economic weakness. There is no objective, mechanical way to determine what portion of caseload changes result from the business cycle. HHS would have to use its judgment in this regard. That judgment would affect total federal Medicaid costs as well as each state's Medicaid grant level.

- The inability to predict state-by-state caseload growth rates with perfect precision would not be quite as costly to the federal government as described under the *"Heads I Win; Tails You Lose"* section of this report. That is because under this interpretation of the governors' proposal, errors made in developing the original predictions of state caseloads would not compound over time. States that reduce their caseload and reap a windfall would get a smaller windfall. The windfall also might be of shorter duration.

APPENDIX B: DATA AND METHODOLOGY

The CBO forecast of federal Medicaid spending from 1996 through 2002 is used as the projection of federal Medicaid expenditures under current law. The corresponding amount of total state baseline spending during this period is derived from the CBO forecast of federal Medicaid spending. Total state baseline spending is then divided among states in proportion to the state-by-state baseline spending projections that the Urban Institute issued in December 1995.[21]

It is assumed that gross federal Medicaid reductions would be made across-the-board and that the special payments for undocumented aliens (see footnote 13) would be distributed as specified in the reconciliation bill. An alternative assumption — that the level of grants (other than for undocumented aliens) would be *increased* across-the-board relative to the grant levels that would be made under the reconciliation bill, rather than reduced across-the-board relative to baseline levels — leads to aggregate results virtually identical to those presented here. Under the alternative approach, the state-by-state distribution of the cuts would differ, but the total amount of cuts would not.

Finally, the amounts assumed for the level of federal Medicaid reductions in 2002 under the President's budget and the latest Republican budget offer are taken from documents prepared by the Administration and the House and Senate Budget Committees. These documents show the level of federal Medicaid savings in 2002 under these budget plans.

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[21] See *The Impact of the "Medigrant" Plan on Federal Payments to State*, December 1995, prepared by John Holohan and David Liska of the Urban Institute for the Kaiser Commission on the Future of Medicaid, Table 7.

Appendix C: Federal Medical Assistance Percentages (FMAPs)*

(The percentage of Medicaid costs that the federal and state governments pay)

	Current law, 1996 est.		Reconciliation bill		NGA with 40% maximum**	
	Federal	State	Federal	State	Federal	State
Average	56.7%	43.3%	63.0%	37.0%	62.2%	37.8%
Alabama	69.9%	30.2%	72.9%	27.1%	69.9%	30.2%
Alaska	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Arizona	65.9%	34.2%	65.9%	34.2%	65.9%	34.2%
Arkansas	73.6%	26.4%	74.1%	25.9%	73.6%	26.4%
California	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Colorado	52.4%	47.6%	60.0%	40.0%	60.0%	40.0%
Connecticut	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Delaware	50.3%	49.7%	60.0%	40.0%	60.0%	40.0%
DC	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Florida	55.8%	44.2%	65.7%	34.3%	60.0%	40.0%
Georgia	61.9%	38.1%	61.9%	38.1%	61.9%	38.1%
Hawaii	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Idaho	68.8%	31.2%	68.8%	31.2%	68.8%	31.2%
Illinois	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Indiana	62.6%	37.4%	62.6%	37.4%	62.6%	37.4%
Iowa	64.2%	35.8%	64.2%	35.8%	64.2%	35.8%
Kansas	59.0%	41.0%	60.0%	40.0%	60.0%	40.0%
Kentucky	70.3%	29.7%	74.7%	25.3%	70.3%	29.7%
Louisiana	71.9%	28.1%	77.1%	22.9%	71.9%	28.1%
Maine	63.3%	36.7%	65.2%	34.8%	63.3%	36.7%
Maryland	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Massachusetts	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Michigan	56.8%	43.2%	61.2%	38.8%	60.0%	40.0%
Minnesota	53.9%	46.1%	60.0%	40.0%	60.0%	40.0%
Mississippi	78.1%	21.9%	80.7%	19.3%	78.1%	21.9%
Missouri	60.1%	39.9%	60.5%	39.5%	60.1%	39.9%
Montana	69.4%	30.6%	69.4%	30.6%	69.4%	30.6%
Nebraska	59.5%	40.5%	60.0%	40.0%	60.0%	40.0%
Nevada	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Hampshire	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Jersey	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Mexico	72.9%	27.1%	73.0%	27.1%	72.9%	27.1%
New York	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
North Carolina	64.6%	35.4%	64.6%	35.4%	64.6%	35.4%
North Dakota	69.1%	30.9%	69.1%	30.9%	69.1%	30.9%
Ohio	60.2%	39.8%	60.2%	39.8%	60.2%	39.8%
Oklahoma	69.9%	30.1%	69.9%	30.1%	69.9%	30.1%
Oregon	61.0%	39.0%	61.0%	39.0%	61.0%	39.0%
Pennsylvania	52.9%	47.1%	60.0%	40.0%	60.0%	40.0%
Rhode Island	53.8%	46.2%	60.0%	40.0%	60.0%	40.0%
South Carolina	70.8%	29.2%	74.0%	26.0%	70.8%	29.2%
South Dakota	66.7%	33.3%	66.7%	33.3%	66.7%	33.3%
Tennessee	65.6%	34.4%	69.6%	30.4%	65.6%	34.4%
Texas	62.3%	37.7%	62.8%	37.3%	62.3%	37.7%
Utah	73.2%	26.8%	73.2%	26.8%	73.2%	26.8%
Vermont	60.9%	39.1%	60.9%	39.1%	60.9%	39.1%
Virginia	51.4%	48.6%	60.0%	40.0%	60.0%	40.0%
Washington	50.2%	49.8%	60.0%	40.0%	60.0%	40.0%
West Virginia	73.3%	26.7%	75.8%	24.2%	73.3%	26.7%
Wisconsin	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%
Wyoming	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%

* GAO estimate of State FMAPs. The national average is weighted in accordance with the Urban Institute's December 1995 estimate of the state-by-state distribution of baseline Medicaid spending from 1996 through 2002.

** It is unclear whether the governors' plan envisions that the matching rates be those which are shown in these two columns or those shown in the columns titled "reconciliation bill;" see page 16.

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NEW YORK STATE LEGISLATURE

cc Christ
Jenk
FMI.
—Dlaw

March 12, 1996

The Honorable George Pataki
Governor, New York State
Executive Chamber
Albany, New York 12224

Dear Governor Pataki:

Thank you for sharing your proposed joint letter to President Clinton. In the spirit of bipartisanship in which it was no doubt proffered, allow us to suggest an alternative approach that, unlike the National Governor's Association proposal which you endorse, would promote long-term budget stability for New York, while maintaining comprehensive protections for working New Yorkers, their children, and their aging parents.

Your letter is directed to President Clinton, when in fact, it makes much more sense to target our joint efforts to Majority Leader Dole and Speaker Gingrich. Indeed, President Clinton and Speaker Silver discussed increasing the Federal Matching Assistance Payment (FMAP) for Medicaid from 50- to 60-percent, and the President was receptive to the change. And while Senator Dole, Speaker Gingrich, and the National Governor's Association advocate devastating reductions in Medicaid coverage for children and the elimination of Federal guarantees of quality and accountability for health programs for seniors and children alike, the President has been steadfast in his commitment to maintaining these critical Federal safeguards. Finally, as you noted in your original budget submission, President Clinton's plan provides, for Medicaid alone, $14 billion this year and $15.2 billion next year -- a billion dollars more this year than offered by Speaker Gingrich or Senator D'Amato, and two billion dollars more next year.

While it is critical to ensure that fundamental, long-term restructuring of health services in Washington maintains the Federal promise of health care to seniors, children, and the disabled, and provides New Yorkers with their fair share of the Federal budget dollar, it is equally important that we address our near and long-term budget obligations here at home in New York State. Toward that end, we renew our plea that you join us in

crafting a sensible plan that will extend New York's budget until a final Federal solution is adopted. We and Senator Bruno have presented just such a plan. Now, we need to move beyond letter-writing, and begin the difficult work of crafting a stop-gap budget that will carry New York through these uncertain times.

We look forward to working with you in these joint endeavors.

Sincerely,

MARTIN CONNOR
Senate Minority Leader

SHELDON SILVER
Assembly Speaker

cc: Senator Joseph Bruno, Majority Leader
Assemblyman Thomas Reynolds, Minority Leader

MEDICAID

DRAFT

Building off the foundation of the National Governors' Association (NGA) resolution, a Medicaid compromise in within reach. Although there are second tier issues that need to be fleshed out (e.g., issues relating to quality, family financial protections, and bill drafting), the key issues that need to be resolved to reach a bipartisan compromise are:

FINANCING: The Conference Agreement provides for fixed ("block-granted") federal payments. The Administration proposal limits federal spending growth per recipient and reduces disproportionate share (DSH) payments. The NGA proposal combines elements of both a block grant and a per capita cap. It provides for a minimum federal base payment, but allows federal payments to increase when enrollment unexpectedly increases. (The specifics behind the financing proposal -- as of March 5th -- are still being worked out by the Governors and their staffs.)

- **Areas of Potential Agreement:** Accept and work off the NGA financing formula, which has no cap and is intended to ensure that Federal support increases with enrollment. Ensure the formula can be scored for adequate savings without undermining "dollars follow people" principle. To achieve this, it may be necessary to delete or modify certain provisions in the NGA resolution, including the lower state matching requirements and the provider tax provisions.

- **Principals' Issues:** Staff will likely need direction from the Principals at some point about allocation of dollars, particularly DSH dollars, to the states. However, most of the outstanding issues should be able to be worked out if staff is given direction to produce the financing scheme around the parameters outlined above.

ELIGIBILITY: The Conference Agreement allows the states to define eligibility and has no minimum federal eligibility definitions. In lieu of federal standards, states are required to spend certain percentages of their block grant ("set-asides") on low income families, people with disabilities and seniors. The Administration proposes to retain current federally-defined eligibility categories. The NGA proposal retains current law's eligibility categories with the exceptions of the phase-in of coverage of poor children ages 13-18 and the federal definition of disability.

- **Areas of Potential Agreement (Eligibility):** Accept NGA eligibility definitions with two modifications: (1) Retain kids phase-in and (2) retain the federal disability eligibility definition, but redefine it to mirror the welfare reform definition of eligibility. (This excludes from mandatory coverage alcoholics, chemical and substance abusers, and some definitions of functionally impaired kids.)

- **Principals' Issues:** Because it is the most visible non-financing issue, closure on the outstanding eligibility definition issues will be difficult to achieve without authorization and direction from the Principals.

BENEFITS: With the exception of the current requirement that states cover vaccines and limited family planning services, the Conference Agreement leaves the definition of the benefit package up to the individuals states. The Administration maintains the current, federally defined benefits package. The NGA resolution resembles the Administration's proposal in that it retains the federal list of basic benefits now covered. However, the proposal provides no federally-defined standard of adequacy, it eliminates the comparability and statewideness protections for both mandatory and optional benefits, and it limits the treatment portion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children. Specifically, states would no longer be required to cover any treatment prescribed from the screening process; only mandatory services would be guaranteed.

- **Areas of Potential Agreement:** Accept the NGA benefits definition, but work to develop standards to ensure that the benefits are meaningful, are provided to all eligible populations and cannot be designed to discriminate against certain populations. Retain standards for mandatory benefits, but work on providing much greater flexibility for optional benefits. Amend the NGA recommendation on the EPSDT benefit to at least include optional benefits.

- **Principals' Issues:** Providing general parameters to staff on their philosophy of defining appropriate standards to assure that the benefits package is "meaningful."

ENFORCEMENT: All three proposals (the Conference Agreement, the President's proposal, and the NGA resolution) repeal the primary legal and financial headache for the Governors -- the Boren Amendment. The Conference Agreement and the NGA resolution go further and eliminate all provider right of actions. They also eliminate the federal right of action for Medicaid recipients who have eligibility or benefit disputes and require recipients to exhaust the state administrative appeal process prior to filing any court appeal. (The court appeal would be processed through the state court system.) The President's proposal retains the federal right of action for disputes by recipients.

- **Areas of Potential Agreement (Enforcement):** Accept NGA proposal to eliminate all provider right of action suits (although constitutionality questions need to be checked out). Preserve federal right of action for Medicaid recipients, but accept NGA proposal that requires all state administrative appeals to be exhausted prior to any Court appeal being permitted to be filed.

- **Principals' Issues:** Any discussions related to the elimination of the federal right of action for Medicaid recipients.

SAVINGS: The Conference Agreement provides for $133 billion in savings from the program over 7 years, although the Republican Leadership has indicated their support for $85 billion in reductions. The Administration 7-year savings number is $59 billion. (The Breaux/Chafee compromise calls for $62 billion over 7 years.)

- **Areas of Potential Agreement:** Regardless of the number chosen, the staff can work out formulas that achieve the savings target. However, the higher the number, the more difficult it will be to allocate politically acceptable reductions in federal dollars to the states.

- **Principals' Issues:** This is a budget and politically-driven number that must be provided by the Principals.

MEMORANDUM

March 26, 1996

TO: Distribution

FR: Chris Jennings

RE: Democratic Senate NGA letter

Attached is a letter that will be forwarded to Chairman Roth tomorrow urging him to work in a bi-partisan fashion to draft Medicaid and welfare legislation. As you will note, the letter has been signed by every member of the Senate Finance Committee.

The letter points out that Democrats feel they have not been in the least bit consulted on any Medicaid/welfare legislation and believe that a continuation of such an exclusionary process would be totally counterproductive.

The Democrats wanted to put their marker out prior to the expected Medicaid/welfare "NGA" bill release on Thursday or Friday.

KENT CONRAD
NORTH DAKOTA
202-224-2043

COMMITTEES
AGRICULTURE, NUTRITION, AND FORESTRY
FINANCE
BUDGET
INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510-3403

March 27, 1996

The Honorable William V. Roth, Jr.
Chairman
Senate Committee on Finance
United States Senate

Dear Mr. Chairman:

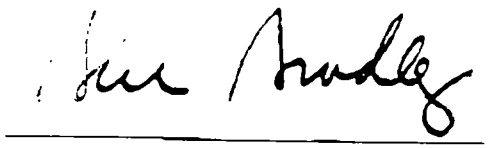
It is our understanding that this week you intend to introduce a modified version of the National Governors' Association's (NGA) proposals to reform Medicaid and welfare. We share your view that changes can and should be made in these programs to strengthen and improve them, and to make them more efficient so that we can achieve savings for the Federal and state governments. However, the events of the last year have made it abundantly clear that a partisan effort in these areas cannot be enacted into law.

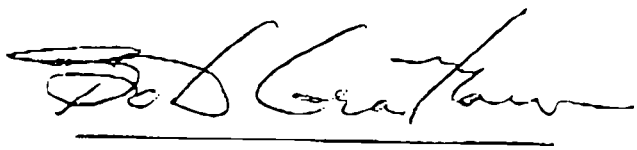
For this reason, we welcomed your assurance, in response to Senator Rockefeller's comments at the February 22 hearing with the NGA, that you intended to work with all members of the commitee to develop a bill that has broad support in creating the Chairman's mark. You went on to say that you were interested in reform that could get through the Congress and be signed by the President.

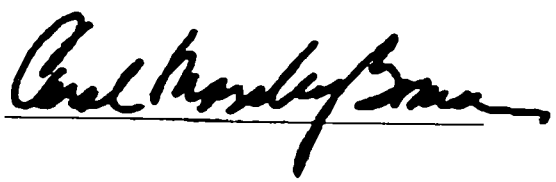
Unfortunately, we and our staff have not been involved in the process of developing the bill you intend to introduce, and we do not believe it has the broad support necessary to be enacted. We fear that a partisan process, while it may score political and rhetorical points, will only hinder final enactment of needed reforms, and leave governors and taxpayers without the improvements, flexibility, and savings bipartisan reform can achieve. We understand that you needed to move quickly to develop this legislation. But we also need time to review these complex changes affecting more than $1 trillion in spending over the next seven years. Consequently, we urge you to consult with all members of the committee immediately and over the full course of the April recess to modify your bill into a truly bipartisan Chairman's mark for consideration by the Committee when the Senate reconvenes.

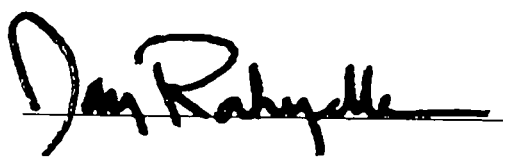
We look forward to working with you in the coming weeks to fashion a bipartisan approach to Medicaid and welfare reform.

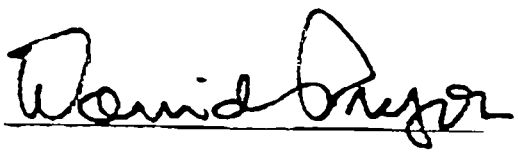
Sincerely,











- Vaccines kept
- Abortion language dropped

← Eliminates
suit under
ADA etc. ?

OVERVIEW OF NGA DRAFT LEGISLATIVE LANGUAGE
5:00 Monday 3/11/96

Structure

- New title of Social Security Act: Consistent with NGA outline and Conference Agreement.
- The NGA bill appears to be based on the Conference Agreement, with modifications in those areas where the Governors had explicit policies which differed from the Conference Agreement. Wherever the governors did not have a specific position on an issue, the draft bill language generally defaults to the Conference Agreement.
  - For example, the draft bill frequently refers to Title XXI, which exists under the Conference Agreement but not under the NGA plan.

Federal Right of Action

- Consistent with NGA outline.

Eligibility

- Mandatory populations - Generally consistent with NGA outline; consistent with the Conference Agreement.
- Optional populations -- Unclear.
  - The bill is silent in discussing the "optional" eligible. (The section on definitions makes reference to optional populations, but they are not listed in the eligibility section of the draft bill. This section is consistent with the Conference Agreement.)
- Limitations on Eligibility -- Expands on NGA documents, consistent with Conference Agreement.
  - The bill requires States to report whether they impose any restrictions on eligibility based on age, residence, spend-down status, immigration status, or employment status. This clause implies that States are permitted to restrict eligibility based on these factors. While such limitations were never mentioned in previous NGA documents, they were included in the Conference Agreement.

- Disabled Eligibility -- Consistent with Conference Agreement and NGA outline, with the following two exceptions:

  - While the 2/27 revisions gave States three options for how to define disability, the bill does not contain these options. Rather, it simply states that States will define disability.

  - The bill limits the 209(h) exception to States who currently use it. This provision was not included in previous NGA documents.

- Disabled Set-Aside -- Consistent with NGA outline. Higher than Conference Agreement. (90% versus 85%)

- Medicare populations -- Consistent with NGA documents, including the 2/27 revisions.

  - The bill provides SLMBs and QDWIs the same guarantees as QMBs. It also allows States to pay Medicaid rates for services provided to these individuals.

- AFDC populations -- Consistent with NGA revisions. Conference Agreement is silent on this point.

- Welfare-to-Work -- Inconsistent with NGA revisions. Conference Agreement is silent on this point.

  - While the 2/27 revisions guaranteed Medicaid eligibility for one year for people transitioning from welfare to work, the bill does not mention this issue.

- Measurement of income – Expands on NGA documents; consistent with Conference Agreement

  - The bill eliminates the current requirement that States must use AFDC methodology for measuring income and assets when determining eligibility. It allows States to decide how income and assets should be measured.

Benefits

- "Guaranteed" benefits -- Mostly consistent with NGA outline (and broader than the Conference Agreement). However, the bill expands on previous NGA documents with the following two provisions:

  - *Family planning services*: The bill limits these to "pre-pregnancy family planning

services". This term is not defined. The Conference Agreement did define "family planning" as pre-pregnancy only.

- *FQHCs and RHCs*: Services provided through these entities are included on the list of "guaranteed" benefits for the first two years only of the new program.

- Optional benefits: Expands on NGA documents in the following areas:

  - *Institutions for Mental Disease*: The bill allows State Medicaid programs to pay for services provided at IMDs for individuals between the ages of 21 and 64.

  - *Over-the-Counter Drugs*: The bill includes over-the-counter drugs as an optional service.

  - *Abortion*: The bill states that abortion is permitted only in the case of rape or incest or to save the life of the mother. This would be the first time that the use of federal funds for abortion services would be statutorily defined.

- Amount, Duration, and Scope – Consistent with original NGA outline and Conference Agreement; does not include the standards for ADS which were included in the 2/27 revisions.

- Comparability and Statewideness -- No provision; consistent with NGA outline and the Conference Agreement.

- EPSDT -- Treatment component is consistent with NGA; rules about qualified providers are an expansion of previous NGA documents. (The Conference Agreement does not address EPSDT; it would be left to the states to define.)

  - *Qualified providers*: The bill eliminates the current requirement that States must allow any qualified provider to provide EPSDT services.

- Vaccines for Children: Expands on previous NGA documents; consistent with the Conference Agreement.

  - While previous NGA documents did not address this issue, the bill would repeal VFC effective the day of enactment.

- Drug Rebate Program: Consistent with NGA's 2/27 revisions; identical to Conference Agreement.

Quality of Service

Nursing Home:

- Quality Standards: They appear to be consistent with NGA documents.
- Federal Role in Enforcement: This role is still unclear; further review is required.

Managed Care:

- There are no provisions on managed care quality; this is consistent with NGA documents.

ICF/MR:

- There are no provisions on ICF-MR quality; this is consistent with NGA documents.

Service Delivery

- Allows states to use any delivery system. This is consistent with the NGA documents and the Conference Agreement. Expands on NGA to include solvency standards and capitation rate setting that is consistent with the Conference Agreement.

Payment Flexibility

- Boren Amendment: Consistent with NGA documents and the Conference Agreement.
- FQHCs and RHCs: Consistent with NGA documents; inconsistent with the Conference Agreement.

Indian Health Service

- The States' Relationships with IHS facilities: Expands on NGA documents; consistent with Conference Agreement.
  - While the NGA documents did not address this issue, the bill makes it optional for States to deal with IHS providers.

- Funding for IHS Facilities: Language on funding has not yet been provided.

Utilization Controls

- Cost-sharing: Expands on NGA documents; consistent with Conference Agreement.
  - While previous NGA documents did not address this issue, the bill provides language similar to the Conference Agreement.
- Utilization Incentives: Expands on NGA documents; consistent with Conference Agreement.
  - The bill allows States to establish incentives for people to not use services.

Family Protections

- Spousal Impoverishment: Largely consistent with the 2/27 NGA revisions and the Conference Agreement. Also expands on both of these items.
  - Consistent with NGA revisions, the bill maintains the current law protections.
  - The bill expands on previous NGA documents in two ways:
    - by increasing the personal needs allowance for nursing home residents (added in the Conference Agreement), and
    - by allowing States to deem the income of outside spouses to help pay for spouses inside nursing homes.
- Adult Children of Nursing Home Residents: Expands on NGA documents; inconsistent with the Conference Agreement.
  - While the NGA documents did not address this issue, the bill states that adult children can not be held responsible for their parents' nursing home bills. (The Conference Agreement would hold some children responsible.)
- Liens: Expands on NGA documents. Inconsistent with the Conference Agreement.
  - The bill maintains current law rules about imposing liens. (Previous NGA documents did not address this issue.)

- Asset Transfer: Inconsistent with NGA revisions. Consistent with the Conference Agreement.
  - While the 2/27 NGA revisions addressed the issue of asset transfers, the bill is silent on this issue.
- Estate Recoveries: Inconsistent with NGA revisions. Consistent with the Conference Agreement.
  - While the 2/27 revisions addressed the issue of estate recoveries, the bill is silent on this issue.

1115 Waivers

- Consistent with NGA outline and revisions. Consistent with the Conference Agreement.
  - The bill makes no mention of 1115 waivers.

STATE OF NEVADA
EXECUTIVE CHAMBER
Capitol Complex
Carson City, Nevada 89710

BOB MILLER
Governor

TELEPHONE
(702) 687-5670
Fax: (702) 687-4486

March 14, 1996

FOR IMMEDIATE RELEASE
Contact: Jim Mulhall, Gov. Bob Miller's Office, Nevada, 702-687-5670
Charlie Salem, Gov. Lawton Chiles' Office, Florida, 904-488-2272
Jim Carpenter, Gov. Roy Romer's Office, Colorado, 303-866-2471

Republican Governors 'Jump the Gun'
*** * *Democratic Governors Reaffirm Bipartisan Support for Medicaid and Welfare* * ***

The three Democratic members of the National Governors' Association Medicaid Task Force were disappointed and concerned today by the announcement of their Republican colleagues and Speaker of the House Newt Gingrich that an agreement has been reached on substantive and procedural issues for handling Medicaid and welfare reform.

"They're getting a little ahead of themselves. We still have serious substantive concerns as well as procedural concerns on the Medicaid proposal," said Nevada Gov. Bob Miller, NGA vice-chair. "We have been working in good faith and today's announcement was unfortunate and extremely premature. Recent history should tell us one important lesson — if we want to get things done, we need to work together — Democrats and Republicans both in the Governors' mansions and on Capitol Hill."

"We still want to work together, but there must be bi-partisan participation at every step of the way, not just when it seems to suit one party," said Gov. Miller. "We have not given up the possibility of working out the differences on substance and procedure. These programs are too important to the states and the people they help."

"Bi-partisan means two parties, not Republican governors and Republican legislators deciding things. The outline of the agreement was forged in bi-partisan spirit. The Republicans' recent actions threaten that very bi-partisanship," said Gov. Lawton Chiles (D-Fla.). "Bi-partisanship means Democratic and Republican governors and Democratic and Republican members of Congress working together with the White House to pass a bill we can all support."

"Passage of Medicaid reform legislation this year will not be successful unless it is drafted, sponsored and passed in a bi-partisan way. There is more work to be done," said Gov. Roy Romer (D-Colo.).

--MORE--

"We have yet to agree to a final draft of the legislation, including specific language on a host of issues," said Gov. Chiles. " No Democratic governor, no Democratic member of Congress nor the President have seen the so-called 'Governors' Bill' in a final form."

"We are very disappointed the Republican leadership in Congress and the Republican governors chose a partisan setting today to comment on the 'work-in-progress' that is the NGA Medicaid proposal," said Gov. Romer. "Moreover, Democratic and Republican governors have not yet agreed that the passage of welfare and Medicaid should be linked."

"The nations governors were rightly praised when we agreed on an outline for Medicaid and welfare reform in February. It would be a shame if that praise turned to criticism because of a failure to work together," said Gov. Chiles.

Over the past several months, a task force of six governors have come together to negotiate on behalf of all the nation's governors with the Federal government on the issues of Medicaid and welfare reform. Those governors include Tommy Thompson (R-Wisc.), John Engler (R-Mich.), Michael Leavitt (R-Utah), Miller, Romer, and Chiles. The governors met as recently as last Tuesday in Chicago to iron out differences and talk about legislative strategy.

- 30 -