MediGrant II State Growth Rates

Highest Growth Bracket: 9.3% in 2002	
California	Nevada
Florida	New Mexico
Idaho	Oklahoma
Mississippi	
High Bracket: 7.7% in 2002	
Alabama	Kentucky
Alaska	Louisiana
Arizona	South Carolina
Arkansas	Texas
Colorado	Utah
Delaware	Virginia
Georgia	Wyoming
Low Bracket: 5.6% in 2002	
Illinois	North Dakota
Indiana	Ohio
Iowa	Oregon
Kansas	Pennsylvania
Maryland	South Dakota
Michigan	Tennessee
Missouri	West Virginia
Montana	Wisconsin
North Carolina	
Lowest Bracket: 3.0% in 2002	
Connecticut	Nebraska
District of Columbia	New Hampshire
Hawaii	New Jersey
Maine	New York
Massachusetts	Rhode Island
Minnesota	Washington

Source: US General Accounting Office.

* Vermont is the only state that does not fall into one of the Floor and Ceiling categories by 2002; it receives funding according to the "small state minimum".

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Detailed Description of the Medicaid Financing Reform, February 6, 1996

I. PER CAPITA CAP:

Index: Five-year historical average of nominal gross domestic product growth per capita plus an additive factor to yield:

Year:	Index:	Nominal GDP +:
1996	6.3%	+ 2.5%
1997	5.1%	+ 1.0%
1998	5.3%	+ 1.0%
1999	4.6%	+ 0.5%
2000	4.5%	+ 0.5%
2001	3.9%	+ 0%
2002	4.0%	+ 0%
Avg.	**4.6%**	

II. DISPROPORTIONATE SHARE REFORM:

Financing:

Federal Payment Limits: Current (1995) Federal DSH payments are phased out by 2000, and a new DSH program is phased in by 2000. The transition occurs in 25 percent increments. This yields Federal payment limits of:

Year:	Federal Limit:
1997	$9.3 billion
1998	$7.9 billion
1999	$6.4 billion
2000	$5.0 billion
2001	$4.5 billion
2002	$4.0 billion

Note: Louisiana and New Hampshire are phased to their new allotments without a transition period (in 1997).

III. POOLS:

Three capped pools of Federal funds are designated for payments to specific states and providers to help them transition from the current to the new Medicaid program.

A. UNDOCUMENTED POOL

Financing: A temporary pool for states with high numbers of undocumented persons is created to pay for emergency health services. No state matching payments would be required. Maximum Federal spending is limited to the following amounts:

Year:	Federal Limit:
1997	$700 million
1998	$700 million
1999	$700 million
2000	$700 million
2001	$700 million
Total:	**$3.5 billion**

State Allotments: The 15 states with the highest number of undocumented persons, according to Immigration and Naturalization Service data (October 1992), are eligible. Each state gets an allotment from the pool according to its share of the number of undocumented persons in the 15 states.

B. POOL FOR FEDERALLY-QUALIFIED HEALTH CENTERS & RURAL HEALTH CLINICS

Financing: A pool for supplemental payments to federally-qualified health centers (FQHCs) and rural health clinics (RHCs) is created. Maximum Federal spending is limited to the following amounts:

Year:	Federal Limit:
1997	$500 million
1998	$500 million
1999	$500 million
2000	$500 million
2001	$500 million
2002	$500 million
Total:	**$3.0 billion**

Design: Funding is allocated to states in proportion to their share of Medicaid payments to facilities (as reported by NACHC).

C. HOLD HARMLESS POOL:

Financing: A pool for payments to states to assist in the transition from the current to the new Medicaid program is created. Maximum Federal spending is limited to the following amounts:

Year:	Federal Limit:
1997	$3.3 billion
1998	$3.3 billion
1999	$2.6 billion
2000	$2.6 billion
2001	$1.9 billion
Total:	**$13.7 billion**

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Equity Adjuster:

The 10 states with highest and lowest 1994 spending per beneficiary (adjusted for case mix) will get different funding. This could be done through differential growth rates, adjustements to the base or adjustements to the limits. The adjustments are budget neutral.

Year:	Federal Limit:
1997	+ / - $2 billion
1998	+ / - $2 billion
1999	+ / - $2 billion
2000	+ / - $2 billion
2001	+ / - $2 billion
Total:	**$0 billion**

Medicaid Savings (fiscal years; dollars in billions)

	1995	1996	1997	1998	1999	2000	2001	2002	1996-2002
Baseline	89.1	97.3	107.3	118.1	129.7	142.5	156.8	172.6	**924.3**
Per Capita Cap									
Savings		0.0	-1.9	-2.8	-4.6	-6.7	-10.0	-13.8	**-39.8**
Index Value:		6.3%	5.1%	5.3%	4.6%	4.5%	3.9%	4.0%	**4.6%**
Nominal GDP Plus:		2.5%	1.0%	1.0%	0.5%	0.5%	0.0%	0.0%	
DSH									
Gross Savings		0.0	-2.0	-3.9	-6.0	-8.0	-9.2	-10.3	**-39.4**
Pools: FQHC Pool			0.5	0.5	0.5	0.5	0.5	0.5	**3.0**
Undocumented Pool			0.70	0.70	0.70	0.70	0.70		**3.5**
Hold Harmless			3.3	3.3	2.6	2.6	1.9		**13.7**
Total									
Savings		0.0	0.6	-2.3	-6.8	-10.9	-16.0	-23.6	**-58.9**
Growth		9.2%	11.0%	7.3%	6.2%	7.0%	7.0%	5.8%	**7.6%**
Per capita growth		5.5%	6.7%	4.5%	3.2%	3.9%	4.5%	3.1%	**4.5%**

Assumptions:
- Estimated by group
- Offset of 33%
- Administrative costs included; Medicare cost sharing excluded.
- CBO December baseline; does not include any adjustment for state-specific growth rates.
- New DSH Pool: $5 billion in 2000; $4.5 billion in 2001; $4.0 billion in 2002.

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PRELIMINARY DRAFT

Comparison of Federal Medicaid Spending: The "MediGrant" Proposal and the President's Proposal

(Dollars in billions, FY 1996 to 2002)

	Republicans	President's Plan		Difference (President = +)	
		Baseline Enrollment	Recession / Higher Enrollment	Baseline Enrollment	Recession / Higher Enrollment
Total	830.2	865.3	880.7	+ 35.1	+ 50.5
Alabama	13.7	13.7	13.9	-0.0	+ 0.2
Alaska	1.8	2.1	2.1	+ 0.3	+ 0.3
Arizona	12.5	12.7	12.9	+ 0.3	+ 0.5
Arkansas	9.1	9.4	9.5	+ 0.3	+ 0.4
California	86.3	86.6	88.2	+ 0.3	+ 1.9
Colorado	6.9	7.0	7.6	+ 0.2	+ 0.7
Connecticut	11.3	11.7	11.9	+ 0.4	+ 0.7
Delaware	1.8	2.1	2.1	+ 0.3	+ 0.2
District of Columbia	3.9	4.4	4.5	+ 0.6	+ 0.7
Florida	35.3	36.6	37.6	+ 1.3	+ 2.3
Georgia	21.9	25.5	26.0	+ 3.6	+ 4.1
Hawaii	2.5	2.7	2.8	+ 0.2	+ 0.3
Idaho	2.6	2.6	2.6	+ 0.0	+ 0.0
Illinois	31.6	31.9	32.5	+ 0.3	+ 0.9
Indiana	16.7	17.9	18.2	+ 1.2	+ 1.5
Iowa	7.2	7.6	7.7	+ 0.4	+ 0.5
Kansas	6.1	6.1	6.2	-0.0	+ 0.1
Kentucky	14.2	14.9	15.2	+ 0.7	+ 1.0
Louisiana	19.0	26.9	27.3	+ 7.9	+ 8.3
Maine	5.4	5.8	6.3	+ 0.4	+ 0.9
Maryland	11.8	12.9	13.1	+ 1.1	+ 1.4
Massachusetts	22.2	23.0	23.8	+ 0.8	+ 1.6
Michigan	29.9	29.9	30.2	+ 0.0	+ 0.3
Minnesota	13.8	15.8	16.1	+ 1.9	+ 2.3
Mississippi	11.8	11.8	12.0	-	+ 0.2
Missouri	16.5	16.5	16.9	-	+ 0.4
Montana	2.8	3.1	3.1	+ 0.3	+ 0.3
Nebraska	3.8	4.2	4.4	+ 0.5	+ 0.6
Nevada	2.7	3.0	2.9	+ 0.3	+ 0.2
New Hampshire	2.6	3.2	3.3	+ 0.7	+ 0.7
New Jersey	22.2	24.0	24.4	+ 1.8	+ 2.2
New Mexico	6.0	6.0	6.1	+ 0.0	+ 0.1
New York	100.3	103.5	106.6	+ 3.2	+ 6.3
North Carolina	22.5	24.3	24.7	+ 1.8	+ 2.2
North Dakota	2.1	2.1	2.1	-	+ 0.1
Ohio	34.5	34.5	34.7	-0.0	+ 0.1
Oklahoma	8.5	8.5	8.3	-0.0	-0.3
Oregon	9.4	9.4	9.5	-	+ 0.1
Pennsylvania	38.0	38.0	38.9	+ 0.1	+ 0.9
Rhode Island	4.2	4.6	5.1	+ 0.4	+ 0.9
South Carolina	14.6	14.6	14.2	-	-0.4
South Dakota	2.3	2.3	2.4	-0.0	+ 0.1
Tennessee	22.1	22.1	21.9	-	-0.2
Texas	59.8	59.8	60.0	-0.0	+ 0.2
Utah	4.4	4.4	4.4	-	+ 0.0
Vermont	2.0	2.0	2.1	+ 0.0	+ 0.1
Virginia	10.6	11.1	11.3	+ 0.4	+ 0.7
Washington	13.7	15.2	15.4	+ 1.6	+ 1.8
West Virginia	9.9	11.3	11.5	+ 1.4	+ 1.6
Wisconsin	14.6	14.6	15.0	-0.0	+ 0.3
Wyoming	1.1	1.3	1.3	+ 0.2	+ 0.2

Republican estimates from the GAO estimates of the block grant allocation of the MediGrant II, 1/30/96

Note: These estimates include supplemental payments for illegal aliens, Nebraska, Nevada & Louisiana.

President's estimates from the Dept. of Health & Human Services' adjusted Urban Institute Medicaid Baseline, controlled to the December CBO baseline.

The Per Capita Cap Allotment pool was allocated to states whose "anticipated enrollment growth" is less than 2% in proportion to enrollees.

"Recession / higher enrollment" assumes that enrollment growth for all groups is 0.5 percentage points higher than CBO's baseline estimates.

6-Feb-96

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PRELIMINARY DRAFT

Comparison of Federal Medicaid Spending: The "MediGrant" Proposal and the President's Proposal

(Dollars in billions, FY 1996 to 2002)

	Republicans	President's Plan		Difference (President = +)	
		Baseline Enrollment	Recession / Higher Enrollment	Baseline Enrollment	Recession / Higher Enrollment
Total	830.2	866.5	880.2	+ 36.3	+ 50.0
Alabama	13.7	13.3	13.5	-0.4	-0.2
Alaska	1.8	2.0	2.0	+ 0.2	+ 0.3
Arizona	12.5	12.7	12.9	+ 0.2	+ 0.5
Arkansas	9.1	9.4	9.5	+ 0.2	+ 0.4
California	86.3	86.7	88.2	+ 0.4	+ 1.9
Colorado	6.9	7.4	7.6	+ 0.6	+ 0.7
Connecticut	11.3	11.7	11.9	+ 0.4	+ 0.7
Delaware	1.8	2.0	2.1	+ 0.2	+ 0.2
District of Columbia	3.9	4.4	4.5	+ 0.6	+ 0.7
Florida	35.3	36.9	37.6	+ 1.6	+ 2.3
Georgia	21.9	25.5	26.0	+ 3.7	+ 4.1
Hawaii	2.5	2.7	2.8	+ 0.2	+ 0.3
Idaho	2.6	2.6	2.6	-0.0	+ 0.0
Illinois	31.6	32.1	32.5	+ 0.5	+ 0.9
Indiana	16.7	17.9	18.2	+ 1.1	+ 1.5
Iowa	7.2	7.5	7.7	+ 0.4	+ 0.5
Kansas	6.1	6.1	6.2	+ 0.0	+ 0.1
Kentucky	14.2	14.9	15.2	+ 0.7	+ 1.0
Louisiana	19.0	26.8	27.3	+ 7.8	+ 8.3
Maine	5.4	6.1	6.3	+ 0.8	+ 0.9
Maryland	11.8	12.9	13.1	+ 1.1	+ 1.4
Massachusetts	22.2	23.4	23.8	+ 1.2	+ 1.6
Michigan	29.9	29.9	30.2	+ 0.0	+ 0.3
Minnesota	13.8	15.8	16.1	+ 2.0	+ 2.3
Mississippi	11.8	11.8	12.0	-0.0	+ 0.2
Missouri	16.5	16.6	16.9	+ 0.2	+ 0.4
Montana	2.8	3.1	3.1	+ 0.3	+ 0.3
Nebraska	3.8	4.3	4.4	+ 0.6	+ 0.6
Nevada	2.7	2.8	2.9	+ 0.2	+ 0.2
New Hampshire	2.6	3.2	3.3	+ 0.7	+ 0.7
New Jersey	22.2	24.0	24.4	+ 1.8	+ 2.2
New Mexico	6.0	5.9	6.1	-0.0	+ 0.1
New York	100.3	105.0	106.6	+ 4.7	+ 6.3
North Carolina	22.5	24.2	24.7	+ 1.7	+ 2.2
North Dakota	2.1	2.1	2.1	+ 0.0	+ 0.1
Ohio	34.5	34.3	34.7	-0.3	+ 0.1
Oklahoma	8.5	8.2	8.3	-0.3	-0.3
Oregon	9.4	9.4	9.5	+ 0.0	+ 0.1
Pennsylvania	38.0	38.4	38.9	+ 0.5	+ 0.9
Rhode Island	4.2	5.0	5.1	+ 0.8	+ 0.9
South Carolina	14.6	14.0	14.2	-0.6	-0.4
South Dakota	2.3	2.3	2.4	+ 0.0	+ 0.1
Tennessee	22.1	21.7	21.9	-0.4	-0.2
Texas	59.8	59.2	60.0	-0.6	+ 0.2
Utah	4.4	4.3	4.4	-0.0	+ 0.0
Vermont	2.0	2.0	2.1	+ 0.0	+ 0.1
Virginia	10.6	11.1	11.3	+ 0.5	+ 0.7
Washington	13.7	15.2	15.4	+ 1.5	+ 1.8
West Virginia	9.9	11.2	11.5	+ 1.3	+ 1.6
Wisconsin	14.6	14.8	15.0	+ 0.2	+ 0.3
Wyoming	1.1	1.3	1.3	+ 0.2	+ 0.2

Republican estimates from the GAO estimates of the block grant allocation of the MediGrant II, 1/30/96

Note: These estimates include supplemental payments for illegal aliens, Nebraska, Nevada & Louisiana. Excludes Per Capita Allotment Pool and territories.

President's estimates from the Dept. of Health & Human Services' adjusted Urban Institute Medicaid Baseline, controlled to the December CBO baseline.

"Recession / higher enrollment" assumes that enrollment growth for all groups is 0.5 percentage points higher than CBO's baseline estimates.

3-Feb-96

THE PER CAPITA CAP
The Administration's Plan to Control Medicaid Spending
January 22, 1996

Description of Administration Per Capita Cap and Republican Block Grant Proposal

The President's Medicaid plan provides incentives for restraining Medicaid spending while guaranteeing coverage even in the event of recessions, natural disasters or other events beyond the control of either States or the Federal government.

- The plan does this by establishing a "per capita cap," a limit on the amount the Federal government will pay for each Medicaid beneficiary for any fiscal year.

The per capita cap for each State under the Administration proposal would be based on fiscal year 1995 Medicaid spending per beneficiary in that State, fully updated for inflation. The overall annual Medicaid spending limit for each State under the President's proposal would be the sum of separate limits for each group of Medicaid beneficiaries--non-disabled children and adults, the elderly and persons with disabilities. The limit for each group would be calculated by multiplying the number of Medicaid beneficiaries in that category that year by the maximum Federal payment per beneficiary in that group (which would in turn be based on the State's FY 1995 Medicaid spending on that group, fully adjusted for inflation). This approach would ensure that States with above-average numbers of elderly or disabled recipients, who tend to be sicker and require more expensive services, would be treated equitably under the President's plan.

- The Republican Medicaid plan, by contrast, would place a preset limit on total Federal payments to each State in a year, regardless of the number of persons meeting the State's eligibility criteria for medical assistance.

In other words, the total amount of Federal reimbursement for spending on medical assistance would be capped. Under current law, for example, if a State with a 50 percent Medicaid match rate spent $100 on Medicaid, it would receive $50 in Federal reimbursement. The Republican proposal would cap the amount of Federal reimbursement so that this State would be limited to, for example, $40 in reimbursement. If the State nonetheless spent $100 on medical assistance, it would have to absorb an additional $10 in costs.

A Per Capita Cap Protects Individuals and States; A Block Grant Does Not

Critics of the per capita cap claim that it represents "the largest unfunded federal mandate on states," because it retains guaranteed coverage and benefits while limiting the growth of Federal spending. Under the Administration's plan, however, spending per Medicaid beneficiary is estimated to grow by 4.8 percent annually, as opposed to 2.2 percent--a full percentage point less than inflation--under the Republican plan. Moreover, under the

President's proposal, if the number of poor children, elderly or disabled in a State increased more rapidly than expected, Federal Medicaid matching funds would rise to meet the need.

Those arguing against the per capita cap assume that States will be unsuccessful in controlling the growth in spending per Medicaid beneficiary. If this turns out to be the case, however, the Republican proposal would put States in an extremely difficult position. Under the Republican plan, spending per beneficiary does not even keep pace with inflation. In addition, Federal funding would remain fixed, even if the number of people meeting a State's eligibility criteria increased sharply due to changing economic or demographic conditions.

Under the Republican plan, a State that did not draw down its full allotment of Federal funding for a fiscal year would be permitted to draw down the unused amount in subsequent years. Given that the legislation does not provide States sufficient funding to maintain current Medicaid services, it is not clear how many States could do with less than their full allotment for a fiscal year (and consequently be able to reserve Federal dollars to meet future need).

The President's Proposal Gives States the Flexibility to Control Per Capita Spending

Supporters of the Republican proposal maintain that only converting the Medicaid program into a block grant will allow States to serve the same number of beneficiaries at a lower cost, i.e., to lower per capita spending.

The President's plan, however, gives States wide latitude to implement cost containment measures. The "Boren Amendment," the provision in current Medicaid law that requires States to pay hospitals and nursing homes rates that would be reasonable for efficiently operated facilities, would be repealed. This provision has served as the basis for numerous lawsuits brought by hospitals and nursing home groups against States regarding Medicaid payment rates.

- The Senate Finance Committee majority, during consideration of its Medicaid legislation, asserted that "the most problematic payment provision has been the 'Boren Amendment'..." (mark-up document for Finance Committee 1995 reconciliation legislation)

Repeal of this amendment would give States considerably greater control over Medicaid payments to hospitals and nursing homes. Other payment requirements currently in Medicaid law, including the provision requiring States to reimburse rural health clinics and Federally qualified health centers for 100 percent of reasonable costs incurred in treating Medicaid patients, would also be repealed.

Perhaps most important, the President's plan would allow States to require Medicaid recipients to enroll in managed care plans, provided that each recipient had a choice of at

least two plans. Supporters of the Republican Medicaid legislation argue that managed care is the best hope for substantially reducing Medicaid expenditures. States are already moving rapidly in this direction, however, which may limit potential future savings. The percentage of Medicaid recipients in managed care has increased from 9.5 percent in 1991 to 23.2 percent in 1994 to 32.1 percent in 1995. The President's plan would also permit States to waive income criteria and other requirements to offer home and community-based care to individuals in nursing homes or at risk of institutionalization. Community-based care is generally more cost-effective than institutional care.

The Republican Plan Would Force States to Reduce Benefits and Coverage

Under the Republican plan, the total amount of Federal medical assistance funding would be capped at a level at least $85 billion (and as much as $117 billion) below what CBO projects would be needed to maintain services for people now covered by Medicaid. Moreover, Federal funding would not respond to unexpected increases in the number of poor children, elderly and disabled due to recessions, natural disasters such as Hurricane Andrew and other events no State can control. Many States would be left with no choice but to scale back services or drop beneficiaries from the rolls, especially during economic downturns, when the need would be the greatest.

The Republican plan gives States complete latitude to do just that. Under the proposal, States are required to provide coverage to poor pregnant women and children under 13 and to persons with a disability. The decision as to what (if any) services to provide, however, is left entirely to the States. Senator John H. Chafee, a senior Republican Finance Committee member and the sponsor of the amendment establishing these requirements, noted that this guarantee of coverage might not amount to much: "The states could say, 'for this group there will be one aspirin a year'...but at least you have to cover everybody in the group." (*The Washington Post*, October 31, 1995). The only services guaranteed by the legislation are immunization for children and family planning.

Lewin-VHI, a nonpartisan health care research firm, estimated that by FY 2002, 8.5 million individuals would lose Medicaid coverage as a result of the Republican budget plan. (*Potential Cost Shifting under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995*, Lewin-VHI, Inc., November 21, 1995). This is consistent with earlier projections by the Urban Institute, an independent think tank, which found that the Medicaid cuts in the House and Senate budget resolutions would result in the loss of coverage for between 3 and 9 million persons.

Congressional Republicans and Republican governors insist that notwithstanding these predictions, States would resist the pressure created by the legislation to drop recipients from the Medicaid rolls. Many of these same GOP governors, however, vigorously protested the Chafee amendment, even though under that provision States would have complete control over the level of benefits provided.

In an October 6 letter to Senate Majority Leader Robert J. Dole, 24 Republican governors claimed that the Senate Finance Committee Medicaid legislation included "overly prescriptive and onerous provisions that will militate against the states' ability to implement reforms. Among these are individual entitlements [the Chafee amendment], which create both a huge potential cost shift to States and unlimited potential for litigation." (*The Washington Post*, October 10, 1995)

- If the 24 governors are intent on maintaining Medicaid coverage for individuals now eligible, it is not immediately apparent why they objected so strongly to the Chafee amendment, which would have guaranteed only minimal coverage for a fraction of current Medicaid recipients.

On the other hand, even the relatively modest language in the Chafee amendment might pose an obstacle to a State planning to drastically reduce Medicaid coverage.

Conclusion

The President's proposal is consistent with the pledges made by Republican governors. It preserves basic health benefits for the low-income children, parents, elderly and disabled now covered, while granting States the latitude needed to control per capita Medicaid spending.

The American Academy of Pediatrics, whose 48,000 members provide care for many of the 18 million children currently covered by Medicaid, has suggested per capita caps as a way to restrain Medicaid spending while maintaining coverage: "The Academy believes the congressional goals of controlling federal spending and increasing state flexibility can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents. This can be done by allowing states to easily move Medicaid into managed care or *through reasonable per-capita funding caps.* (July 31, 1995 press release)

- The Republican proposal, conversely, leaves States little choice but to drop people from the Medicaid program and reduce services for those remaining eligible.

Medicaid: Major Points in the Discussion of Block Grant Versus Entitlement

1. **Shared Responsibility:** State governors, like the President, are committed to providing quality health care for low-income, elderly and disabled Americans. However, under a block grant, the Federal government is reneging on its end of the thirty-year partnership to share in the unpredictable costs of health care inflation.

   Under a block grant:

   - **States bear 100 percent of the risk.** Health care inflation has always been higher -- usually nearly twice as high -- as general inflation. Leaving states 100 percent at risk for these costs is unfair.

   - **States are not protected from economic downturns.** In any given year, some states prosper and others suffer from local economic downturns. When a major industry closes in a state or a recession hits, Medicaid enrollment often increases since working people lose their health insurance with their jobs and turn to Medicaid for temporary help. This increase in enrollment -- and costs -- occurs at the same time as the state's revenues are suffering.

     Under a block grant, each state gets a fixed amount of money regardless of what is currently happening in the state. This amount is based on a formula created in Washington in 1995. There is no way that this formula -- or any block grant formula -- can predict and protect a state from a recession in 1999, for instance.

   The President's plan maintains the Federal partnership that protects states from this double bind by sharing in the unexpected costs.

2. **People Would Lose Medicaid Coverage.** Regardless of governors' intentions, basic economics dictate that the Republicans' block grant funding is not enough to pay for health care for the people who would be covered under current law.

   - **25 percent reduction in spending per person by 2002.** States will only get three out of the four Federal dollars that CBO projects that they will get under current law by 2002.

   - **Federal spending growth below inflation.** Once inflation is taken into account, the block grant spending per person declines over the seven-year period. The amount that the Federal government will contribute to the coverage of a Medicaid beneficiary will grow at rates less than inflation, meaning that its growth won't keep up with the value of the dollar. Maintaining spending growth per person at this level is unprecedented, both in the private and public sectors. This leaves states with only one choice: reduce the number of people covered.

- **Experts agree: Millions could lose coverage.** The Urban Institute, the Kaiser Commission on the Future of Medicaid, the Council on the Economic Impact of Health Care Reform, Lewin-VHI, and the Department of Health and Human Services have all come to the same conclusion: that the level of funding proposed in the block grant will leave millions of Americans without Medicaid by 2002. [get a quote]

3. **Common Safety Net.** The United States is one of the few industrialized nations that lacks a universal health insurance program -- and is the only nation other than South Africa that does not insure all of its children [check]. Under current law, we would meet the goal of covering all poor children by 2001 through Medicaid. Additionally, Medicaid protects people with disabilities and low-income elderly who are in need of help with Medicare payments, and who cannot afford expensive nursing home care.

   The commitment to cover these people is one that is made as a nation. A poor child should not lose basic health care covered by Medicaid by crossing a state border. Similarly, why should the definition of "coverage" be subject to states' discretion when most people know that health insurance means paying for doctor's visits, hospital care clinic visits and other basic services?

   The President's plan offers states even more flexibility than they currently have to cover low-income people, to implement innovative new delivery systems, and to change their benefits package without a Federal waiver. However, allowing 50 different standards of which children, seniors and people with disabilities deserve health coverage -- and 50 different definitions of what coverage means -- is not flexibility. It is an end to a state and federal commitment to cover certain vulnerable people regardless of where they live.

Medicaid: Major Points in the Discussion of Block Grant Versus Entitlement

1. **Shared Responsibility:** State governors, like the President, are committed to providing quality health care for low-income, elderly and disabled Americans. However, under a block grant, the Federal government is reneging on its end of the thirty-year partnership to share in the unpredictable costs of health care inflation.

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   - **States bear 100 percent of the risk.** Health care inflation has always been higher -- usually nearly twice as high -- as general inflation. Leaving states 100 percent at risk for these costs is unfair.

   - **States are not protected from economic downturns.** In any given year, some states prosper and others suffer from local economic downturns. When a major industry closes in a state or a recession hits, Medicaid enrollment often increases since working people lose their health insurance with their jobs and turn to Medicaid for temporary help. This increase in enrollment -- and costs -- occurs at the same time as the state's revenues are suffering.

     Under a block grant, each state gets a fixed amount of money regardless of what is currently happening in the state. This amount is based on a formula created in Washington in 1995. There is no way that this formula -- or any block grant formula -- can predict and protect a state from a recession in 1999, for instance.

   The President's plan maintains the Federal partnership that protects states from this double bind by sharing in the unexpected costs.

2. **People Would Lose Medicaid Coverage.** Regardless of governors' intentions, basic economics dictate that the Republicans' block grant funding is not enough to pay for health care for the people who would be covered under current law.

   - **25 percent reduction in spending per person by 2002.** States will only get three out of the four Federal dollars that CBO projects that they will get under current law by 2002.

   - **Federal spending growth below inflation.** Once inflation is taken into account, the block grant spending per person declines over the seven-year period. The amount that the Federal government will contribute to the coverage of a Medicaid beneficiary will grow at rates less than inflation, meaning that its growth won't keep up with the value of the dollar. Maintaining spending growth per person at this level is unprecedented, both in the private and public sectors. This leaves states with only one choice: reduce the number of people covered.

- **Experts agree: Millions could lose coverage.** The Urban Institute, the Kaiser Commission on the Future of Medicaid, the Council on the Economic Impact of Health Care Reform, Lewin-VHI, and the Department of Health and Human Services have all come to the same conclusion: that the level of funding proposed in the block grant will leave millions of Americans without Medicaid by 2002. [get a quote]

3. **Common Safety Net.** The United States is one of the few industrialized nations that lacks a universal health insurance program -- and is the only nation other than South Africa that does not insure all of its children [check]. Under current law, we would meet the goal of covering all poor children by 2001 through Medicaid. Additionally, Medicaid protects people with disabilities and low-income elderly who are in need of help with Medicare payments, and who cannot afford expensive nursing home care.

   The commitment to cover these people is one that is made as a nation. A poor child should not lose basic health care covered by Medicaid by crossing a state border. Similarly, why should the definition of "coverage" be subject to states' discretion when most people know that health insurance means paying for doctor's visits, hospital care clinic visits and other basic services?

   The President's plan offers states even more flexibility than they currently have to cover low-income people, to implement innovative new delivery systems, and to change their benefits package without a Federal waiver. However, allowing 50 different standards of which children, seniors and people with disabilities deserve health coverage -- and 50 different definitions of what coverage means -- is not flexibility. It is an end to a state and federal commitment to cover certain vulnerable people regardless of where they live.

THE PER CAPITA CAP: The Administration's Plan to Control Medicaid Spending
December 29, 1995

The President's Medicaid plan provides incentives for restraining Medicaid spending while guaranteeing coverage even in the event of recessions, natural disasters or other events beyond the control of either States or the Federal government.

- *The plan does this by establishing a "per capita cap," a limit on the amount the Federal government will pay for each Medicaid beneficiary for any fiscal year*, rather than by placing a preset limit on the total amount of Federal payments--the approach taken in the Republican plan.

The per capita cap for each State under the Administration proposal would be based on fiscal year 1995 Medicaid spending per beneficiary in that State, fully updated for inflation. By contrast, if the Republican plan were adopted, spending per Medicaid beneficiary would increase by only 1.6 percent per year--half the rate of inflation. The Congressional Budget Office projects that private sector health spending per capita will grow by 7.1 percent annually over the same period.

The overall Medicaid spending limit for each State under the President's proposal would be the sum of separate limits for each group of Medicaid beneficiaries--non-disabled children and adults, the elderly and persons with disabilities. The limit for each group would be calculated by multiplying the number of Medicaid beneficiaries in that category by the maximum Federal payment per beneficiary in that group (which would in turn be based on the State's FY 1995 Medicaid spending on that group, fully adjusted for inflation). This approach would ensure that States with above-average numbers of elderly or disabled recipients, who tend to be sicker and require more expensive services, would be treated equitably under the President's plan.

The American Academy of Pediatrics, whose 48,000 members provide care for many of the 18 million children currently covered by Medicaid, has suggested per capita caps as a way to restrain Medicaid spending while maintaining coverage: "The Academy believes the congressional goals of controlling federal spending and increasing state flexibility can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents. This can be done by allowing states to easily move Medicaid into managed care or *through reasonable per-capita funding caps*. (July 31, 1995 press release)

Why Not a Per Capita Cap?

Opponents of the per capita cap claim that it represents "the largest unfunded federal mandate on states," because it retains guaranteed coverage and benefits while limiting the growth of Federal spending. This argument assumes that States will be unsuccessful in controlling the growth in spending per Medicaid beneficiary. *If this is the case, however, the $117 billion Medicaid cut in the Republican budget plan would seem to represent a substantially larger unfunded mandate.*

Under the Republican proposal, each State would be limited to a fixed sum of Federal funding,

regardless of the number of people meeting the State's medical assistance eligibility criteria. On the other hand, under the Administration's plan, if the number of low-income children, parents, elderly or disabled rose, Federal Medicaid matching funds would rise accordingly.

The President's Proposal Enhances State Ability to Control Per Capita Spending

Supporters of the Republican proposal maintain that only converting the Medicaid program into a block grant will give States the flexibility to serve the same number of beneficiaries at a lower cost, i.e., to lower per capita spending.

The President's plan, however, grants States wide latitude to implement cost containment measures. The "Boren Amendment," the provision in current Medicaid law that requires States to pay hospitals and nursing homes rates that would be reasonable for efficiently operated facilities, would be repealed. This provision has served as the basis for numerous lawsuits brought by hospitals and nursing home groups against States regarding Medicaid payment rates. The Senate Finance Committee majority, during consideration of its Medicaid legislation, asserted that "the most problematic payment provision has been the 'Boren Amendment...' (mark-up document for Finance Committee 1995 reconciliation legislation)

Repeal of this amendment would give States considerably greater control over Medicaid payments to hospitals and nursing homes. Other payment requirements currently in Medicaid law, including the provision requiring States to reimburse rural health clinics and Federally qualified health centers for 100 percent of reasonable costs incurred in treating Medicaid patients, would also be repealed.

Perhaps most important, the President's plan would allow States to require Medicaid recipients to enroll in managed care plans, provided that each recipient had a choice of at least two plans. Supporters of the Republican Medicaid legislation argue that managed care is the best hope for substantially reducing Medicaid expenditures. States are already moving rapidly in this direction, however, which may limit potential future savings. The percentage of Medicaid recipients in managed care has increased from 9.5 percent in 1991 to 23.2 percent in 1994 and to 32.1 percent in 1995. The President's plan would also give States greater flexibility to offer home and community-based care to individuals in nursing homes or at risk of institutionalization, without having to obtain a Federal waiver. Community-based care is generally more cost-effective than institutional care.

The Republican Plan Gives States the Flexibility to Reduce Benefits and Coverage

Under the Administration's Medicaid proposal, States would have the ability to pursue a wide range of methods to control spending.

- The Republican plan, however, does provide States with even greater flexibility. In particular, it allows States to drastically scale back services available to Medicaid beneficiaries or drop individuals from the program entirely.

Under the Republican Medicaid proposal, States are required to provide coverage to poor pregnant women and children under 13 and to persons with a disability. The decision as to what, if any, services to provide, is left entirely to the States. Senator John H. Chafee, a senior Republican Finance Committee member and the sponsor of the amendment establishing these requirements, noted that the guarantees might not amount to much: "The states could say, 'for this group there will be one aspirin a year'...but at least you have to cover everybody in the group." (*The Washington Post*, October 31, 1995) The only services guaranteed by the legislation are immunization for children and family planning services.

Lewin-VHI, a nonpartisan health care research firm, estimated that by FY 2002, 8.5 million individuals would lose Medicaid coverage as a result of the Republican plan. (*Potential Cost Shifting under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995*, Lewin-VHI, Inc., November 21, 1995). This is consistent with earlier projections by the Urban Institute, an independent think tank, which found that the Medicaid cuts in the House and Senate budget resolutions would result in the loss of coverage for between 3 and 9 million persons.

Congressional Republicans and Republican governors insist that notwithstanding these predictions, States will not take the opportunity provided by the legislation to drop recipients from the Medicaid rolls. Many of these same GOP governors, however, vigorously protested the Chafee amendment, even though under that provision States would have complete control over the level of services provided.

In an October 6 letter to Senate Majority Leader Robert J. Dole, 24 Republican governors claimed that the Senate Finance Committee Medicaid legislation included "overly prescriptive and onerous provisions that will militate against the states' ability to implement reforms. Among these are individual entitlements [the Chafee amendment], which create both a huge potential cost shift to States and unlimited potential for litigation. (*The Washington Post*, October 10, 1995)

If the 24 governors are intent on maintaining Medicaid coverage for individuals now eligible, it is not immediately apparent why they objected so strongly to the Chafee amendment, which would require only minimal coverage of a fraction of current Medicaid recipients. On the other hand, even the relatively modest language in the Chafee amendment might pose an obstacle to a State planning to drastically reduce Medicaid coverage.

- The President's proposal is consistent with the pledges made by Republican governors. It preserves basic health benefits for the poor children, parents, elderly and disabled now covered, while granting States the latitude needed to control per capita Medicaid spending.

- The Republican proposal, conversely, gives States the ability to do what Republican governors insist they will not do--deny Medicaid coverage to individuals currently eligible.

argue that HCBS would be the most vulnerable because they have the least political power in the states.)

To some extent, Bergman is acting as if we have some big opportunity to fix all the ills of the current system, particularly his belief that it is biased toward institutional care. I have told him the action must be on protecting what we already have. He responds that if big changes are made there won't be any more legislative change to Medicaid for a few years, and that in some ways a block grant is preferable to a per capita cap.

Bergman solution is to require states to continue to spend the same proportion of dollars on HCBS services that they do today; I've told him that how unlikely that is with the Hill/Governors.

The response to this that Jen and I have come up with is:

(1) our growth rate per beneficiary under the per capita cap is not so harsh -- it is 5-6% per bene vs. current rate of about 7%, vs Repub. rate of 1.6% -- so it won't be so hard for Governors to find ways to live within the caps;

(2) we are giving Governors flexibility to keep per capita costs low (Boren, FQHC rates, managed care (not that disability groups love to hear that));

(3) most of our savings are not from the per capita cap, but from DSH and other things; only $17b of the $54 is per capita cap (although it is true that the full $54b will put pressure on states).

(By the way, at the bigger meeting with advocates at the Truman conference center several days ago, someone asked you whether the changes we've made to home and community based waivers would affect the requirement that a person must need institutional level care in order to qualify for a waiver. I think you had answered you weren't sure and asked the person if they were asking about the cold bed rule.)

(I think they were referring to the fact that the HCBS waivers do require a level of disability that would otherwise lead the person to be in an institution. That has not changed in our Medicaid proposal, whereas the Republican block grant would eliminate that requirement. All we have done is to make it a state plan amendment rather than a waiver, to the best of my knowledge.)

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO: Joe Stiglitz

Take Necessary Action	___
Approval or Signature	___
Comment	___
Prepare Reply	___
Discuss With Me	___
For Your Information	✓
See Remarks Below	___

Re: Medicaid Per Capita Growth Limits

FROM: NANCY-ANN MIN DATE: 12/13/95

REMARKS:

Attached, as we discussed on Tuesday, are ① Richard Kogan's memo on the inflation-based index he prefers, and ② the OMB staff's response.

I'd appreciate your reaction.

cc: Gene Sperling
Jennifer Klein

December 5, 1995

The Allowable Growth Multiplier under a Medicaid Per-Capita Cap Should be "X Percent Above Current Inflation"

What is the appropriate "allowable growth multiplier" in any proposal to cap the per-capita amount of federal Medicaid payments to states?[1] Two choices are under consideration: a multiplier equal to "X percent above inflation"[2] or a multiplier equal to the annual percentage change in the five-year historical average of nominal Gross Domestic Product (GDP)[3]. "Inflation plus" is the better choice, for a number of reasons.

Both "average nominal GDP" and "inflation plus" build in some real growth and cover inflation in some way. There are two issues: 1) Should the inflation adjustment be contemporaneous, i.e. reflecting inflation in the "current" year, or should it be based on the historical average? 2) Should the amount of allowable real growth be a fixed number, determined in advance by statute (as with inflation plus), or should it depend on historical real growth?

- To provide meaningful inflation protection to states, the inflation adjustment should be contemporaneous. If, for example, inflation jumps from 3 percent to 5 percent in 1997, using "inflation plus" the federal per-capita payment would also be 2 percent higher than expected. Using the historical average, the states would have to absorb *all* the costs of the extra 2 percent in 1997, 80% of the costs of the extra 2 percent 1998 (and all the costs of any extra 1998 inflation, as well), and so on.

  One of the main reasons a state should favor a per-capita cap over the Congressional proposal of a fixed block grant is the complete inflation

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[1] Under a Medicaid per-capita cap, federal payments to states are limited to the number of current enrollees times a constant. The constant is the product of the base-year (1995) cost per enrollee and the allowable growth multiplier. Thus, a per-capita cap limits the *growth rate* per-capita federal payments. It does not limit the total, since the number of enrollees is an uncapped variable.

[2] When growth rates are combined, as in "2.0 percent above inflation," they must be calculated by expressing each value as a ratio and multiplying the ratios. In this case, "2.0 percent above inflation" is calculated as 1.020 times 1.028, which equals 1.04856, or almost 4.9 percent.

[3] The five-year historical average would cover the five fiscal years immediately preceding the "current" year.

protection a per-capita cap can supply. This argument would be seriously compromised by using lagged, historical inflation data.

- The component of the allowable growth multiplier that represents real growth should be some fixed number rather than a lagged, historical average.

  One advantage of a per-capita cap over a fixed block grant is that the extra caseload occurring when the economy performs badly is automatically covered; after all, the federal payments are calculated *per enrollee*. Using an allowable growth multiplier of "inflation plus," this recession protection is complete. But using historical average GDP, the effect of a recession would be to *reduce* the dollar amount the federal government would pay to states in each of the five years following a recession. (And the effects of a recession on caseload persist for years after a recession has technically ended.)

  Thus, the federal government would be covering the additional, recession-caused enrollees *but would simultaneously be reducing the per-capita payment for all enrollees*. Hence, using historical average GDP weakens, rather than strengthens, the recession protection provided by a per-capita cap.

- Arguably, using historical rather than current data provides states with greater certainty about the amount of their federal payment. But the federal payment to the state ultimately depends on the number of "full-year equivalent enrollees" in the state, a figure that won't be known, much less verified, until after the fiscal year has closed and HHS has reviewed the state's data. So there will be an after-the-fact adjustment in federal payments in any event; further adjusting that after-the-fact adjustment to reflect final inflation data will not materially increase a state's uncertainty.

- Nominal GDP grew at about 4½ percent per year from 1991 through 1995. Assuming some generic measure of inflation growing at 3 percent per year, "inflation plus 1½ percentage points" yields the same multiplier as "average nominal GDP." If the purpose of using average nominal GDP is to hide the built-in real growth, no one will be fooled; the level of real growth will have to be negotiated in any case.

- If an argument in favor of average nominal GDP is that health care costs can afford to grow as fast as revenues (which track nominal GDP) but not faster, that argument is undercut by the fact that Medicaid costs will grow *faster* than nominal GDP; under a per-capita cap with such a

multiplier, they will grow at nominal GDP *plus caseload*. Again, no one will be fooled.

It should be noted that most of the per-capita caps introduced by Republican Senators and Congressmen last year used some measure of contemporaneous inflation to calculate their allowable growth multipliers; they did not generally use fixed multipliers; neither did they use historical averages.

For all the above reasons, the allowable growth multiplier should reflect current inflation and be in the form of "inflation plus." The rest of this memo discusses such an "inflation plus" multiplier. As noted, "inflation plus" is intended to provide states full inflation protection (at least respecting the federal share of Medicaid costs). If inflation were one percent per year higher than expected, the extra Medicaid burden on the states would total $65 billion over 1996-2002.

Put differently, if inflation were higher than CBO projected, the existing Medicaid program would grow faster than expected and so would an "inflation plus" per-capita cap; the total amount of federal *savings* will hardly be changed.

The possibility that inflation will surpass current expectations should not be ignored. As noted, CBO is projecting that general inflation will average 2.8 percent per year for the foreseeable future. Yet in the 1980s general inflation averaged 5.2 percent per year, and in the 1970s, 7.0 percent per year.[4] Further, CBO's record on economic forecasting, though as good or better than others', is hardly perfect. For example, in early 1988 CBO overestimated inflation for the year already in progress by 1.0 percentage points; in 1990 CBO underestimated inflation for the year in progress by 0.5 percentage points.

Over a longer period of time, the projections are even more speculative, by necessity. For example, CBO's baseline economic assumptions published in January 1995 imply prices in 2002 that are 4.3 percent higher than implied by CBO's January 1993 assumptions. In contrast, CBO's economic assumptions of January 1985 implied prices that, seven years later, actually turned out to be 4.5 percent lower. The conclusion is that high-quality, unbiased seven-year price assumptions 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 might be $15 billion higher or lower than CBO expects solely because of uncertainty about inflation.

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[4] These figures and the inflation and price figures reflect the average annual percent change in the GDP implicit price deflator on a calendar-year basis. Note, however, that low inflation is not unprecedented. For example, in the 1960s general inflation averaged 2.7 percent per year.

Further, general inflation has almost no effect on the federal budget deficit. If inflation is higher than expected, federal outlays increase but so do federal revenues, and by almost the same amount.[5]

Finally, real cost growth should be calculated relative to *general* inflation (e.g. the GDP implicit price deflator, the GDP chain-linked price deflator, or the GDP fixed-weight price deflator) rather than to medical price inflation. GDP inflation and medical price inflation do not always move in tandem, so calculating real growth relative to medical price inflation would *not* necessarily result in deficit neutrality. Additionally, if the existing gap between general inflation and medical inflation widens, it may be appropriate for federal policy to squeeze harder. Perhaps most importantly, there is considerable doubt about the accuracy of medical price indices.[6]

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[5] 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. Under a matching grant system, higher inflation would lead to higher state Medicaid costs and higher state revenues in the same proportion. Under a block grant, higher inflation would force the state to absorb the state *and federal* share of higher Medicaid costs; in such a case, state Medicaid costs would grow because of inflation much more rapidly than would state revenues.

[6] Henry Aaron, Director of Economic Studies, the Brookings Institution, has written, "To put the matter bluntly, health care price indices are largely worthless" Health Affairs, Winter 1994, p. 10.

Paul

December 7, 1995

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:	The Director Nancy-Ann Min	Decision needed Please sign Per your request Please comment For your information	___ ___ ___ ___ X
THROUGH:	Barry Clendenin BC 12/8 Mark Miller	With informational copies for: HD Chron., HFB Chron., B. Anderson	
Subject:	Richard Kogan's Memo on An Appropriate Medicaid Growth Index	Phone: 202/395-4930 Fax: 202/395-7840 E-mail: PATEL_PA@A1.EOP.GOV Room: #7001	
From:	Parashar Patel Bonnie Washington		

In a recent memo, Richard Kogan of the Center on Budget and Policy Priorities asserts that the allowable growth index under a Medicaid per capita cap should be an "inflation plus X percent" (hereafter referred to as "inflation plus") based index rather than an index based on the five-year historical average of change in nominal gross domestic product per capita (hereafter referred to as "average nominal GDP").[1] The latter is included as part of the President's Medicaid reform proposal.

After reviewing the memo we had an extended discussion with Richard Kogan. At the end of the discussion he indicated that he now sees the advantages of the index contained in the President's proposal and is reevaluating his ideas. (Richard acknowledged that one significant advantage of the historical, GDP based index is that it would be more counter-cyclical than an "inflation plus X" index.) Below are the main points we discussed with Richard.

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[1]Note that the memo actually refers to an index equal to the annual percentage change in the five-year historical average of nominal gross domestic product (GDP). In fact, the President's policy uses an index based on the average annual change in the nominal GDP *per capita* for the five previous years.

Issues Raised in the Memo

The memo acknowledges that both "average nominal GDP" and "inflation plus" allow for inflation and real growth. However, the memo raises two issues:

1) should the adjustment be contemporaneous (i.e., reflect inflation in the "current" year) or historical (i.e., reflect inflation over the last several years)?

2) should the allowable real growth component of the index be fixed (i.e., inflation plus 2 *percentage points*) or should real growth reflect historical real growth?

The Center offers two main reasons in support of choosing an index which is contemporaneous and fixes real growth in statute (e.g., inflation plus X percent). The first is that if inflation increases faster than expected, states would be immediately and fully protected from unexpected increases in Medicaid costs. Second, using historical average GDP would reduce the federal payments for Medicaid during the years following a recession. (The memo points out that "the effects of a recession on caseload persist for years after a recession has technically ended.")

HFB Staff Response

First, HFB staff pointed out that there is no empirical evidence that indicates that state Medicaid costs closely follow inflation trends in the *short-run*. Because state Medicaid reimbursement policies generally do not allow for automatic inflation adjustments, a sudden increase in inflation is unlikely to increase state Medicaid reimbursement rates. There is considerable literature suggesting that one way states control Medicaid spending is to delay updating provider payment rates. Therefore, a Medicaid growth index does not necessarily have to be immediately responsive to changes in inflation.

HFB staff also discussed the following advantages of an "average nominal GDP" index:

- A 5-year rolling average index provides stability in the growth rate and allows states (and the federal government) to better predict growth in federal per capita limits. States would not be subject to short-run fluctuations in inflation.

- During a recession in which inflation is falling, the rolling average would provide a cushion for the state. (Under such a recession, if a contemporaneous based index is used, federal payments to states would actually decrease.)

  While its true that during a recession in which inflation is increasing, a historical based index would not be as responsive as a contemporaneous index, it is unlikely that state Medicaid reimbursement rates will be immediately responsive to increased inflation. (Under either index, the per capita nature of the cap protects states from increased caseloads during and after a recession.)

HFB staff also raised the following concerns with an "inflation plus X" index:

- Both HFB staff and Richard agreed that a Medicaid growth index should encompass inflation and other factors contributing to growth. Both indices discussed in the memo capture inflation and other factors. However, under the "inflation plus X" index, important questions must be addressed: What is X and how is it determined? Should X be set a 0.5, 1.0, 1.5, etc.? The arbitrariness of this factor could make it vulnerable to do downward adjustments for purposes of achieving budget savings in the future.

  In contrast, using an "average nominal GDP" approach means that the index is automatically increased by inflation plus real economic growth. This approach has the advantage of tying growth beyond inflation to real growth in the economy and may make it less vulnerable to arbitrary adjustments for the purpose of achieving budget savings.

- As the memo points out, using a contemporaneous index may require an "after-the fact" adjustment in federal payments. We pointed out the difficulties that could arise as a result of such retroactive adjustments.

  For example, if a state's per capita limit in FY 1997 is $1000 and inflation is projected to increase by 5%, its limit for FY 1998 would be $1050. Suppose that the state spent $1045. Now suppose that inflation actually increased by 3% (making FY 1998's actual limit only $1030).[2] The federal government would have to go back and recoup $15. Such a situation would make many states angry and given the historical experience with federal disallowances, the federal government may not be successful in recouping the difference.

  On the other hand, suppose the state, after some cost-cutting measures to try to stay within the cap spent only $1045. Now suppose inflation actually increased by 7%. The state might be upset that it took cost-cutting measures to stay within the cap only to find that such measures were unnecessary because the projection was wrong.

  We agree that reconciliation will be necessary under a per capita cap to adjust for end-of-the-year recipient and expenditure data. However, given the federal experience with disallowances, we wanted to limit the number of issues that affect the reconciliation process. In addition, while we expect the quality of enrollment and expenditure data to improve significantly over time, we do not expect comparable improvements in the accuracy of economic projections.

- A contemporaneous index based on projections is more subject to manipulation than an index based on historical, widely disseminated data. For instance, a future administration could "game" an inflation projection to lower allowable federal Medicaid growth. States would be in the same situation as above, except the discrepancy between projected and actual inflation rates would be intentional, not forecasting errors.

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[2]As the memo points out, making even short-range projections of inflation is difficult.

Given our discussion of these issues, Richard decided to reconsider his approach. **HFB staff, after considering the advantages and disadvantages of an "inflation plus X" index, favor retaining the approach (5-year historical average of changes in GDP per capita) used in the President's Medicaid policy.**

Please also note that we had extensive discussions with EP staff before choosing an index. EP staff continue to agree with our choice, ever after reviewing the Center's memo.

12-15-95

From Oval -

Send to RM ?

Yes ✓

No ____

cc: Jennifer Klein

December 16, 1995

Dear Mr. President:

The undersigned organizations write to support the concept of a per capita cap as a positive alternative to current Congressional proposals to block grant the Medicaid program. The Medicaid program provides basic health and long term-care services to approximately 36 million American men, women, and children. The block granting of Medicaid would jeopardize coverage for families -- especially seniors, children and persons with disabilities -- at a time when fewer Americans are receiving employer-paid health coverage and the number of uninsured persons continues to rise.

By linking federal funds to the number of people eligible for Medicaid services, a per capita cap would allow states the flexibility to respond to changing economic and demographic conditions. Most importantly, a per capita cap -- unlike a block grant -- creates a disincentive for states to remove people from their Medicaid program. We appreciate your commitment to the per capita cap as an important safeguard for the health of America's most vulnerable populations.

Sincerely,

AIDS Action Council
Alzheimer's Association
American Academy of Pediatrics
American Civil Liberties Union
Bazelon Center for Mental Health Law
Catholic Charities USA
Catholic Health Association of the United States
Center on Disability and Health
Child Welfare League of America
Children's Defense Fund
Families USA
Family Service America
Generations United
InterHealth/Protestant Health Alliance
Legal Action Center
March of Dimes
National Association of Child Advocates
National Association of Children's Hospitals
National Association of Counties
National Association of People with AIDS
National Association of Public Hospitals
National Association of Social Workers
National Association of State Ombudsman Programs
National Citizens' Coalition for Nursing Home Reform
National Community Mental Healthcare Council
National Council of Senior Citizens
National Mental Health Association
National Women's Law Center
Older Women's League
San Francisco AIDS Foundation
Service Employees International Union
TB AIDS Citizen Action Project
The Arc
Women's Legal Defense Fund
Worker Options Resource Center

PER CAPITA CAPS

What are Per Capita Caps?

- Per capita caps would limit growth in federal matching payments per Medicaid beneficiary to some specified index rate.
  - + For states whose spending growth per beneficiary is *below* the index, the federal government would pay its full share of the program as under current law.
  - + For states whose spending growth per beneficiary *exceeds* the index, federal matching payments would be limited to the cap.

- Under a per capita cap system, states would have increased flexibility in the operation of their programs.

Per Capita Caps Have Clear Advantages over Block Grants

- Per capita caps, because they limit payments on a per-person -- rather than an aggregate -- basis, would accommodate states' need to cover additional persons due to economic and demographic changes they cannot control. That is, because the federal government would allow matching payments for each new person who became eligible, states would not be penalized for eligibility growth. By contrast, states trying to live within block grants would be under financial pressure to cut eligibility.

- By contrast to block grants, per capita caps would protect against increases in the number of uninsured in the states. Increases in states' uncompensated care costs and cost-shifting would thus be prevented.

- Under per capita caps, states would have enhanced discretion and flexibility in the operation of their programs.

Administration of Per Capita Caps

Per capita caps would limit annual growth in federal Medicaid matching payments per beneficiary.

- Per capita caps could be calculated separately for subgroups of Medicaid beneficiaries. The subgroups might be: aged; disabled, adults in families with children; and children. By setting different caps for different subgroups, the system would be able to respond to changes in the mix of beneficiaries the state covers.

- In calculating the per capita caps, spending on DSH, Medicare premiums and cost-sharing, Indian Health Service facilities and the Vaccines for Children program could be excluded. Administrative costs could be included in the caps, or they could be capped separately.

- The index rate limiting annual growth in federal matching payments per beneficiary could be an inflation-related factor, adjusted to meet the budgetary target.

- Existing data systems and mechanisms for grants to states and enforcement would be modified to ensure that per capita caps operate effectively.