Families USA FOUNDATION

PRESS RELEASE

FOR IMMEDIATE RELEASE
JUNE 17, 1996

DISASTROUS ASSAULT ON MEDICAID HIDDEN IN WISCONSIN WELFARE REFORM

Health Consumer Group Cites Diversion of Millions of Federal Health Care Dollars To Non-Health Uses, Shortchanging Children

"Hidden behind the Wisconsin welfare plan everybody is talking about is a plan to weaken Medicaid nobody is talking about," according to consumer advocate Ron Pollack.

"The Wisconsin plan would do more damage to Medicaid than any other Medicaid plan now before Congress," Pollack said. "The Wisconsin plan would even violate the Medicaid plan recently introduced at the behest of Republican governors generally and Wisconsin Governor Thompson in particular."

Pollack is executive director of Families USA, the national health consumer group.

In a report issued in Washington today, Families USA turned a spotlight on radical Medicaid changes in the Wisconsin welfare proposal. These changes include allowing the state government to divert nearly $18 million in federal Medicaid funds to non-health care services.

"The Wisconsin plan is not crystal clear on what non-health uses they can shift health funds to. But the issue isn't what non-health use they come up with. The issue is how many kids lose health care," according to Families USA policy director Judy Waxman.

The Wisconsin plan institutes complicated new red tape in eligibility rules, threatening protection especially for working families. But, even eligible families won't be sure of getting medical help under the new plan, because all guarantees of protection are eliminated for families and children.

"First they divert $18 million out of health care. Then, they take the guarantee of health care protection away and tell families you won't get the care you need if we run out of money. The only real guarantee is that the plan will run out of money, and families will be dumped," Pollack said.

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The Wisconsin plan cuts off health coverage for children between ages 12 and 19 who are now protected under federal law.

"America protects these children because we want them to stay in school, be healthy, and grow up to be decent, productive members of the community. The Wisconsin plan says that childhood ends at 12 as far as medical care goes," according to Waxman.

"Even children under five years old will lose coverage if their families are poor, but not quite poor enough to meet new, more restrictive standards," Waxman said.

The Wisconsin plan promises to extend new coverage to families not now protected, but Waxman says that is a phony promise.

"For every new family they promise to include, they have a new rule that will cut that family off. The promise is made of hot air," according to Waxman.

The Families USA report does not comment on the non-health portions of the Wisconsin plan.

"We're not welfare experts, we're health care consumers. Just from the standpoint of health care, Wisconsin's politicians have a lot of work to do to fix this Medicaid plan. They should restore the guarantee that families on Medicaid will get care, they should put up a fence around Medicaid funds so they don't get rustled by the politicians, and they should restore care for the many thousands of kids who would be injured by this ill-conceived plan," Pollack said.

"What's at stake here isn't bureaucratic mumbo jumbo. It's the health of farm families in Grant County and working families in Milwaukee, the health of infants and schoolchildren who are the future of Wisconsin," according to Anne Arnesen of the Wisconsin Council on Families and Children.

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SPECIAL REPORT

A Publication of Families USA, June, 1996

THE WISCONSIN WELFARE PROPOSAL'S MINEFIELD: A MEDICAID BLOCK GRANT

The State of Wisconsin has proposed a radical overhaul of its welfare program – a move that has drawn significant national attention. Overlooked in the debate about the Wisconsin welfare proposal is a Medicaid minefield: the proposed "Wisconsin Works" (W-2) program would convert Medicaid into a block grant.

In some key respects, the Wisconsin proposal's health coverage is more restrictive than the Medicaid legislation recently introduced by Congressional leaders that the President has pledged to veto – a legislative proposal (H.R. 3507) introduced at the behest of Republican governors generally and Wisconsin Governor Tommy Thompson in particular. As a result of the Wisconsin proposal, health coverage for low-income people in the State will be put in jeopardy and health funds will be diverted to other, non-health purposes.

In order to implement this radical new design, the federal government must waive the requirements of several federal laws. Wisconsin's application for these waivers is now pending at the U.S. Department of Health and Human Services (HHS). At least one portion of the Wisconsin proposal is beyond the scope of a waiver and requires a change in the federal statute. There are several other problems with the Medicaid portion of the W-2 proposal that HHS and Wisconsin should correct before any waiver is granted.

The W-2 proposal repeals the current Medicaid program for families and children and replaces it with the Wisconsin Works Health Plan. The W-2 Health Plan is a significant departure from current federal law. Key changes include:

- The guarantee of health care for all people who meet the eligibility criteria is eliminated.
- Many children and families will lose health care coverage.
- Every individual and family will be required to pay a premium which, for many, will be unaffordable.
- Health services for eligible sick children will be curtailed.
- Federal Medicaid funds will be diverted from health care to pay for non-health care services.

GUARANTEED HEALTH COVERAGE WILL BE ELIMINATED

The Wisconsin Works statute states that "notwithstanding fulfillment of the eligibility

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requirements for any component of Wisconsin Works, an individual is not entitled to services or benefits under Wisconsin Works." The waiver application requests that the guarantee to health care for eligible individuals found in current federal law be eliminated. Thus, the W-2 Health Plan constitutes the first state waiver ever to request elimination of this basic principle of guaranteed coverage.

The loss of the guarantee means that groups of people included under the W-2 Health Plan will only get coverage as long as funds last. The promise of coverage is conditional and, therefore, is not a promise at all.

MANY CHILDREN AND FAMILIES WILL LOSE HEALTH COVERAGE

Many children and families will lose health coverage as a result of the Medicaid-related changes contemplated by the W-2 Health Plan. These coverage losses will occur for a variety of reasons, including:

- Children 12 Years of Age and Over Will Lose Coverage: Under existing federal law, all children under 19 years of age, whose family incomes fall below the poverty line, will be phased into guaranteed Medicaid coverage. The Wisconsin proposal will eliminate this coverage for children 12 years of age or older.
- New Income Computation Rules Will Disqualify Health Coverage: Many low-income families will be rendered ineligible for health coverage due to Wisconsin's proposed new income computation rules. In determining income eligibility for health coverage, Wisconsin – for the first time – will include the value of support derived from such sources as the Job Training Partnership Act, educational assistance, school lunches, other child nutrition programs, older Americans assistance, foster care and adoption assistance, low-income home energy assistance, disaster relief, and numerous other programs.
- New Assets Test Will Disqualify Health Coverage: For the first time, Wisconsin will impose an assets test in determining health coverage eligibility for low-income children. This eligibility test will disqualify children and families from health coverage if they have assets in excess of $2,500, excluding a homestead and $10,000 of market value in vehicles.
- Income Eligibility Will Be Reduced for Children Through Five Years of Age: Currently, the Wisconsin Medicaid program covers all children through five years of age whose family incomes are up to 185 percent of poverty. The proposed new program will reduce that eligibility standard to 165 percent of poverty.

Moreover, many families will lose health coverage when they lose their eligibility for public assistance under the W-2 jobs program. In total, the Wisconsin Legislative Fiscal Bureau estimates that 30 percent of the families currently receiving Medicaid will lose their health care coverage.

WISCONSIN'S PROMISE OF EXTENDED COVERAGE IS HOLLOW

The Wisconsin proposal asserts that the W-2 Health Plan will expand coverage for families with incomes up to 165 percent of poverty (currently $2,163.33 a month for a family of three). For families with incomes below this eligibility standard, health coverage will continue even if such families' incomes

subsequently increase (such as through wage raises) up to 200 percent of poverty. On its face, these income standards suggest that coverage will be extended to many families who currently do not have health coverage. A closer examination, however, shows otherwise.

For most families who might qualify for the W-2 Health Plan as a result of these new income standards, other new rules will disqualify them. New rules relating to the potential availability of employer health coverage, even where such coverage is not truly affordable to a working family, will undermine the new income eligibility standards for health coverage.

For example, individuals whose employers offer health coverage will be automatically ineligible for the W-2 Health Plan, even if employers require their workers to pay up to one-half of health insurance premiums and even if such premiums are unaffordable for the workers. The unsubsidized cost of a family insurance plan comparable to the Wisconsin W-2 health plan is estimated to be about $399 per month, resulting in a 50 percent worker premium of approximately $200 per month – an amount that is unaffordable for many low-wage workers. Such health coverage would be especially unaffordable for employer health plans that also require workers to pay significant deductibles and copayments in addition to insurance premiums.

Similarly, families will be disqualified if they had access to employer health coverage in any of the 18 months prior to their application for the W-2 Health Plan. Thus, if someone switched jobs within the past 18 months – and the old employer did, but the new employer did not, offer health coverage – the worker's family might be ineligible for the W-2 Health Plan.

Families will also be disqualified if, after they are employed for one year, the employer offers totally unsubsidized health coverage.

The Wisconsin Legislative Fiscal Bureau estimates that these employer-related rules will disqualify approximately 60 percent of the families from the W-2 Health Plan. These are the families who fall within the income eligibility standard and are not part of the W-2 jobs program.

LOW-INCOME FAMILIES WILL BE REQUIRED TO PAY UNAFFORDABLE PREMIUMS

Under current federal law, states may not charge premiums for low-income Medicaid beneficiaries. However, under the W-2 Health Plan, every participant will be required to pay premiums. Premiums will even be imposed on children and pregnant women.

These new premiums will start at $20 per month for families with incomes below 160 percent of poverty. Once a family's income reaches 160 percent of poverty, the premiums begin to rise, reaching $143 per month for families with incomes at 200 percent of poverty. Families who participate in the W-2 Jobs Program will be required to participate in the W-2 Health Plan and will have their premiums automatically deducted from their monthly payments. Most families will be liable for substantial child care copayments as well. For thousands of program participants, these premiums will be unaffordable and will force them to forgo other necessities.

HEALTH SERVICES FOR SICK CHILDREN WILL BE CURTAILED

Under current federal law, young children

are guaranteed access to crucial preventive services that may be essential to their long-term development. These services – known as early periodic screening, diagnosis and treatment (EPSDT) – will be significantly altered by the Wisconsin proposal. The State will eliminate children's access to some home health, skilled nursing care and dental services as well as over-the-counter products.

MEDICAID FUNDS WILL BE DIVERTED FOR NON-HEALTH CARE SERVICES

The Medicaid statute provides federal funding so that states can offer medical assistance to low-income families. Until now, no state has ever asked for a waiver that would allow federal Medicaid dollars to be diverted for non-health care purposes – a request inherent in the Wisconsin proposal. If granted, an ominous precedent would be established. Granting this waiver of federal law could open the floodgates to requests from other states to use Medicaid dollars for other purposes, such as the building of roads or stadiums.

The waiver application states that "the fiscal underpinning of W-2 is the flexibility to reallocate funds. It will be necessary to allocate AFDC (Aid to Families with Dependent Children) and MA (Medicaid, also called Medical Assistance) funds to supportive services." (emphasis added) Based on documents appended to the Wisconsin waiver request, the State appears to be counting on $299.1 million in federal Medicaid funds for the 1997 fiscal year. The revenue and expenditure documents included in the waiver application indicate that the State will need $281.4 million in federal funds to pay for the W-2 Health Plan, leaving nearly $18 million in federal Medicaid dollars that would be diverted to non-health care purposes.

WISCONSIN'S PROPOSAL IS CONSIDERABLY MORE RESTRICTIVE THAN THE MEDICAID LEGISLATION INTRODUCED RECENTLY BY CONGRESSIONAL LEADERS THAT PRESIDENT CLINTON PLEDGED TO VETO

There are three aspects of the W-2 health plan which could not be implemented even if the Medicaid Block grant legislation pending before Congress were passed:

- W-2 eliminates coverage for all children whose family incomes are below the poverty line when they turn 12. H.R. 3507 requires that 12 year-old children be covered. An amendment adopted by the House Commerce Committee on June 13 requires all children who are under 19, whose incomes are under the poverty line, to be phased in for coverage.
- W-2 charges everyone premiums. H.R. 3507 prohibits the imposition of premiums on children, pregnant women and families who are participants in the state's cash assistance program.
- W-2 proposes to spend Medicaid dollars on non-health care support services. H.R. 3507 provides funds for medical assistance only.

A PORTION OF THE W-2 MEDICAID PROPOSAL CANNOT BE APPROVED BY HHS UNDER ITS CURRENT STATUTORY AUTHORITY

Under current law, the Secretary of HHS does not have the authority to allow Wisconsin to eliminate or restrict eligibility for certain

children and pregnant women. The statute clearly asserts that all states, including states that operate programs under a waiver, must continue to cover certain children and pregnant women as required by the Medicaid law (Section 1902 (l)(4)(A) of the Social Security Act).

CONCLUSION

Changes must be made in the W-2 waiver request before it can be approved. The guarantee to coverage must be restored. No child should lose coverage or benefits. Families should not lose coverage. Premiums should be prohibited. Medicaid funds must be spent on medical assistance only. Without these changes, the most vulnerable Americans will be denied care that is available to them now.

LOSS OF MEDICAID ASSURANCE UNDER H.R. 3507

The House Republican proposal (H.R. 3507) to reform welfare effectively loosens the link between welfare receipt and eligibility for Medicaid. Under the Medicaid reform proposal many more people will lose their assurance of medical coverage. For poor AFDC recipients the loss of cash assistance and health coverage would be devastating.

The House Republican plan keeps as a mandatory group for Medicaid coverage recipients of cash assistance. Yet the details of the proposal would place many recipients at-risk for the loss of coverage. The proposal clearly states that 'certain low income families' namely individuals and members of families who meet current AFDC eligibility criteria related to income and resources would retain Medicaid eligibility. But the proposal goes on to offer states two options to redefine this group:

1. States with high income and resource criteria under current law could lower them to the national average; thus in those states cash assistance recipients would be denied Medicaid coverage.

2. States could link Medicaid eligibility and eligibility for cash assistance under a newly defined State plan under Part A or E (cash assistance block grant or foster care). This provision effectively changes the eligibility criteria from current law to whatever new criteria a state includes in the new state plan. Under this option states could change not only the definition of income and resources but also household filing unit, budgeting and reporting periods, and other non-financial eligibility criteria. This second option allows states to expand or contract the eligible population but any expansions would not incur any additional federal financial participation.

Under the House Republican proposals adult AFDC recipients (except poor, pregnant women) as well as all children aged 13 and older could lose the guarantee if the State opts to either lower Medicaid eligibility criteria to the national average or restrict eligibility for its cash assistance program. In addition, poor families that leave welfare for work or because of increased child support payments will lose the guarantee of transitional Medicaid benefits (the Archer welfare markup document may seek to restore the transitional benefit). Finally, even if the Congress restored the current eligibility rules many members of families subjected to the Federally mandated five year time limit as well as the optional State imposed shorter time limits would lose the Medicaid guarantee.

The numbers presented in the attached table indicate the number of adults and children who will be either placed at-risk to lose their guarantee of Medicaid or lose that coverage under the proposal. These estimates are based upon the current law projections of the size of the AFDC caseload and the characteristics of the recipients in 1994.

Draft: aspe/dto June 11, 1996

In FY 1997 almost 44 percent of all recipients of AFDC will be placed at-risk; only children less than 13 years of age and pregnant women would be certain of continued eligibility. Of the 5.9 million at-risk recipients just less than two million are child recipients aged 13 and over. The remaining 3.9 million at-risk recipients are adults.

The loss of the Transitional Medicaid guarantee would eliminate the guarantee for recipients who leave welfare to work or through increased child support payments. Under current law those who leave for work (adults and their children) and have income below the poverty line are eligible for one year of transitional coverage.

It is estimated that almost 2.2 million recipients would leave welfare for work and be in their first 12 months after exit in the average month in FY 1997. Of these 1.7 million would be eligible for transitional coverage because their incomes are below the poverty line. Under the proposal only the poor children under 13 and pregnant women who be eligible for coverage (note: this eligibility has nothing to do with transitioning off welfare -- these are mandatory groups under the proposal). Thus in FY 1997 780 thousand former recipients would be ineligible for coverage. Of these recipients 25 percent would be poor children aged 13 and over; in 1997 this would mean the loss the Medicaid guarantee for almost 200 thousand children. The total average monthly number of losers would be expected to grow to 830 thousand by the year 2002.. In addition, an unknown number of recipients who leave welfare because of increased child support would lose the Medicaid transitional benefits. In 1994 the Office of Child Support Enforcement reported close to 300 thousand case closures due to increased child support collections. States could, at their option, continue to provide this coverage to those families who leave welfare for work or due to increased child support under the terms of the proposal.

Restoring the link between current AFDC eligibility rules and Medicaid would still leave many families who would be subjected to a time limit of 5 years or less, at State option, with a loss of the Medicaid guarantee. In fiscal year 2002, some 3.2 million recipients could be dropped from the AFDC program if all States imposed a two-year time limit and provided a full 20 percent exemption. Of these recipients 1.2 million would be children aged 13 and older. When the full impact of the federally mandated 5 year limit is felt (assuming states fully utilize the 20% exemption) about 1.7 million recipients, including 700,000 children aged 13 and older, would lose the guarantee to Medicaid coverage.

6/11/96

INDIVIDUALS WHO ARE PUT AT RISK OF MEDICAID LOSS UNDER NEW GOP BILL
(numbers in 1000s)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
TOTAL RECIPIENTS AND WORK LEAVERS	15,584	15,803	16,028	16,224	16,421	16,617	16,817	17,020	17,223	17,426
TOTAL RECIPIENTS AND WORK LEAVERS WHO ARE PUT AT RISK	***6,638***	***6,731***	***6,827***	***6,910***	***6,994***	***7,078***	***7,163***	***7,249***	***7,336***	***7,422***
Adults	4,488	4,552	4,616	4,673	4,730	4,786	4,844	4,902	4,960	5,019
Children	2,149	2,180	2,210	2,238	2,265	2,292	2,319	2,347	2,375	2,403
TOTAL AFDC RECIPIENTS	13,414	13,603	13,795	13,964	14,133	14,302	14,474	14,649	14,824	14,998
TOTAL RECIPIENTS PUT AT RISK	***5,857***	***5,940***	***6,023***	***6,097***	***6,171***	***6,248***	***6,320***	***6,396***	***6,472***	***6,548***
Adult Recipients	3,905	3,960	4,016	4,065	4,114	4,164	4,214	4,264	4,315	4,366
Men	545	553	561	568	575	581	588	595	603	610
Nonpregnant Women	3,360	3,407	3,455	3,498	3,540	3,582	3,625	3,669	3,713	3,757
nonpregnant teen moms < 18 yrs	38	39	39	40	40	41	41	42	42	43
Child recipients (> 13 yrs)	1,952	1,979	2,007	2,032	2,056	2,081	2,106	2,131	2,157	2,182
nonpregnant teen moms < 18 yrs	29	30	30	30	31	31	31	32	32	33
LOSE GUARANTEE DUE TO 5 YEAR TIME LIMIT (20% EXEMPT)*	0	0	0	0	0	0	484	1,444	1,652	1,709
Adult Recipients	0	0	0	0	0	0	268	799	914	946
Men	0	0	0	0	0	0	37	112	128	132
Nonpregnant Women	0	0	0	0	0	0	231	687	786	814
Child recipients (> 13 yrs)	0	0	0	0	0	0	216	645	738	763
LOSE GUARANTEE DUE TO 2 YEAR TIME LIMIT (20% EXEMPT)*	0	0	0	1,268	2,857	3,205	3,307	3,359	3,402	3,443
Adult Recipients	0	0	0	803	1,809	2,030	2,094	2,127	2,154	2,180
Men	0	0	0	112	253	283	292	297	301	304
Nonpregnant Women	0	0	0	691	1,556	1,747	1,802	1,830	1,854	1,876
Child recipients (> 13 yrs)	0	0	0	465	1,048	1,176	1,213	1,232	1,248	1,263
TOTAL LEAVERS FOR WORK (1ST 12 MONTHS)	2,169	2,200	2,233	2,260	2,288	2,315	2,343	2,371	2,399	2,427
LEAVERS FOR WORK WHO LOSE GUARANTEE	***781***	***792***	***804***	***813***	***823***	***833***	***843***	***853***	***863***	***874***
adults	583	592	600	608	615	623	630	638	645	653
children	197	200	203	206	208	211	213	216	218	221

Source: ASPE projections
Note: This does not include families who lose their guarantee because they left welfare due to increased child support.
* States have the option of choosing a time limit shorter than 5 years.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: JENNIFER KLEIN

FAX Number:

FROM: Jeanne + Judy

Pages:

Comments:

HERE is (a) Commerce Bill Language,
(b) Louisiana, to contrast.

P.S. It was Great to run into you on Saturday!

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which is the total number of the hospital's patient days in that period.

"(iv) PATIENT DAYS.—For purposes of clause (iii), the term 'patient day' includes each day in which—

"(I) an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere; or

"(II) an individual makes one or more outpatient visits to the hospital.

"(2) CONDITIONS FOR GUARANTEES AND RELATION OF GUARANTEES TO FINANCING.—The guarantees of States required under subsection (a) and (b) of section 1501 and subsection (d) of this section are subject to the general eligibility guidelines of States described under the plan under paragraph (1)(A) and are subject to the limitations on payment to the States provided under section 1511 (including the provisions of subsection (g), relating to supplemental umbrella allotments). In submitting a plan under this title, a State voluntarily agrees to accept payment amounts provided under such section as full payment from the Federal Government in return for providing for the benefits (including the guaranteed benefit package) under this title.

"(3) SECONDARY PAYMENT.—Nothing in this section shall be construed as preventing a State from denying benefits to an individual to the extent such benefits are available to the individual under the medicare program under title XVIII or under another public or private health care insurance program.

"(4) RESIDENCY REQUIREMENT.—In the case of an individual who—

"(A) is described in section 1501(a)(1),

LOUISIANA

D.C. CHARTERED, HC.

surveying and certifying renal dialysis facilities for compliance with the conditions and requirements of section 1881(b) of the Social Security Act.

(2) REPORT.—Not later than July 1, 1997, the Secretary shall transmit to Congress a report on each of the studies provided for under paragraph (1). The report on the study under paragraph (1)(A) shall include (and the report on the study under paragraph (1)(B) may include) a specific framework, where appropriate, for implementing a process under which facilities covered under the respective study may be deemed to meet applicable medicare conditions and requirements if they are accredited by a national accreditation body.

SEC. 517. The Secretary of Health and Human Services shall grant a waiver of the requirements set forth in section 1301(a)(2)(A)(ii) of the Social Security Act to D.C. Chartered Health Plan, Inc. of the District of Columbia: Provided, That such waiver shall be deemed to have been in place for all contract periods from October 1, 1991 through the current contract period or October 1, 1999, whichever shall be later.

SEC. 518. Section 119 of Public Law 104-99 is hereby repealed.

OPTIONAL, ALTERNATIVE MEDICAID PAYMENT METHOD

SEC. 519. (a) ELECTION.—A heavily impacted high-DSH State (as defined in subsection (d)) elect to receive payments for expenditures under title XIX of the Social Security Act for the period beginning October 1, 1995, and ending June 30, 1996 (in this section referred to as the "9-month period"), for State fiscal year 1996–1997, and (subject to subsection (e)(4) for State fiscal year 1997–1998 in accordance with the alternative payment method specified in subsection (b) rather than in accordance with section 1903(a) of such Act.

(b) ALTERNATIVE PAYMENT METHOD.—

(1) IN GENERAL.—Under the alternative payment method specified in this subsection—

(A) any percentage otherwise specified in section 1903(a) of the Social Security Act for expenditures in the 9-month period or a State fiscal year for which the election is in effect shall be equal to 100 percent minus the non-Federal participation percentage (specified under paragraph (2)) for the State for that period or State fiscal year, and

(B) the total payment for the 9-month period or a State fiscal year in which the election is in effect may not exceed the maximum Federal financial participation specified in paragraph (5) for the period or year.

In applying subparagraph (B), there shall not be counted as payments for any period or fiscal year any payment that is attributable to an expenditure which is exempt under subsection (c)(1). In applying such subparagraph to the 9-month period, there shall be counted payments (other than those described in the previous sentence) that are attributable to an expenditure for periods occurring in the 9-month period and before the date of the enactment of this Act.

(2) NON-FEDERAL PARTICIPATION PERCENTAGE.—For purposes of paragraph (1), the "non-Federal participation percentage" for a State for the 9-month period or State fiscal year is equal to the ratio of—

(A) the State's base State expenditures (as defined in paragraph (3)) plus the applicable percentage (as defined in paragraph (4)) of the difference between the amount of such expenditures and the amount of the State expenditures that would be required for the State to qualify for the maximum Federal financial participation specified in paragraph (5A) under title XIX of the Social Security Act if this section did not apply for such period or State fiscal year; to

(B) the total expenditures under the State plan of the State under such title for such period or State fiscal year.

Such ratio shall be calculated as if total expenditures under the State plan were no greater than necessary for the State to receive the maximum Federal financial participation specified in paragraph (5).

(3) BASE STATE EXPENDITURES.—For purposes of this subsection, the term "base State expenditures" means—

(A) for the 9-month period, $266,250,000, or

(B) for State fiscal year 1996–1997, $355,000,000, or

(C) for State fiscal year 1997–1998, $320,000,000.

(4) APPLICABLE PERCENTAGE.—For purposes of this subsection, the "applicable percentage"—

(A) for the 9-month period is 20 percent,

(B) for State fiscal year 1996–1997 is 28 percent, and

(C) for State fiscal year 1997–1998 is 36 percent.

(5) MAXIMUM FEDERAL PARTICIPATION.—For purposes of this section, the maximum Federal financial participation specified in this paragraph for a State—

(A) for the 9-month period, $1,995,500,000,

(B) for State fiscal year 1996–1997 is $2,622,000,000, and

(C) for State fiscal year 1997–1998 is $2,628,000,000.

(c) ADDITIONAL RULES.—

(1) LIMITING APPLICATION TO EXPENDITURES FOR PERIODS IN WHICH ELECTION IN EFFECT.—This section (and the maximum Federal financial participation specified in subsection (b)(5)) shall not apply to any expenditure that is applicable to a reporting period that is not covered under an election under subsection (a), including any expenditures applicable to any reporting period before October 1, 1995.

(2) ELECTION PROCESS.—An election of a State under subsection (a) shall be made, by notice from the Governor of the State to the Secretary of Health and Human Services, not later than 30 days after the date of the enactment of this Act.

(3) LIMITATION.—For any period (on or after the date of an election under this section) in which an election is in effect for a State under this section—

(A) the Federal Government has no obligation to provide payment with respect to items and services provided under title XIX of the Social Security Act in excess of the maximum Federal financial participation specified in subsection (b)(5) and such title shall not be construed as providing for an entitlement, under Federal law in relation to the Federal Government, to an individual or person (including any provider) at the time of provision or receipt of services; and

(B) the State shall provide an entitlement to any person to receive any service or other benefit to the extent that such person would, but for this paragraph, be entitled to such service or other benefit under such title.

(4) CONDITION FOR STATE FISCAL YEAR 1997.—This section shall not apply to State fiscal year 1997–1998 except to the extent provided for in a subsequent appropriation act.

(d) DEFINITION.—For purposes of this section, the term "heavily impacted high-DSH State" means the State of Louisiana.

(e) STATE FISCAL YEARS DEFINED.—For purposes of this section—

(1) the term "State fiscal year 1996–1997" means the period beginning July 1, 1996, and ending June 30, 1997, and

(2) the term "State fiscal year 1997–1998" means the period beginning July 1, 1997, and ending June 30, 1998.

SEC. 520. (a) Congress finds that—

(1) the practice of female genital mutilation is carried out by members of certain cultural and religious groups within the United States; and

(2) the practice of female genital mutilation often results in the occurrence of physical and psychological health effects that harm the women involved.

(b) The Secretary of Health and Human Services shall do the following:

(1) Compile data on the number of females living in the United States who who have been subjected to female genital mutilation (whether in the United States or in their countries of origin), including a specification of the number of girls under the age of 18 who have been subjected to such mutilation.

(2) Identify communities in the United States that practice female genital mutilation, and design and carry out outreach activities to educate individuals in the communities on the physical and psychological health effects of such practice. Such outreach activities shall be designed and implemented in collaboration with representatives of the ethnic groups practicing such mutilation and with representatives of organizations with expertise in preventing such practice.

(3) Develop recommendations for the education of students of schools of medicine and osteopathic medicine regarding female genital mutilation and complications arising from such mutilation. Such recommendations shall be disseminated to such schools.

(c) For purposes of this section the term "female genital mutilation" means the removal or infibulation (or both) of the whole or part of the clitoris, the labia minor, or the labia major.

(d) The Secretary of Health and Human Services shall commence carrying out this section not later than 90 days after the date of enactment of this Act.

TITLE VI—ADDITIONAL APPROPRIATIONS

SEC. 601. In addition to amounts otherwise provided in this Act, the following amounts are hereby appropriated as specified for the following appropriation accounts: Health Care Financing Administration: "Program Management", $395,000,000; and Office of the Secretary, "Office of Inspector General", $22,330,000, together with not to exceed $20,670,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund.

SEC. 602. Appropriations and funds made available pursuant to section 601 of this Act shall be available until enactment into law of a subsequent appropriation for fiscal year [illegible] for any project or activity provided for in section 601.

TITLE VII—AMENDMENTS TO THE GOALS 2000: EDUCATE AMERICA ACT

SEC. 701. ELIMINATION OF THE NATIONAL EDUCATION STANDARDS AND IMPROVEMENT COUNCIL AND OPPORTUNITY-TO-LEARN STANDARDS.

The Goals 2000: Educate America Act (20 U.S.C. 5801 et seq.) is amended—

(1) by repealing part B of title II (20 U.S.C. 5841 et seq.);

(2) by redesignating parts C and D of title II (20 U.S.C. 5851 et seq. and 5871 et seq.) as parts B and C, respectively, of title II; and

(3) in section 241 (20 U.S.C. 5871)—

(A) in subsection (a), by striking "(a) NATIONAL EDUCATION GOALS PANEL.—"; and

(B) by striking subsections (b) through (d).

SEC. 702. STATE AND LOCAL EDUCATION SYSTEMIC IMPROVEMENT.

(A) PANEL COMPOSITION; OPPORTUNITY-TO-LEARN STANDARDS; AND SUBMISSION OF PLAN TO THE SECRETARY FOR APPROVAL.—

(1) STATE IMPROVEMENT PLAN.—Section 306 of the Goals 2000: Educate America Act (20 U.S.C. 5886) is amended—

(A) by amending subsection (b) to read as follows:

"(b) PLAN DEVELOPMENT.—A State improvement plan under this title shall be developed by a broad-based State panel in cooperation with the State educational agency and the Governor.";

(B) by striking subsection (d).

(2) LOCAL PANEL COMPOSITION.—Section 306(a)(2)(A) of such Act (20 U.S.C. 5886(a)(2)(A)) is amended—

(1) in the matter preceding clause (i), by striking "that—" and inserting a semicolon; and

(2) by striking clauses (i) and (ii).

CENTER ON BUDGET AND POLICY PRIORITIES

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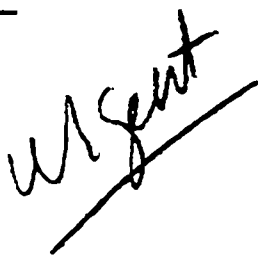

fr: Ellen Nissenbaum

re: **NEW ANALYSIS OF WISCONSIN WAIVER BILL & MEDICAID COVERAGE**

June 5, 1996

In anticipation of the House's consideration tomorrow of the bill approving Wisoncon's welfare waiver, we've produced the attached analysis. While the waiver could, in the short run, expand health care coverage, it would eliminate the guarantee of health care under Medicaid to nondisabled children, pregnant women and poor families. In addition, the piece notes that some Medicaid recipients could lose their coverage while others would have to pay premiums to retain their benefits.

Hope this is useful.

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

CENTER ON BUDGET AND POLICY PRIORITIES

Jen
FYI
-Pauline

June 5, 1996

THE WISCONSIN WAIVER SEEKS TO MAKE FUNDAMENTAL CHANGES IN THE MEDICAID PROGRAM

by
Cindy Mann

Those aspects of the Wisconsin waiver that would replace AFDC with a work-based system have received a great deal of attention. Little attention, however, has been paid to those parts of the waiver that would make fundamental changes to the Medicaid program. Yet, the Wisconsin plan seeks a number of unprecedented Medicaid waivers, including permission to *eliminate the federal and state guarantee to Medicaid coverage for all nondisabled children, low-income families and pregnant women.*

There are several positive aspects of the W-2 health plan that could expand health care coverage to persons who are now uninsured. Subject to the limitations discussed below, the state plans to provide Medicaid coverage to families with children whose income is below 165 percent of the federal poverty line. Those who initially qualify based on the 165 percent of poverty standard would remain eligible for coverage until their income rose above 200 percent of the poverty line. These changes would increase the income eligibility limit for many people and eliminate current rules that deny coverage to most parents in low-income, two-parent families.

The waiver would also, however, make many people who currently have Medicaid coverage ineligible for Medicaid and make health care coverage unaffordable for others. Among those who could lose coverage under this waiver proposal are the following groups:

- Children over age 11 in working poor families could be denied Medicaid if their parent is offered employer-based coverage even if the employer plan is unaffordable.

- Pregnant women and families, including those with very low incomes, would be required to pay premiums as a condition of receiving Medicaid. When combined with the new W-2 child care copayments, the premiums could impose heavy burdens on families with very modest earnings.

Most important, the Wisconsin waiver would fundamentally alter the basic commitment to provide health care coverage to low-income pregnant women and families, including children, by eliminating the federal and state entitlement to coverage. *No other state has received a waiver to eliminate the guarantee of coverage.*

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Robert Greenstein, Executive Director

Summary of Key Waiver Provisions

The waiver would end the guarantee of Medicaid coverage for all nondisabled children, pregnant women, and low-income families.

Although Wisconsin plans to provide health care coverage under the Medicaid program to certain low-income children, families, and pregnant women, it is seeking an unprecedented waiver for permission to get out from under any legal obligation to provide such coverage. If the waiver is approved as submitted, the federal and state assurance of health care coverage for these groups would end.

If costs in Wisconsin rose above projected levels, because, for example, the state's economy experienced a downturn, Wisconsin could deny coverage to some or all of the low-income children, parents and pregnant women who must be covered under current law. The W-2 waiver would explicitly grant the Wisconsin Department of Health and Family Services authority to restrict coverage for children, families and pregnant women who are entitled to Medicaid under current law.

The waiver would deny coverage to older poor children whose parents are offered insurance through the workplace

Under the waiver, parents and children over age 11 would lose Medicaid coverage immediately if the parent is offered employer-subsidized health insurance, and they would lose Medicaid after 12 months of work if the parent is offered an unsubsidized plan. A plan is considered to be subsidized if the employer pays at least half the cost of the plan.

The Wisconsin Legislative Fiscal Bureau estimates that the average cost to employees of the premium for an employer-subsidized plan would be $140 per month, or $1680 per year. This would amount to 16 percent of gross earnings for people working for $5.00 per hour. The cost of an unsubsidized private insurance plan that offers benefits comparable to the Wisconsin W-2 health plan is estimated to be about $360 per month, well out of reach for most low-wage workers. Despite these costs, under the Wisconsin plan, Medicaid coverage would be denied without regard to whether the family could afford to purchase the private insurance.

The waiver would depart from current law in several ways. Under current law, all children with family income under the poverty line are or will be covered under Medicaid in coming years, under a phase-in requirement adopted in 1990 with strong bipartisan support. Currently, poor children through age 12 are covered; by the year 2002 all poor children under 19 will be covered. The waiver, by contrast would deny

coverage to poor children over age 11 if their parents are offered insurance through the workplace.

In addition, under current law, families with earnings that cause them to lose eligibility for welfare are assured up to 12 months of transitional Medicaid coverage. Under the waiver, neither the parent nor any child over age 11 would receive the benefit of transitional assistance if the parent was offered an employer-subsidized plan. And finally, under current law, a state can require the parent to enroll in a private plan, but Medicaid must pay the premium and other cost-sharing requirements and supplement the benefits available under the plan. Under the Wisconsin waiver, parents and older children would be denied Medicaid coverage on the grounds that private coverage was available, without these cost-sharing and benefit protections.

Wisconsin thus would depart significantly from current law in ways that would cause many older children and some parents to lose Medicaid coverage to which they are entitled under current law. Ironically, the children adversely affected by this provision would be the children of parents who are doing exactly what is expected of them under W-2 — parents who are working but nonetheless have incomes too low to afford private coverage.

Other features of the Wisconsin waiver

The W-2 health plan creates winners and losers. As noted, the people who could gain eligibility under the plan are primarily parents and children who become eligible for coverage under the new income limits and who are not disqualified on the basis of the employer-based insurance rules discussed above. Various other groups of people could lose coverage under provisions in the waiver including the following:[1]

- The waiver would require all children, pregnant women and low-income families, no matter how poor, to pay a Medicaid premium. Copayments and deductibles also may be charged. (Premiums are not allowed under current law. Copayments, to the extent allowed, generally must be "nominal.") For low-income wage earners with child care expenses, these new health care costs would be in addition to substantial new child care copayments that would be imposed by other aspects of the W-2 plan. Together, these costs could impose very high burdens on working families with very modest incomes.

[1] The Wisconsin Legislative Fiscal Bureau projects that about the same number of people who qualify for Medicaid under current rules will qualify under the W-2 health plan if the waiver is granted, but cautions that this projection rests on assumptions which may or may not prove to be accurate. Little is known about how the vast changes in Medicaid rules proposed by the W-2 waiver would affect enrollment or access to care.

- The income of stepparents would be counted as available to children applying for coverage even if the stepparent does not support and has no legal obligation to support the child.

- Teen parents and their babies would be denied coverage if they are not living with the teen's parents or in a supervised setting. If the teen is living with her family, the family's income is counted in determining the baby's eligibility even if the grandparent is not supporting the baby.

In addition, the waiver would dispense with current rules requiring the timely provision of coverage, and it would restrict the benefits available under the program for those who would retain coverage.

- Over-the-counter medications that are prescribed by a doctor, other than insulin, would no longer be covered, even for children.

- Special medical services for children now guaranteed under federal "EPSDT" rules would no longer be covered.

- Benefits for home health services, skilled nursing home care and alcohol and drug treatment all would be capped.

Conclusion

There is nothing new about a state applying for a Medicaid waiver to expand coverage for some people while restricting coverage for others. What distinguishes Wisconsin's Medicaid waiver is its request to waive the entitlement to coverage for all nondisabled children, pregnant women and low-income families. Although Wisconsin projects that coverage will be provided to a broad group of families under W-2, the plan makes no commitment to assure that any poor Wisconsin child, pregnant woman or family receives Medicaid coverage. If approved as proposed, the waiver would give Wisconsin broad authority to deny, delay or restrict coverage in virtually any way it saw fit if budget or political pressures eventually push in that direction.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

96 JUN 6 All : 38

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Wisconsin Medicaid waiver provisions

MEDICAID PROVISIONS

W-2 PROVISIONS	DESCRIPTION OF PROVISION	WAIVER CITATIONS
1. Entitlement status of MA	W-2 provides separate eligibility determinations for all programs and benefits are provided upon payment of required premiums. There is no entitlement or categorical eligibility as under current provisions except that W-2 employment position participants are required to participate in the W-2 Health Plan.	1902(a)(10)(A)(I)
2. Elimination of MA extension	In general, W-2 provides an unlimited extension to families until they reach 200 percent of poverty, as long as premiums are paid. Under the MA program AFDC recipients who have received benefits in three of the last six months and who lose eligibility because of increased hours, increased income or loss of the earned income disregards are guaranteed an extension of MA benefits.	1902(a)(10) & (52) 1925
3. HMOs	The W-2 Health Plan will incorporate a mandatory HMO enrollment or primary provider program for all W-2 recipients. In most areas, there will be a choice of HMO organizations. This requires a waiver of the related SSA that guarantees the freedom of choice of MA recipients.	1915(b)
4. Maintenance of Effort MA	W-2 Health Plan expands eligibility to previously ineligible groups of individuals. Previously ineligible groups that could be eligible for W-2 are not entitled to the 60 percent federal match for MA without a waiver.	1902 1903(I)
5. Loss of W-2 Health benefits when employer health plan is available	W-2 Health Plan eligibility ends when the participant becomes eligible for employer health benefits. The SSA has no similar provisions.	1902(a)(10) 1912
6. W-2 Health Plan premiums	W-2 Health Plan has a mandatory premium for all recipients. The federal law states that MA recipients cannot be charged a premium.	1916
7. MA Income Eligibility Limits	The W-2 Health Plan tests income eligibility for all using 165 percent of the federal poverty level. Waivers are needed to allow consistent treatment of all families.	1902(r)(2) 1903(f)(4)

W-2 PROVISIONS	DESCRIPTION OF PROVISION	WAIVER CITATIONS
8. Income Disregards	W-2 simplifies income disregards currently used in the AFDC program. The W-2 Health Plan will use the new disregards established by W-2.	1902(a)(10)(A)
9. Assets	Asset limits under W-2 are increased for some assets (vehicles, liquid assets) and exclusions eliminated for some other assets that are excluded under the current AFDC policy, which also apply to MA.	1902(r)(2)
10. Privatization	W-2 local agency provider selected through a competitive bidding process (RFP) and non-competitive selection based on performance indicators of current providers. Allowing a non-government agency to determine eligibility for the W-2 Health Plan requires a waiver.	42 CFR 433.10
11. Treatment of Stepparent Income	Under W-2 stepparents income will always be considered in the gross income eligibility determination. Current MA eligibility only includes the income of a stepparent that is considered an essential person or deems stepparent income to the AFDC group.	1902(a)(17)(D) except that court ordered payments made to individuals not in the W-2 household will continue to not be counted.
12. Minor Parents Required to Live at Home	To be eligible for the W-2 Health Plan a minor parent must be living with a custodial parent or in an approved living arrangement. This requires further restrictions of the groups identified as eligible for MA under the federal regulations.	1902(a)(10)(I)
13. Agency Review of W-2 Cases	Under MA, an applicant or recipient can appeal an eligibility or benefit decision of a county or tribal economic support agency to the state. Under the W-2 program, agency reviews of eligibility or benefit decisions are limited to applicants or recipients of W-2 employment positions. There is no appeal or review process for the W-2 Health Plan.	1902(a)(3)

W-2 PROVISIONS	DESCRIPTION OF PROVISION	WAIVER CITATIONS
14. Sanctions for Failing to Cooperate with Child Support	W-2 sanctions are more stringent than sanctions under the MA program. Pregnant women who fail to cooperate with child support may lose W-2 Health Plan eligibility whereas the current system maintains MA eligibility through the pregnancy plus an additional 60 days with no requirement to cooperate with child support. Under MA only the non-cooperating adult becomes ineligible for failure to cooperate with child support whereas under the W-2 Health Plan children whose parents do not cooperate with child support will also lose W-2 Health Plan eligibility.	1912(a)(1)(v)

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Please let me know if you need more information or changes. Thanks!

JL

DRAFT: June 7, 1996

Partnerships for Stronger Families: a Family's-Eye View
Talking Points for the First Lady

. Partnerships for Stronger Families is an effort to change the way the federal government works with communities to serve children and families. People who work "on the ground" in communities have good ideas about ways to help children and families, and they often find that federal government programs need to change in order to work in their community.

. We know, for instance, how important it is for every child who starts kindergarten to be ready to learn. But that can take a whole "village" of people in a community working together with families: someone who can help a new mother learn to take care of her baby; someone who can make sure that children get immunized on time; someone who can work with fathers so they will read with their children regularly.

. So when communities have a good idea about the ways they want to help parents and children, we want the federal government to be a good partner to them.

. In Partnerships for Stronger Families, the federal agencies are working together - the people from Health and Human Services with Education and Labor and Justice and Agriculture and Housing and Urban Development and all the rest so that they can help families and communities. They are thinking about whole families, and about towns and communities like the one where you live. And people in the government are looking at communities such as the Empowerment Zones and Enterprise Communities and states like Oregon and to learn from the experiences they have had in changing the ways the federal government works for families and children.

. For example. they are working to find;

- . ways to help people get the information they need whenever they need it, using the Internet and the telephone;
- . ways to teach people to work respectfully with whole families, not just with one program for one member of a family;
- . ways to help communities spend the money they get from the federal government so it really helps their families and children.

. If you have an idea for something they should work on, please write or call.....