DRAFT PROPOSAL ON MEDICAID REFORM

The goal of the states interested in the Medicaid reform coalition is to develop a non-partisan proposal for reform of the Medicaid program in the context of a cap on the federal contribution to the program. The coalition seeks to satisfy two main objectives: (1) to provide states with the flexibility to structure their programs so that they can be successfully administered in an environment of limited federal contribution; and (2) to develop a proposal that is realistic so as to be acceptable to the Congress and the Administration who will determine what is ultimately enacted into law. A key premise is that only a reform proposal that all states can jointly support stands a strong chance of enactment.

Over the last several weeks, a large group of states have worked together to develop positions on major issues in Medicaid program design within the following general context: The present Title XIX would be repealed, and states would develop their own medical assistance programs, utilizing appropriate public processes. The program design would be submitted to a designated federal agency, but would not be subject to federal approval. Federal funds would be made available based on state certification of expenditures and of commitment of a specified state contribution.

The following are the principal elements of the states' bipartisan proposal.

Program Design and Oversight

Public Process for Program Design

Proposal: Each state would develop a state program design which would specify: (1) who the state plans to cover in its medical assistance program; (2) what benefits the state plans to provide for the populations it chooses to cover; (3) how the state plans to assure the quality of the services provided; and (4) what the state's methodology is for determining payment to providers. The states would provide opportunity for public participation in the development of the medical assistance program design. While the federal statute would not prescribe any particular required process, the following would be listed as guidance for states in providing for public participation:

- One or more public hearings at which the general public has the opportunity to provide input into the program design.
- Publication of the program design in one or more state newspapers of general circulation, or in a state register, accompanied by a period of time for submission of comments.
- Legislative committee hearings on a proposed program design, or adoption of the design by the state legislature.
- Focus group meetings with members of the general public and/or stakeholder groups.

Rationale: While states the federal government should not have the authority to approve state medical assistance program designs, states do understand that there should be some means for the public to be aware of a state's intentions and to voice its opinion. The approach recommended is loosely modeled after the process used in developing a social services plan under Title XX.

Federal Oversight Role

Proposal: The role of the designated federal agency in the administration of the new medical assistance program would be significantly limited. There would be no federal approval of state program designs. Apart from the responsibility to develop model quality guidelines, the chief function of the federal agency would be to assure that the state maintained its minimum financial contribution, provided services to low-income pregnant women and children as specified by the state, and did not use federal funds for non-health care related purposes.

Rationale: The federal government will continue to invest close to $800 billion in Medicaid over the next seven years. States recognize and acknowledge the federal government's interest in assuring that the federal dollars are spent in the provision of health care services and that states maintain their level of contribution.

Program Structure

Covered Populations

Proposal: There would be no individual entitlement to be covered by the program. But there would be an obligation on states to serve low-income pregnant women and children up to age 19 at or below income levels specified by the state. If the federal government

determined that a state was not providing coverage to pregnant women and children in accordance with its published program design, and after such a determination the state did not come into compliance with or change its program design within a reasonable time, the federal government could withhold, prospectively, a portion of the state's federal funds. However, there would be no right of individuals to sue for coverage.

There would be no state obligation to cover cost sharing amounts for Medicare eligibles. However, a state could choose to cover Medicare co-payments, premiums and deductibles, which could be conditional on the individual agreeing to participate in specified delivery systems.

There would be no coverage obligations for the elderly and the disabled. However, the state would define the health needs of these groups in the state, and include in its published program design how it intends to address those needs (though there would be no right to sue to enforce these intentions). Federal requirements regarding transfers of assets would be repealed.

Rationale: The proposal recognizes that while the disabled and the elderly have powerful and well-organized advocacy at the state level, poor women and their children often do not. A bill with no assurances of coverage for low-income pregnant women and children has little, if any, chance of enactment.

The proposal acknowledges the interest in serving the elderly and disabled. At the same time, the proposal reflects the proposition that under a cap, a state cannot be required to provide all services to all populations. States will have to identify the needs and prioritize them. The proposal provides a mechanism for assuring that states address the needs of these groups, without imposing federal requirements as to who must be included in these groups and how they must be served.

Covered Services

Proposal: There would be no federal mandates to provide particular services. A state would decide what services to provide, and could choose to provide different levels of coverage to different populations. The only requirement is that the state's medical assistance program provide health-related services as defined by the state and that the covered services be identified in its published program design, which could be amended whenever the state wishes to do so.

Rationale: One of the most expensive and least effective aspects of the current Medicaid program is the almost unlimited nature of the federally prescribed benefit package and, in particular, its emphasis on institutional care. States now have credible experience is

developing benefit packages appropriate to specific populations and should be allowed to tailor benefits to meet the needs and priorities of the population to be served.

Cost Sharing

Proposal: States will be free to impose cost-sharing requirements on recipients of their medical assistance plans. For example, state will be free to require a financial contribution from recipients who visit emergency rooms for non-emergency care.

Rationale: Present law forbids cost sharing for many categories of recipients and for a variety of services. Where permitted, cost sharing must be at "nominal" levels. As states have tried to privatize their programs and mainstream the Medicaid population, this federal prohibition has created barriers. Further, the prohibition goes against the concept that everyone should be expected to contribute something to the cost of his or her care.

Payment for Services

Proposal: The Boren amendment and all other federal standards governing reimbursement of providers would be repealed. Further, there would be no payment standards for services provided through intermediaries (e.g., managed care or private market insurance). However, because of the importance of hospitals for the present delivery system and their reliance on public funding, the proposal provides for a payment standard for non-specialty hospital in-patient services during a three-year period during which hospitals can be expected to transition to a market-based system. To the extent some states will continue to reimburse these hospitals on a fee-for-service basis, specific criteria would be set in statute, accompanied by "safe harbors" so that reimbursement rates that met one or more of the safe harbors could not be challenged.

For purposes of reimbursing non-specialty hospital in-patient services, the federal minimum would be a rate sufficient to assure reasonable access for Medicaid eligibles, but not to exceed marginal costs necessarily incurred in serving Medicaid eligibles. A rate that met any one of the following "safe harbors" would be deemed to meet the federal minimum:

a. The rate is sufficient to cover a state-specified percentage of total allowable costs necessarily incurred in serving the patients.

b. The rate has previously been approved by HCFA and is currently encompassed in the state's plan.

c. The rate is at least equal to a rate offered by the hospitals under a selective contracting or other contractual arrangement.

Why exception?

Should a state adopt a rate that does not meet one of the safe harbor tests, a provider could ask the designated federal agency to review the rate against the standard set forth above. There would be no judicial intervention in advance of the federal agency review. All state laws not consistent with the federal payment provisions would be preempted.

As in current law, the federal standard would not apply in a managed care context or when the state arranges care through contract intermediaries. There would be no payment standard for any other providers. Issues relating to payments to teaching hospitals and the definition of essential community providers would be left to the states.

Rationale: Mere repeal of all statutory payment standards might invite courts (federal or state) to develop their own standards for judging payments. The proposal avoids this in the managed care context by emphasizing that market forces are intended to determine payments to providers. In the case of hospitals in a fee-for-service context, the proposal gives states substantial leeway in setting reimbursement rates during the transition period, the precludes judicial intervention until administrative review has been completed in any case where a rate is questioned. Federal review would be confined only to the level of the rate, and not on how the state went about arriving at its rate.

Experience under the Boren Amendment reveals the futility of attempting to legislate a process for developing reimbursement rates, and the mischief that such provisions can cause. However, complete and immediate elimination of any payment standard for hospitals would be fiercely resisted and difficult to achieve. The three year period during which a federal standard would be maintained affords time for hospitals to adjust to the expected greater reliance on managed care.

Similar protection for nursing homes is not needed, since they are well organized and have demonstrated the ability to secure protection from state legislatures. The repeal of the Boren Amendment and the failure to adopt even an interim reimbursement standard for nursing homes should deter any federal court from exercising substantive review over nursing home rates.

In the non-institutional provider context, federal courts have begun to develop Boren-type standards for judging reimbursement. By repealing the statutory provisions on which these actions have been based, the proposal ought to eliminate any basis for further federal court review, even where these providers continue to be reimbursed on a fee-for-service basis.

Quality Standards

Proposal: A state would be required to develop its own quality assurance standards. Provisions would be made for development of model standards by an appropriate federal entity. States could adopt these standards, or those used in Medicare, or privately

developed standards, or state licensing standards, or any combination of them. States also would be encouraged to perform and publish outcome studies.

Rationale: States would like to have complete flexibility to design their programs, including the quality assurance aspects. However, states recognize the importance of assuring the public that they will continue to insist on high quality programs. The coalition provision seeks to assure the states' continued commitment to quality standards without reverting to the intrusive, detailed and rigid prescriptive approach that characterizes the Medicaid program today.

State Issues

State Financial Contribution

Proposal: In order to draw down the full amount of the federal share (including the growth rate incorporated into the federal limit), the state would have to maintain a base level of funding [to be defined.] This minimum amount would remain constant over time. If the state's contribution fell below that baseline, the increment in the federal contribution would be reduced by a percentage equal to the percentage state shortfall. For example, if in any year a state's contribution decreased by 5% below its defined minimum, the increase in federal contribution for that year would be reduced by 5%. Existing provisions on provider taxes and donations would apply only to the state's minimum contribution and be modified to eliminate overly restrictive federal interpretations.

Rationale: The proposal recognizes the need to maintain a certain level of financial contribution on the part of the state to ensure the continued provision of medical assistance to low-income populations. The proposal builds in incentives to states to lower costs, by letting them share in the savings achieved as a result of their innovations.

Impact on Section 1115 Waivers

Proposal: A State would have the option to maintain its section 1115 waiver in its current form for the life of the waiver. States that elect this option would be expected to continue to conform to their approved waiver project with respect to populations covered and services provided.

Rationale: The states with waivers have devoted substantial resources in the development of their programs. The terms have been worked out painstakingly at the federal and state level. Many complex contractual relationships have been established. Further, many states feel that there is continued value in programs they have worked so hard to develop. For financial and other reasons, a state should have the option to maintain its

demonstration project for the life of the waiver, without new federal conditions. This is not likely to have any noticeable impact on overall program cost.

Drug Rebates

Proposal: The federal rebate program would be repealed. States would be authorized to develop their own programs for drug cost control.

Rationale: The rebate program limits state ability to control drug prescriptions. Also, rebates are not available for drugs administered in managed care settings, which will likely become the predominant service delivery method. States can achieve greater savings if they are free to control prescriptions through closed formularies, etc.

Transition Provisions.

Proposal: It would not be fair to impose a cap on federal funding of Medicaid effective October 1, 1995, since it will not be possible for states to convert from their existing programs to their new programs in the short time that remains until then. At the least, funding caps should not take effect until October 1, 1996. After that date, states would be allowed to "self waive" any provisions of existing Medicaid law as necessary to maintain their programs in modified form before their conversion to new programs.

Rationale: For many states it will not be possible to convert to a new program even by October, 1966. Those states will nonetheless require relief from current program requirements in order to survive under the proposed federal funding caps. The proposal would allow states to make interim alterations in existing programs to live within the funding limits, pending completion of a public process and conversion to the new program that will replace the current Medicaid program.

Technical Issues

Revisions of Provider Tax Rules.

Proposal: The 1991 legislation sets forth the principles and specific provisions for judging the validity of provider-specific taxes. One key element of that legislation was the establishment of a waiver process, in recognition that not all situations could be anticipated and dealt with in advance. HCFA's regulations are in some respect more rigid than they need to be, and they are being applied (or threaten to be applied) so as to penalize states for taxes that do not violate the principles on which the 1991 legislation is predicated.

The following corrective provision should be adopted to assure proper application of the 1991 statute:

a. In the waiver context, a state's actual tax should be judged by comparison to any of the model taxes that qualify under the statute (not just the most restrictive one).

b. A patient-day tax should be considered as uniform, and in compliance with the statutory standards.

c. User fees that are imposed as a condition to seeking a benefit (such as a certificate of need) should not be treated as taxes that must satisfy the statutory criteria.

d. A change only in the rate of tax should not require submission of a new waiver application.

e. States may combine provider classes in a single tax in which case the waiver tests would apply in the aggregate.

f. States should be permitted to make grants to private pay nursing home residents coincident with imposition of taxes on nursing homes. (Note – this is a highly controversial issue and could spark considerable resistance from the Administration. An alternative would be to validate these "granny grants" for the past but not the future.)

Rationale: As long as there is some requirement of state financial participation, there will be a need for rules on what kinds of provider taxes are permissible. This makes it necessary to amend the 1991 legislation to overcome HCFA interpretations that threaten to invalidate provider taxes that do not raise the kinds of "gaming" issues that the 1991 legislation was designed to prevent.

Western Governors' Association
Proposed Resolution 95 - W

June 26, 1995
Park City, Utah

SPONSOR: Governors Symington and Romer
SUBJECT: Block Grant Principles

A. BACKGROUND

1. Congress is now considering the block granting of welfare and Medicaid.

2. The method of distributing the block grant funds to the states has not been finalized.

3. The states are growing in population at various levels.

4. Current federal outlays for Medicaid and welfare are widely disparate (on a per recipient basis) from state to state.

5. The need for welfare and Medicaid is related to the business cycle.

B. GOVERNORS' POLICY STATEMENT

In formulating the block grant proposals for welfare and Medicaid the Western Governors Association strongly urges Congress to account for four realities in order to implement block grant funding in an equitable fashion:

1. State population levels are growing at different rates, and differences must be recognized in any block grant formula.

2. States have different benefit levels for both welfare and Medicaid and the block grant should not reward states that have been granting excessive benefits and penalize states that have maintained only a modest safety net.

3. The need for welfare and Medicaid are related to the business cycle, and the federal government should offer assistance to states during down cycles that is timely and responsive.

4. Maximum flexibility must be allowed the states under the block grant concept.

C. GOVERNORS' MANAGEMENT DIRECTIVE

1. A copy of this Resolution is to be forwarded to the Senate and House leadership and the respective Congressional delegations of all member states of the Western Governors' Association.

Testimony of Governor Roy Romer

Submitted to the
House Commerce Committee
Subcommittee on Health and the Environment

June 8, 1995

Mr. Chairman and members of the committee, thank you for the opportunity to submit testimony on the critical issue of proposed changes in the Medicaid program.

As a governor, I have very mixed feelings about the changes in Medicaid this Congress is proposing. I have been a consistent participant in efforts to reduce the federal deficit. I believe that Medicaid must be considered along with all other federal programs as a possible source for savings as we seek to balance the budget. At the same time, I do not see a credible set of programmatic changes that can be put into place to reach the savings that you intend to achieve in Medicaid. I do not believe that poor and working families and people with disabilities should bear the full burden of efforts to balance the budget. Yet, so far as I can tell, that will be the primary result of many of the current congressional proposals.

As the former chairman of the National Governors' Association I had the opportunity to lead a discussion among my peers regarding health care reform. Just two short years ago we reached consensus that cost containment and universal coverage were key goals. Medicaid cuts run counter to both of these goals. Two years ago we spoke of the need to end cost shifting from the uninsured to the insured. Today's Medicaid cuts will increase costs for employers, employees, and sole proprietors.

I realize that universal coverage is no longer seriously being considered, but that does not mean we should take steps that we know will increase the number of uninsured. In my state, if it were not for Medicaid, 28% of the children would have no health insurance. In my state, Medicaid pays for 65% of nursing home days. In my state, Medicaid fills in the huge gaps in coverage left by Medicare for 45,000 people. In short: Medicaid is attempting to cover for the fact that this country has no health insurance policy, no long-term care policy, and incomplete coverage for the elderly. No wonder Medicaid costs are rising--like our schools, every year we ask this program to take on new responsibilities because there is no other place to turn.

I believe that Medicaid can be made a more efficient program. If we were to sit down and have a discussion about changes to make in this program, we could identify a number that would decrease Medicaid costs. Governors have repeatedly asked for more flexibility, and I believe flexibility can improve the efficiency of the program. However, the cuts this Congress seeks to make in Medicaid were developed for the purpose of balancing the budget. We cannot make those cuts without eliminating services or cutting people off of the program.

It is nonsense to imagine that the efficiencies created through a block grant will be sufficient to bring down program growth to 4% per year. My state has one of the highest rates of HMO enrollment in the country and we have been aggressive in contracting with these HMOs to serve Medicaid clients. Savings of the size being discussed cannot be generated by relying upon managed care.

If this Congress is not willing to make concrete decisions about which populations it no longer wishes to serve, those decisions will be forced upon governors and state legislatures. We will have to choose between serving our children and serving our elders. We will have to choose between funding our schools and paying for needed health care. And, of course, we will make these decisions with fewer federal resources than we have had in the past.

I am prepared to roll up my sleeves and solve this country's deficit problem. I would like to do that in partnership with the federal government because I believe we need to address this issue as a nation. If the federal policy is block grants combined with substantial cuts, the federal government will have walked away from the problem, rather than grappled with it and solved it.

I strongly encourage this committee to do the hard work of reexamining the Medicaid program and the consequences of the cuts that are proposed. I encourage this committee to struggle with the issues that you may soon force upon governors. If there is a better way to deliver needed health care services to low and moderate income Americans while reducing the federal deficit, let us design that system together.

One of the stated objectives of balancing the federal budget is to reduce the burden our children will bear. If we leave our children unhealthy, without prenatal care, and in a struggle over limited resources against their more politically powerful grandparents, we have done them no favors.

Again, I thank you for the opportunity to present this testimony to the committee.

June 21, 1995

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

We are deeply concerned about the long-term impact of the federal deficit on our nation's economy and strongly support efforts to achieve a balanced federal budget. We feel there is no higher priority for our children's future.

As governors we have experience balancing budgets and we want to commend your leadership in offering a fair and thoughtful balanced budget proposal. Your alternative seeks to eliminate deficit spending while also protecting the economy and the critical investments we must make.

Although details of the budget will be debated and discussed with Congress, we applaud your approach because it invests in our children, rewards work and responsibility, and helps the middle class. In addition, the proposed savings in Medicaid and Medicare are far more responsible than those contained in the Congressional budget resolutions and will be far more reasonable for states to absorb in their on-going efforts to provide health care for all their residents.

Mr. President, you have put ~~policies~~ politics aside for the good of the country and set a new and positive course for America's future. You have our strong support.

Sincerely,

Governor Mel Carnahan, Chair
Missouri

Governor Roy Romer
Colorado

DEMOCRATIC GOVERNORS' ASSOCIATION

MEMORANDUM

TO: JAKE SIEWERT

FROM: KATIE WHELAN

RE: BUDGET LETTER UPDATE

DATE: JUNE 21, 1995

The purpose of this memorandum is to inform you of the following Governors who have signed on to the budget letter. Nineteen Governors have signed onto the letter as of 5:30 p.m. (E.D.T.) today. I look forward to speaking with you. The Governors are as follows:

Governors signing the letter:

Governor Mel Carnahan, Missouri
Governor Gaston Caperton, West Virginia
Governor Tony Knowles, Alaska
Governor Jim Guy Tucker, Arkansas
Governor Roy Romer, Colorado
Governor Tom Carper, Delaware
Governor Lawton Chiles, Florida
Governor Zell Miller, Georgia
Governor Ben Cayetano, Hawaii
Governor Evan Bayh, Indiana
Governor Brereton Jones, Kentucky
Governor Edwin Edwards, Louisiana
Governor Parris Glendening, Maryland
Governor Ben Nelson, Nebraska
Governor Bob Miller, Nevada
Governor Jim Hunt, North Carolina
Governor Pedro Rossello, Puerto Rico
Governor Howard Dean, Vermont
Governor Mike Lowry, Washington

Budget Letter Update
Page 2

Waiting for confirmation:

Governor John Kitzhaber

RECOMMENDED MEDICAID TALK POINTS FOR DEMOCRATIC GOVERNORS

- The House just passed its $188 billion (over seven years) in Medicaid cuts yesterday. (The Stenholm alternative called for an exceptionally high $137 billion too.)

- The Senate is at $175 billion and the pressure on them so far is to reduce the Medicare number, not the Medicaid number.

- The President believes these numbers would devastate the program and force states to cut coverage substantially. As he indicated in his White House Conference on Aging speech, he is not interested in going backwards on coverage.

- We all share the goal of substantially increasing flexibility in the areas of administration, managed care, benefits, and reimbursement. What we want to do is to protect coverage while giving you the tools you need to more effectively run the program.

- The Democrats on the Hill need to believe that there is a viable Medicaid alternative. Unless the Democratic Governors (working with us) produce a moderate yet credible alternative, I fear that the Democratic Members will not hold against the pressure for excessively deep cuts in the program.

- I am informed that you are working on a Democratic Governors' position. At the least, I believe we need to move quickly to better communicate to the public the impact of the Republicans' cuts on the program and state budgets. We will provide any assistance at any time to assist this effort.

DEAN QUESTION: Do you agree with me that we need to immediately come out with a viable alternative that achieves at least $50 billion in Medicaid savings.

ANSWER: I believe that the Democrats have to unify behind something that distinguishes us from the Republicans. We are not apologists. We believe in flexibility and we want to work with you to reduce the Federal strings in this program.

To be credible, some savings will be necessary. I don't know the exact amount and I am not yet prepared to talk about the exact timing. The bottom line, though, is that Democrats stand for maintaining coverage.

DEMOCRATIC GOVERNORS AND MEDICAID: BACKGROUND

Republican Medicaid Cuts

The House-passed budget resolution calls for a $184 billion cut from Medicaid over seven years; the Senate budget resolution proposes a $175 billion Medicaid cut over the same period. The magnitude of these cuts are without precedence and represent a 30 percent cut off of baseline in 2002. As the political pressure for reducing the Medicare number increases, it will be even more difficult to reduce the Medicaid cuts.

Analysis of Cuts

Because of the widespread variation at the State level (in terms of overall economic standing, Medicaid coverage, growth, and reimbursement rates), States would be differentially impacted by these cuts. There is no doubt, however, that over time no State can sustain this level of spending cuts without painful consequences.

HHS, OMB, and every health policy expert we are aware of believe that **the size of these cuts will force states to drop coverage, significantly reduce benefits, and to slash already very low reimbursement rates.** A recent OMB-cleared analysis projects that if the Republican cuts were to be equally distributed between the four most likely areas that States would have to go to achieve savings (coverage, service and reimbursement reductions), the national impact would be as follows: **5-7 million children and 800,000 to 1 million elderly and disabled would lose coverage; all 45 million beneficiaries would lose benefits, which could include the elimination of all preventive screening services for children, home care and hospice services; and already low payments to health providers would be cut between $10.7 and $12.8 billion.** (Our current fact sheet is attached.)

Administration Response to Proposed Medicaid Cuts

To the surprise of some, the Administration has not been shy about publicly raising concerns about the size of cuts from this program for the poor. In his recent White House Conference on Aging speech (a copy of which is attached), the President explicitly raised concerns about the Medicaid cuts likely impact on the elderly and disabled (almost two-thirds of Medicaid expenditures are for these populations) and rejected budget approaches that would force States to push the nation backwards in terms of coverage. Chief of Staff Panetta, OMB Director Rivlin, NEC Chair Tyson, and Secretary Shalala all participated in a White House press briefing in which all decried the level and impact of Medicaid cuts. Speeches by Carol Rasco and other senior officials also have sent a consistent message of concern. And finally, fact sheets, talking points, and testimony with the same message have been given to the Hill.

We also have offered and provided to both the National Governors Association (NGA) and the Democratic Governors Association (DGA) technical assistance in analyzing the cuts and possible alternatives to them. We have been working particularly closely with Governors Dean, Romer, Carnahan, and Chiles in this regard.

On May 3rd, White House and HHS representatives held a meeting with current NGA chair, Governor Dean. In it, we discussed the President's concern about the level of cuts and their potential to turn the clock backwards on the number of uninsured Americans. Governor Dean expressed his interest in working with his Democratic colleagues in producing an alternative that provided state flexibility AND produced Federal savings. He felt strongly that the Governors had to come up with some savings in order to be credible and have even a chance of getting a seat at the negotiating table. He requested and we agreed to provide technical assistance in this effort.

Governors' Response

Similar to the welfare discussions, it has been difficult to impossible for the Governors to unite behind NGA on a broad-based, bipartisan agreement on a Medicaid position. All Governors agree that they would like to have significantly more flexibility in administering the Medicaid program. However, any consensus quickly dissipates when controversial issues are raised such as defining acceptable Federal Medicaid savings levels, Federal matching formulas, and on the issue of whether or not the entitlement to benefits should be preserved.

Democratic Governors' Response and Hill Implications

Even the relatively small number of Democratic Governors have yet to agree on a particular approach to unify behind. In fact, with the exception of Governor Chiles (and Governor Dean to some extent), the Democratic Governors have not been overly audible even on the issue of the magnitude of the Medicaid cut.

The lack of a unified and strong voice from the Democratic Governors has reduced the appetite of most Hill Democrats -- with the exception of the Black Caucus and Henry Waxman -- to be overly protective of the program or its constituents. The longer the Hill Democrats do not focus on this issue, the harder it will become for them (particularly the moderate/conservative Dems) to significantly reduce excessively large Medicaid savings targets from alternative budget proposals. **This is best exemplified by the fact that the Stenholm package from yesterday still assumed a very high $137 billion Medicaid cut.**

Understanding this, following up the May 3rd White House meeting, a group of Democratic Governors and their senior staff -- headed up by Governors Dean and Romer -- established a working group to attempt to develop an alternative proposal that Democratic Governors could stand behind. Most of the staff of the Governors, with the exception of Governor Chiles, were moving in the direction of producing a proposal that achieved approximately $50 to $60 billion in Medicaid cuts through the combination of a per capita (rather than an aggregate) cap and some reductions in disproportionate share payments. (Both OMB and HHS believe that cuts in excess of these amounts virtually guarantees that States will be forced to drop people from the program.)

The intention was to hold a press conference early next week to announce the alterative. However, discussions among the Governors's staff broke down two days ago when Governor Chiles' staff vehemently argued that any savings placed on the table by Democrats would be counterproductive at this time. (It is unclear whether his remarks were cleared by Chiles.) There is no doubt that Governor Dean will ask our views about what is the best negotiating and positioning strategy in terms of Hill politics during today's conference call.

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by $160 to more than $190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if $160 to $190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut $160 to $190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE;** and
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE;** and
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the $190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by $10.7 to $12.8 billion.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 3, 1995

REMARKS BY THE PRESIDENT
TO THE WHITE HOUSE CONFERENCE ON AGING

Washington Hilton
Washington, D.C.

11:52 A.M. EDT

THE PRESIDENT: Thank you so much. Thank you, Mr. Vice President. Thank you for your remarks, and thank you for doing such a good job for America. (Applause.) Thank you, Secretary Shalala, Secretary Brown, Mr. Fleming, Mr. Blancato, Fernando Torres-Gil. Hugh Downs, thank you for being master of ceremonies. I wish I could sit here and watch you work the whole time. I'm delighted to see you. (Applause.)

To Congressman Martinez and Congresswoman Morella, the former members of Congress who are here; the senators who have gone because they have to vote. I want to say a special word of thanks to the Conference chair and one of the best friends I ever had in my life, David Pryor. I think he is a wonderful man. (Applause.)

As all of you know, Senator Pryor is now retiring from the Senate. I can remember when, as a young congressman, he once volunteered as an orderly in Washington area nursing homes to document the conditions under which seniors were then living. And when he couldn't get the members of Congress to listen, he conducted hearings out of a trailer in a parking lot. The trailer led to the creation of Claude Pepper's House Aging Committee. And as chairman of the Senate's Special Committee on Aging, David Pryor has led fight after fight after fight for the interest of the seniors in this country, especially in his efforts to expand the availability and limit the cost of prescription drugs. We will miss him, and we should be grateful to him. (Applause.)

I'm glad to see all of you in such good spirits. I hope you will stay that way. (Laughter.) I hope you'll stay that way because I am identifying more and more with you and -- (laughter) --and I understand Secretary Shalala read the letter we got from the child that

said old people are smart and Bill Clinton is old. (Laughter.)

I remember very clearly about six or seven years ago when I had two events occur within two days, when I knew I was getting older. My hair had begun to gray, but I thought I was still in reasonably good shape. I felt fairly chipper. And I was making the rounds in my state and this beautiful young girl, whose parents were very close friends of mine and, therefore, I felt that I almost had a hand in her upbringing from the time she was born -- she was 18 or 19 years old and she was nearly six feet tall. And she was just beautiful. And she came up to me -- I was so please to see her -- she came up to me and threw her arm around me, looked me straight in the eye, and she said, "Governor, you look so good for a man your age." (Laughter.)

And then, the very next day I was in a different part of the state, and I saw this wonderful retired school teacher who was then 80 years old, who had worked in every single campaign I had ever run. And I was so happy to see her. And she said, "Governor, I'm so glad to see you. You're aging gracefully." (Laughter.)

But I think the right thing about this, you know, is to have a good attitude about it. All of you have a good attitude. (Applause.) And you -- that's a big part of this. (Applause.)

I just want to tell you one more story that illustrates the right attitude. It's a true story. We had a man in north Arkansas in a little rural county who ran a tiny phone company back when there were lots of these little phone companies. And he was about 92 years old. And they decided to give -- actually, he was 96. And the people in the town decided they'd give him a banquet. And everybody got up and said nice things about him, you know, and the time came for him to speak. And he said, "The very first thing I want to do is to thank my secretary." And he introduced her, and she was 72. (Laughter.) He introduced her and said, "I want to thank my secretary. She has been with me for 40 years. She has been wonderful. I don't know what I'm going to do when she passes on." (Laughter and applause.)

So you've got to have the right attitude. Now, if you're all in the right attitude, let's get after it.

I am proud to convene this 1995 White House Conference on Aging. This is the fourth of these conferences in the history of our country; the first to be held since 1981; the last of the 20th century. I thank the members of Congress and the citizens of this country from both parties who have supported this endeavor. These conferences have a productive history -- from the establishment of Medicare, Medicaid and the Older Americans Act, as a result of the 1961 conference, to the creation of the House Select Committee on Aging, coming out of the 1971 conference.

But this conference must be about looking forward, not looking back. All across our country we have seen a dramatic reversal in the way we think about older Americans. We have, after all, twice as many older Americans as we had 30 years ago. And 30 years from now, we'll have twice as many again. People over 55 are younger, healthier, better educated than ever before, and beginning entirely new careers and endeavors in life as they grow older.

Your job here, more than anything else, is to help determine how to use the accumulated experience and judgment of older Americans to make all of our country stronger in the future. That is the purpose of our National Senior Corps, which works with AmeriCorps, our national service initiative in which -- (applause.) Thank you. The AmeriCorps program is a national service program in which young people earn money for their education by doing community service. And not all of them are young. I've met retired naval officers in Texas doing work in Americorps and intending to go back to college.

But the Senior Corps, like the AmeriCorps volunteers, are a new source of energy for American social problems and challenges. And they make sure that as the poet said, "The best is yet to be." Your conference agenda confirms your concern with the future. Issues such as crime, ethics and ways to inspire a renewed sense of community affect all Americans, regardless of their age. To be honest, seniors are in a better position than ever before to help us address these concerns.

I want to mention just a couple of thing that have happened since 1981 that are very important with reference to your agenda. First, briefly, since 1981, you and your generation won the Cold War and the battle against communism. And you can be very proud of that. And we are now trying to finish that work so that for the first time since the dawn of the nuclear age there are no Russian missiles pointing at the American people. (Applause.)

But we know there are still threats to our security, and we were reminded of it very painfully in the last few days. So I ask all of you as you focus on crime to remember that we need to continue to fight to lower the crime rate. And with a strategy of punishment, police and prevention, we can do that.

But we must focus on the special problems of terrorism to which all open societies are vulnerable. I have sent legislation to the Congress to address this terrorism problem. It has broad bipartisan support. The leaders of the Congress are working with me on it. We must pass it and pass it this month. And I urge you to take a stand for that on behalf of all Americans. (Applause.)

The other truly remarkable thing that's happened since 1981

affects you particularly. Just one year after the last conference in 1982, for the first time in this history of the United States, older Americans were less likely to be poor than Americans under 65. In the full span of our country's history, that is a stunning change and remarkable achievement. We have seen it happening over the course of the past several decades. Since 1960, the poverty rate among elderly people has declined by 65 percent. It did not happen by accident. It happened because the American people kept faith with the social compact first forged 60 years ago when President Roosevelt signed the Social Security Act. (Applause.)

That compact has been strengthened over the last three decades with Medicare, with Medicaid, with the cost of living adjustments for Social Security, with community-based services under the Older Americans Act like Meals on Wheels, transportation, with efforts to prevent abuse of the elderly. This is a remarkable record, and you should be proud of it. (Applause.) It happened because people understood that their government could be made to work for them in a positive and strong way. (Applause.) And it is something our country should be very proud of.

Now, our administration is committed to continuing that work -- first, to the core principles that have made Social Security work. America has a solemn commitment to every person still working, no matter what their age, that Social Security will be there for them and their families when they need it. (Applause.)

We have also worked to strengthen retirement and to make it safer through strengthening private pensions. The Retirement Protection Act signed late last year reformed the Pension Benefit Guaranty Corporation and secured 8.5 million pensions that were at risk in this country, stabilizing 40 million others. It was a remarkable bipartisan achievement. (Applause.)

So every American should be proud that we have completely altered the way our people live their lives as they grow older, providing new hope for an entire lifetime of purpose and dignity. But we must remember that with this kind of opportunity in a democracy goes continued responsibility. Our job today is to preserve this progress not only for you during your lifetimes, but for all generations of Americans to come.

You are here to look ahead to the next 10 years and beyond, and not just to the past or to your personal concerns. We know that with regard to seniors our country has been moving in the right direction. (Applause.) But the truth is, we know that too many younger Americans are not. We have to think about this: How are we going to pass along the next century with the American Dream alive and well for our children and grandchildren?

From the year I was born, right after the war, well into the '70s, almost to the end of the decade, people at all levels of our country grew economically, and they grew together. Prosperity was unprecedented. Without regard to income groups, people's incomes rose. Today, we have to face the hard fact that 60 percent of working Americans today are working for the same or lower wages than they were making 15 years ago while working, on average, a longer work week.

We also have a new class of poor people -- mostly unmarried, uneducated young women and their little children. We must do more to discourage the things that create poverty, especially teen pregnancy, and to require more education and efforts to enter the work force for those who are dependent upon welfare.

But the real problem facing this country is the problem of the middle class and stagnant earnings, and the insecurity of the American Dream that so many people feel, and the gnawing worry so many working people have when they come home at night that they won't be able to give their children a better life than they enjoyed.

The new split in the middle class is caused by the global economy and the technology revolution. And it is rooted, more than anything else, in one word -- education. (Applause.) We know that those who have it, and continue to get it and learn from a lifetime, do well, and those who don't tend not to do very well.

So as we look ahead to the next 10 years the question is, how can we preserve the gains and enhance the quality of life further, and enhance opportunities to serve and to live and to grow and to thrive for seniors, while reversing the economic fortunes of those who are stuck and being drivin away from the American Dream, who are younger and dealing with the fundamental problems of this country which include the education deficit, and also the budget deficit?

It exploded in the 12 years before I became President. It, too, is undermining our ability to give your children a better future and to build opportunity.

For the past two years, our administration has made great strides in dealing with that deficit. (Applause.) We've passed two budgets -- (applause) -- we've passed two budget that cut it by $600 billion over five years. I want you to hear this very carefully. When you hear that we have not cut spending, that we have not reduced the deficit -- we have reduced the deficit by $600 billion over five years, and this is the more important fact -- if it were not for the interest we must pay this year on the debt run up between 1981 and the end of 1992, the budget would be in balance today. (Applause.)

We have also worked to strengthen the Medicare trust fund. It

still has problems, but it's stronger than it was on the day I became President. (Applause.) Despite all that, we know we have to do more. I have been consistently saying for three years, beginning with my first address to the Congress and, indeed, all during my campaign in 1992, that we will never fundamentally solve the deficit problem and have the funds we need to invest in education and the future growth in earning of our people until we are able to moderate the growth of health care spending. (Applause.)

Ask any member of Congress here present today -- all defense and domestic spending are either frozen or declining. Social Security and other retirement income is increasing, but only at the rate of inflation. We have to pay interest on the debt, and we're driving that down, but that changes as interest rates change. The only thing that is going up by more than the rate of inflation and the increased population growth in the programs are the health care programs. Over the next five years alone, almost 40 percent of the growth in federal spending will come from the rise in federal health care costs. More than our economy is growing, more than inflation is going up, faster than other items of government spending. So let us not pretend that there is not a challenge here for us to face. And let us face the challenge with good spirits.

You and I know that there is a right way to face this challenge and a wrong way to face the challenge. But not facing the challenge is not an option. I believe it is wrong simply to slash Medicare and Medicaid to pay for tax cuts for people who are well-off. (Applause.) Beyond that, reducing the deficit is terribly important. But it is also important that Congress programs for seniors like Medicare. We must have a sense of what our obligations are. Some proposals would increase the out-of-pocket costs on Medicare by up to $35,000 for our seniors.

I also think it's wrong to cut Medicaid over $150 billion in ways that threaten long-term care for seniors. (Applause.) You know -- let me just say in parentheses here, I hope that if nothing else comes out of this conference, the American people will come to understand that Medicaid is not simply a program for poor people. Yes, it provides health coverage to people on welfare and their children. But two-thirds of the Medicaid budget goes to care for the seniors and the disabled in this country -- two-thirds of the Medicaid budget. (Applause.)

To give you a stark example if Medicaid were not there, middle class people all across this country struggling to raise and educate their children would face nursing home bills for their parents that would average $38,000 a year. Medicaid is primarily a program for the elderly and the disabled.

It is wrong in my judgment to reduce coverage under the Medicare program, or to undermine health services in rural and urban areas that

are already underserved, or to make changes that just simply coerce beneficiaries in managed care. We can't save Medicare and Medicaid by using savings to fund tax cuts for people who are already well-off or other purposes. That is the wrong way to approach this problem. (Applause.) But we must approach the problem. The right way is to start from the perspective of the people the system is intended to serve; to ask, what does it take to preserve and strengthen it, and what is fair to expect of everyone to do that -- to preserve and strengthen it.

For three years I have said that the right way is to strengthen Medicare and Medicaid by containing costs as part of a sensible overall health care reform proposal that works for everyone. (Applause.)

If you want to hold down costs, expand coverage, and reduce the deficit, you must reform the health care system. You have to expand long-term care, for example, in terms of the options for seniors, not restricted. Look at the growth in the population. Look at what's going to happen in the next 30 years. If you don't provide for people to get more long-term care in their home and in other less expensive settings -- (applause) -- if you don't provide --(applause) -- if you don't provide for alternatives to more expensive hospital care, if you don't provide, in other words for the problem in the least costly way, given what you know is going to happen to our population, then we will have greater costs, not lower costs.

So let's look at this in the right way. I do want to work with the Congress. But we must do it in the right way. I have said all along that I will evaluate proposals to change Medicare and Medicaid based on the issues of coverage, choice, quality, affordability and costs.

We ought to have some simple tests. For example, does a proposed change reduce health care coverage by eliminating services or by charging seniors with modest incomes more than they can possibly be expected to pay? Does it deal with this long-term care problem in a way that will lower costs per person in long-term care, but recognize that we have to have more options? Does it restrict choice by forcing seniors to give up their doctors and enter into managed care programs whether they're good ones or not? Or does it, instead increase choice by giving people incentives and options to enter into managed care programs and other less costly options that might be made more attractive to them? Does it reform Medicare and Medicaid to lower the rate of cost increases without threatening the quality of care? Does it keep health care affordable for seniors and does it help to control costs for the government?

Many people say, well, all these things are mutually inconsistent. But that cannot be. We are spending over 14 percent of

our income as Americans on health care. No other country is over 10 percent. We know that there are changes that we can make that will improve coverage, broaden services, control costs, and help us with the deficit. But we can only do it if we start from the point of view of what it takes to have a health care system with integrity that can be fairly paid for in a way fair manner. (Applause.)

So, while I will not support proposals to slash these programs, to undermine their integrity, to pay for tax cuts for people who are well off, or to pay for them -- all by themselves, to pay for these kinds of arbitrary targets on the budget, I cannot support the status quo. And neither can you. (Applause.)

We must find a way to make this system work better that deals with the internal issues of the system, your health care issues and those that are coming behind you, and that deals with the genuine problems the Congress faces with our budgetary situation. That's why I have said repeatedly that when the Republicans present their budget as required by law, we will evaluate where they are in terms of their commitment and what they want to do, where we are, and then we will do our best to work through this. I will not walk away from this issue. (Applause.)

I watched from afar when I was a governor and a citizen for 12 years while people here walked away from problem after problem. And I sustained, as President, an agonizing experience when large numbers of people walked away from problems that I asked them to face for short-term political gain. I will not do that. The status quo is not an option. (Applause.)

But in order for us to have discussions we have to know where everyone stands. I have presented a budget. I have said for three years where I stand. As soon as we see the budget that is legally mandated from the members of Congress who are in the majority, we will then talk about where we go from there and what we can do so that I can make sure that your interests and the interests of people coming behind you are protected, but that no one pretends that the status quo is an option. We can pursue both those goals and do it in the right way. (Applause.)

Now, let me also say there are problems -- right ways to address this problem that we in the Executive Branch can be doing right now. You know, waste, fraud and abuse has become a tired phrase in politics. But the truth is there's a lot of it in the health care system. And you know it as well as I do. With all the problems we have today with income for citizens, and with the budget for the government, people who rip this system off jeopardize the health of beneficiaries and the stability of our government and our economy.

Since the beginning of this administration, Secretary Shalala and Attorney General Reno have worked hard to crack down on fraud and abuse. And I am pleased to announce today that, as a part of phase two of the Vice President's outstanding reinventing government initiative, we are taking an additional strong measure. We are forming a multistate effort to identify, prosecute and punish those who willingly defraud the government and who victimize the public. (Applause.)

In five states, with nearly 40 percent of all the Medicare and Medicaid beneficiaries -- New York, Florida, Illinois, Texas and California -- we will have an unprecedented partnership of federal, state and private agencies. For every dollar we spend, we will save you six to eight dollars in the government's health care programs to stabilize what we need to be doing. (Applause.)

This is a win-win situation for everybody, except the perpetrators of fraud. And it's about time they lost one. (Applause.)

Let me close with this thought. This should be an exciting time for you. You should welcome this challenge. You should know that I will be there with you and for you to protect the legitimate interests of the senior citizens of this country, and not to see us trade the long-term welfare and health of the American people for anybody's short-term gain. (Applause.)

But you should also know that we need you to be here for us. We need for you -- (applause) -- we need for you to say, these are changes that make sense; these are changes that don't; these are things that will make us all stronger; these are things that will help you guarantee higher incomes and better wages and a better future for our children and our grandchildren. These are things that will bring us together.

This country is always strongest when we are together. (Applause.) We are always stronger when we are together. (Applause.)

I'll bet you more than half of the people in this room wept in the aftermath of that terrible tragedy in Oklahoma City. (Applause.) We were for a moment, once again, one family, outraged and heartbroken. And you saw what happened when people gave up their lives and came from all over the country to go there to help with the rescue effort, to help to deal with the families who are grieving, to help with all the efforts that were going on. That's when we're strong.

The theme of this conference is "Generations Aging Together." You know when we're together we're strong. And so many forces in America today are trying to turn us all into consumers --of goods or politics or other things -- so that we're all divided up in little markets and segmented, and we fight with each other all the time. And the people that provoke the fights make a lot of money or votes, or

whatever, out of us when we do that. (Applause.)

But that's not when we're strong. I saw the end of the film, when you quoted my speech at Normandy. I don't know that I have ever or ever will have a greater honor than to go and honor the generation of my parents for winning the second world war. We were one, because of what you did, because of your sacrifice.

And I just want to say to you today, we can win the challenges of today and tomorrow. We can make the 21st century an American century. We can continue the progress in expanding the quality of life for our seniors. We can solve the health care crisis. We can do it if we will do it together. Lead us there; help us there. And I will stay with you.

Thank you, and God bless you all. (Applause.)

END12:25 P.M. EDT