MEDICAID FACTS

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

November 1997

THE MEDICAID PROGRAM AT A GLANCE

What is Medicaid?

Medicaid is the nation's major public financing program for providing health and long-term care coverage to millions of low-income people. Initially designed to pay for the health care of recipients of welfare assistance and certain other needy people, by 1995, 35.2 million people—more than 1 in 10 Americans—were covered by Medicaid at a cost of $152.4 billion.

Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by the state and federal governments and administered by the states. Federal financial assistance is provided to states for coverage of specific groups of people and benefits through federal matching payments based on the state's per capita income. The federal share ranges from 50 to 80 percent of Medicaid expenditures.

Who is Covered by Medicaid?

Being poor does not automatically qualify an individual for Medicaid. Only persons who fall into particular "categories" such as low-income children, pregnant women, the elderly and people with disabilities are eligible. Under the new welfare program, Temporary Aid to Needy Families (TANF), Medicaid eligibility is no longer automatic for families who receive cash assistance. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. As a result, there are large state variations in coverage. Although Medicaid has increasingly been used to expand coverage to the low-income population, it covers only half of poor Americans. While the new State Child Health Insurance Program will expand coverage to low-income uninsured children either through Medicaid or a separate program, millions of low-income people will remain uninsured.

The diverse Medicaid population is comprised of:

- 17.5 million children
- 8.0 million adults in families
- 3.9 million elderly persons
- 5.8 million blind and disabled persons

Although adults and children in low-income families make up nearly three-fourths of beneficiaries, they account for only 28 percent of Medicaid spending. The elderly and the disabled account for the majority (60 percent) of spending because of their intensive use of acute and long-term care services. Disproportionate share hospital (DSH) payments account for about 12.5 percent of Medicaid spending (Figure 1).

What Services are Covered Under Medicaid?

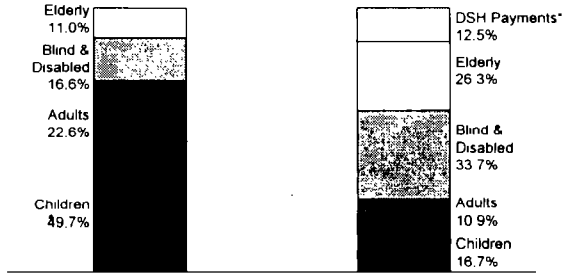
Medicaid covers a broad range of services to meet the complex needs of beneficiaries. Because of the limited financial resources of beneficiaries, cost-sharing requirements are nominal. Federally mandated services include:

- inpatient and outpatient hospital
- physician, midwife, and certified nurse practitioner
- laboratory and X-ray
- nursing home and home health care
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- family planning
- rural health clinics/federally qualified health centers

States have the option to cover additional services and still receive federal matching funds. Commonly offered services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care and intermediate care facilities for the mentally retarded (ICF/MR).

Figure 1

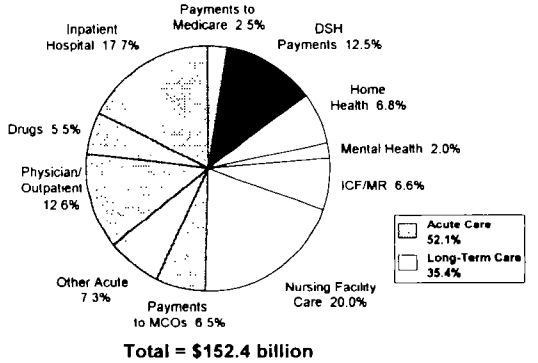
Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995



* Disproportionate share hospital payments.
Note: Total expenditures exclude administrative expenses, adjustments and the territories
SOURCE: Urban Institute Estimates, 1997

Figure 2

Medicaid Expenditures by Service, 1995



SOURCE: Urban Institute Estimates, 1997.

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Of the $152.4 billion Medicaid spent in 1995 (Figure 2):

- Acute care services comprised about half (52.1 percent) of spending. This includes 6.5 percent of spending on Managed Care Organization (MCO) premiums.
- Long-term care services accounted for 35.4 percent of expenditures. Medicaid pays for half of total nursing home care (47 percent) and 14 percent of all home health spending in the United States.
- Payments to Medicare accounted for 2.5 percent.
- Payments to hospitals with a disproportionately large population of indigent patients (DSH) comprised 12.5 percent of total expenditures.

How is Care Delivered Under Medicaid?

As states try to expand insurance coverage to low-income people, improve access, and contain costs, many are adopting new care delivery and financing arrangements under Medicaid. While traditional fee-for-service still predominates, an increasing number of states are enrolling their Medicaid populations in managed care.

As of June 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care, a fourfold increase from 2.7 million in 1991. Medicaid managed care models range from HMOs that use prepaid capitated care to loosely structured networks that contract with selected providers for discounted services and use gatekeeping to control utilization. States have initially targeted low-income families for managed care enrollment rather than aged or disabled beneficiaries.

Until recently, states have used waivers of Section 1915(b) and Section 1115 of the Social Security Act to undertake mandatory managed care programs. However, the Balanced Budget Act (BBA) of 1997 permits states to mandate managed care enrollment for most Medicaid beneficiaries without a waiver (except special needs children, Medicare beneficiaries and Indians.) As a result, mandatory managed care enrollment is likely to rise.

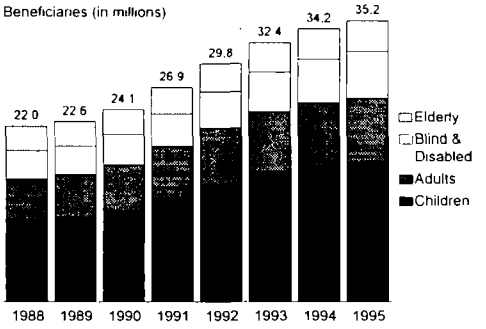
Long-term care is a major component of Medicaid. While over three-fourths of Medicaid spending for long-term care is on institutional services, Home- and Community-Based Services (HCBS) waivers are often used by states to deliver community-based care. Although all states have HCBS waivers, the population served remains small. States also now have the option to provide dual eligibles (Medicaid/Medicare) with acute and community-based long-term care services under the Program for All-Inclusive Care for the Elderly (PACE).

Recent Beneficiary and Expenditure Growth

Medicaid enrollment rose dramatically in the early 1990's, reaching 35.2 million beneficiaries in 1995 (Figure 3). This growth is mostly attributable to expanded coverage of low-income pregnant women and young children and increases in blind and disabled beneficiaries. However, enrollment growth appears to have leveled somewhat, increasing by only 3 percent from 1994 to 1995.

Figure 3

Medicaid Beneficiary Growth by Enrollment Group, 1988-1995



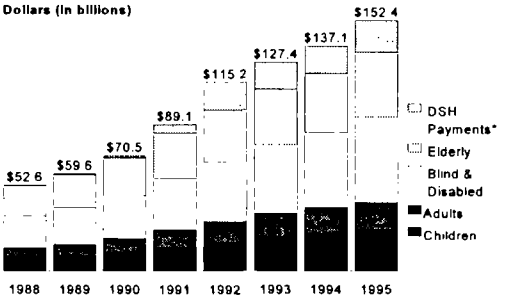
SOURCE: Urban Institute Estimates, 1997

Medicaid has become a major budgetary commitment for both the federal and state governments. Medicaid expenditures escalated rapidly between 1988 and 1992—more than doubling (Figure 4). The rise in spending in that period was attributable to a combination of health care inflation, state use of alternative financing mechanisms, and an increase in enrollment. Only a small fraction of spending growth was attributable to the expansions in coverage of low-income pregnant women and children.

The rate of growth in Medicaid spending has now returned to historic levels—rising 11.2 percent from 1994 to 1995. This suggests that legislation enacted to limit states' capacity to raise funds through provider taxes and DSH payments has played a role in slowing Medicaid spending growth. The BBA of 1997 further reduces the growth in DSH payments by $10.4 billion over the next five years and lowers the state-specific ceilings on federal Medicaid DSH matching payments.

Figure 4

Medicaid Spending by Enrollment Group, 1988-1995



* Disproportionate Share Hospital payments
Note: Total expenditures exclude administrative expenses
SOURCE: Urban Institute Estimates, 1997

Since its enactment in 1965,Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Medicaid has been consistently shown to improve access to health care for the population it serves. Low-income people without insurance coverage use care at considerably lower levels than those with Medicaid coverage. As Medicaid struggles to meet multiple responsibilities under continued fiscal pressure, the program plays a critical role in providing acute and long-term care services to our nation's most vulnerable people.

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID FACTS

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

November 1997

MEDICAID AND MANAGED CARE

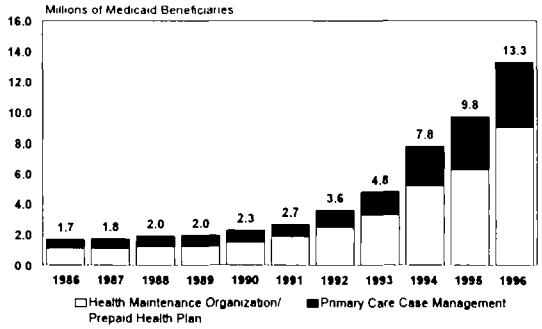
Medicaid provided health and long-term care coverage to approximately 35 million low-income Americans at a cost of $152 billion in 1995. In its role as a purchaser of health services for low-income families, Medicaid increasingly relies on managed care to deliver services. About 40% of Medicaid beneficiaries, predominately poor children and their parents, now receive health care services through a broad array of managed care arrangements.

MEDICAID MANAGED CARE ENROLLMENT

Medicaid's use of managed care has grown dramatically in recent years in response to pressure to contain the growth in Medicaid spending while maintaining access to care for low-income individuals. In 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care, up from 2.7 million in 1991, a four-fold increase (Exhibit 1). Today, all states (except Alaska) are pursuing some managed care initiatives. As of June 1996, 36 states and the District of Columbia had more than one-quarter of their Medicaid population enrolled in managed care (Exhibit 2). Of these, 8 states have more than 75% of their Medicaid beneficiaries enrolled in managed care.

Exhibit 1

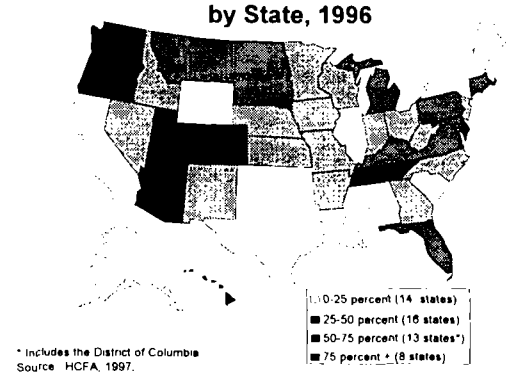
Growth in Medicaid Managed Care Enrollment, 1986-1996



Source: HCFA, 1997 and PPRC, 1997.

Exhibit 2

Medicaid Managed Care Enrollment, by State, 1996



* Includes the District of Columbia

Source: HCFA, 1997.

MODELS OF MEDICAID MANAGED CARE

Managed care includes a broad array of health financing and delivery arrangements designed to reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care. Managed care arrangements are characterized by formal enrollment of individuals in a managed care organization; contractual agreements between the provider and a payer; and some gatekeeping and utilization control.

The major Medicaid managed care models include:

- ***Full-Risk Plans (HMOs or HIOs):*** Under a fully capitated plan, a health plan is paid a fixed monthly fee per enrollee and assumes full-risk for the delivery of a comprehensive range of services. The major types of full-risk plans are Health Maintenance Organizations (HMOs), in which the contracting entity and the providers are integrated into one plan, and Health Insuring Organizations (HIOs), which operate as fiscal intermediaries.

- ***Limited-Risk Prepaid Health Plans (PHPs):*** A PHP is an entity, usually a clinic or large group practice, that either contracts on a non-risk basis or a prepaid, capitated-risk basis to provide services that are not comprehensive (often ambulatory care only).

- ***Fee-for-Service Primary Care Case Management (PCCM):*** In a PCCM plan, a specific provider, usually the patient's primary care physician, is responsible for acting as a "gatekeeper" to approve and monitor the provision of covered services to beneficiaries. These gatekeepers contract directly with State Medicaid agencies, do not assume financial risk for the provision of services, and are paid a per-patient monthly case management fee, as well as fee-for-service payment for medical care.

As of June 1996, 511 Medicaid managed care plans, primarily full-risk HMOs, were in operation -- almost double the number of plans in 1993. The predominance of full-risk plans is reflected in the distribution of enrollees: 67% of all Medicaid managed care beneficiaries were enrolled in HMOs or HIOs, 2% in PHPs, and 31% in PCCMs and other managed care arrangements (Exhibit 3).

STATE MANAGED CARE OPTIONS

States have long had the option to voluntarily enroll Medicaid beneficiaries in managed care plans. Legislative authority to require mandatory enrollment has evolved over time. Until recently, states have used Section 1915(b) freedom-of-choice waivers or Section 1115 research and demonstration waivers to undertake mandatory managed care programs.

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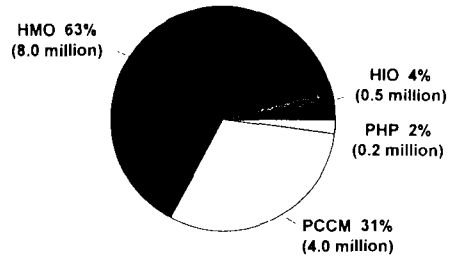
Exhibit 3

Medicaid Managed Care Enrollment, by Type of Plan, 1996



Note: Excludes enrollees in Behavioral and Dental Health Plans.
Source: PPRC, 1997.

Under 1915(b) waivers, in place in 42 states, mandatory managed care has been implemented in part of the state or for certain categories of beneficiaries. Section 1115 waivers have been used to implement statewide mandatory mandatory managed care enrollment, as well as to waive the requirement that 25% of a plan's enrollment be privately insured (the 75/25 rule). As of May 1997, 10 states have implemented Section 1115 waivers (AZ, DE, HI, MN, OH, OK, OR, RI, TN, VT).

The Balanced Budget Act (BBA) of 1997 gives states new authority to mandate enrollment in managed care organizations (MCOs) for Medicaid beneficiaries without obtaining a federal waiver (except for special needs children, Medicare beneficiaries and American Indians). Furthermore, the new law permits the establishment of Medicaid-only plans by eliminating the 75/25 rule. Finally, the law establishes certain new managed care consumer protections, but exempts Section 1915 and Section 1115 waivers from the new requirements (Exhibit 4).

Issues in Medicaid Managed Care

Medicaid beneficiaries are economically disadvantaged, frequently reside in medically underserved areas, and often have more complex health and social needs than do higher-income Americans. The success of managed care depends, in large part, on the future adequacy of the capitation rates and the ability of states and the federal government to monitor access and quality.

As a public program, Medicaid has operated under tight budget constraints. This has resulted in provider payment rates that are often substantially below market rates, contributing to access problems. Capitation rates need to be sufficient to assure that plans are able to adequately serve Medicaid enrollees. Adequate payment levels are particularly important in the context of mandatory enrollment of beneficiaries in Medicaid-only MCOs because these plans are wholly dependent on Medicaid financing and do not have other payers to cover Medicaid shortfalls.

Broadened use of managed care for low-income children and families, the target of most managed care initiatives, is unlikely to accomplish large overall savings for Medicaid. Acute care services for low-income children and adults account for a quarter of program spending, whereas approximately 60% of spending is for the elderly and the disabled. Enrollment of elderly and disabled populations into managed care remains low and is complicated by difficulties in setting appropriate capitation rates, limited plan experience in providing specialized services, as well as lack of systems to coordinate Medicare and Medicaid benefits for "dual eligibles."

Medicaid Managed Care
Selected Provisions in the Balanced Budget Act of 1997

Enrollment/Marketing: Allows states to mandate managed care enrollment, to guarantee managed care enrollment for 6 months for adults and 12 months for children, and to "lock-in" beneficiaries for up to 12 months; prohibits door to door marketing; and requires state default enrollment systems to consider existing beneficiary-provider relationships and traditional Medicaid providers.

Plan Choice: Permits states to limit Medicaid beneficiaries to a choice of two MCOs in urban areas and one MCO in rural areas. Plans may serve Medicaid beneficiaries exclusively.

Access: Requires MCOs to comply with a "prudent layperson" emergency care coverage standard and prohibits physician "gag rules."

Consumer Protections: Requires MCOs to provide information regarding participating providers, enrollee rights and responsibilities, information on covered services, and grievance and appeals procedures (an internal grievance process is required).

MCO Payment Rates: Requires state Medicaid agency capitation payment rates be made on an "actuarially sound basis", and requires DSH payments go directly to providers, not incorporated into capitation payments.

Plan Requirements: Requires plans to demonstrate adequate capacity, including an appropriate range of services and access to preventive and primary care services and a sufficient number, mix, and geographic distribution of providers.

Quality/Oversight: Increases the threshold for prior federal approval of managed care contracts to $1 million; requires states to develop and implement a quality assessment and improvement strategy by 1999 consistent with standards to be established by the Secretary of HHS; and establishes external independent review of MCO performance.

Changes in the delivery system can be made to accomplish savings, but in order to be effective and preserve access to needed services, these changes will require sufficient time to implement, the development of an adequate infrastructure to deliver care, oversight of program implementation, and more experience with enrolling the elderly and disabled.

The BBA provides new standards to assure plan capacity and enforce consumer protections. However, the development of access and quality performance standards for Medicaid MCOs, and the measurement of compliance with those standards, is evolving. Ensuring that plans have provider networks in place, educating both providers and beneficiaries about managed care, and responding to the unique needs of the Medicaid population are critical to assuring access and quality of care in a managed care environment.

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THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

November 1997

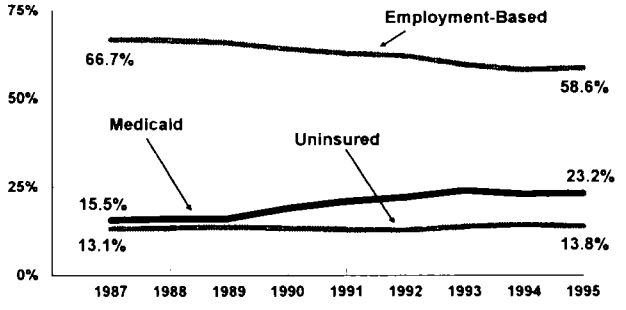
MEDICAID'S ROLE FOR CHILDREN

In 1995, 17.5 million children -- one-quarter of all children under age 18 -- had Medicaid coverage for health care services. Medicaid, the federal/state health program for the poor, pays for a broad range of services for children including well-child care, immunizations, prescription drugs, doctor visits, and hospitalization, and a range of long-term care services for children with disabilities.

Medicaid plays a particularly strong role for low-income children, covering two-thirds (64%) of all poor children and a quarter(27%) of children with incomes between 100% and 199% of the federal poverty level (FPL). While employer-based insurance coverage of children declined from 1987 to 1995, expansions in Medicaid have resulted in greater coverage of children in low-income families (Figure 1). During this same period, Medicaid enrollment grew from about 10 million -- 15.5% of all children -- to 17.5 million children (23.2%).

Figure 1

Trends in Coverage for Children, 1987-1995



Note: Children under age 18
SOURCE: Employee Benefit Research Institute, 1997.

Despite the importance of Medicaid today, about 10 million children are uninsured. Lack of insurance is particularly high among low-income children. Seventy percent of uninsured children are in families with incomes below 200% of poverty. The new State Child Health Insurance Program, enacted as part of the Balanced Budget Act of 1997, is intended to provide coverage to this group.

ELIGIBILITY

Being poor does not automatically qualify a child for Medicaid. In the past 15 years, Medicaid eligibility for children has been broadened considerably through federal legislation and state optional expansions. Prior to 1986, Medicaid primarily served children who received AFDC cash assistance. Today, children qualify for Medicaid based on their age and income.

Medicaid coverage is especially prominent among young children, covering 33% of infants and 29% of children ages 1 to 5. Because recent expansions focused on young children, older children are less likely to qualify for Medicaid. Medicaid covers 22% of children between the ages of 6 to 12 years and 17% of teens between the ages of 13 to 18 years.

Medicaid Coverage of Children:

States are mandated to cover certain groups of children based on age and income criteria. By 2002, all states will be required to have phased-in coverage of children under age 19 with incomes below poverty. States can choose to expand Medicaid eligibility beyond federal minimum standards by raising age and income levels for children (Figure 2). They can also use Section 1115 research and demonstration waivers to broaden eligibility. In total, 41 states have expanded Medicaid coverage to children in one or more age or income levels. Federal coverage requirements for children are as follows:

Up to age 6 with family incomes up to 133% FPL. For infants, 35 states have chosen to expand coverage beyond 133% FPL and 13 have expanded for children age one to six.

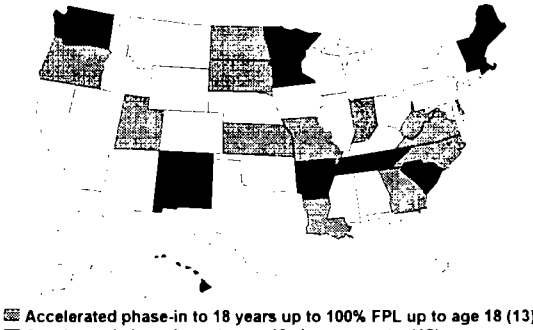
Age 6 to 14 with family incomes below 100% FPL. Fifteen states have opted to expand eligibility beyond 100% FPL.

Age 15 to 19 if family income meets the AFDC criteria of August 1996 (state average is 41% of FPL) with coverage phased-in for poor children born before 9/30/83. 25 states have opted to accelerate this phase-in to cover older children up to age 18 with income below 100% FPL (Figure 2).

Children with disabilities also qualify for Medicaid assistance on the basis of SSI eligibility. Medicaid covers about 1 million additional children with physical or mental disabilities.

Figure 2

States Opting to Accelerate Coverage of Poor Children, 1997



SOURCE: National Governors' Association, 1997

Because states established varied Medicaid income eligibility levels for children, and because of state variations in per capita income there is considerable variation in Medicaid coverage, ranging from 13% of children in Colorado to 47% in West Virginia. Similarly, Medicaid pays for 39% of all births nationally, but coverage varies from 21% of births in Massachusetts to 61% in Georgia.

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The Balanced Budget Act (BBA) of 1997 creates new options for states to strengthen and expand Medicaid coverage for children. The new State Children's Health Insurance Program (CHIP) was enacted as part of the Balanced Budget Act (BBA) of 1997. This new capped federal program allocates $20.3 billion over five years in the form of a matched grant to states to expand coverage to uninsured low-income children through either a separate state program or by broadening Medicaid -- or both. The funds became available on October 1, 1997 and are targeted to uninsured children under 19 with income below 200% of poverty who are not eligible for Medicaid or not covered by private insurance.

Provisions of the Balance Budget Act also included some important changes to Medicaid. It clarifies the state Medicaid option to accelerate the phase-in for children born before September 30, 1983. In addition, the new law gives states the option to extend presumptive eligibility to children, meaning that services provided to low-income uninsured children will be covered by Medicaid before the Medicaid eligibility determination process is complete. States can also offer 12 month continuous eligibility to children, regardless of any changes in family income during that period.

SERVICES AND COSTS

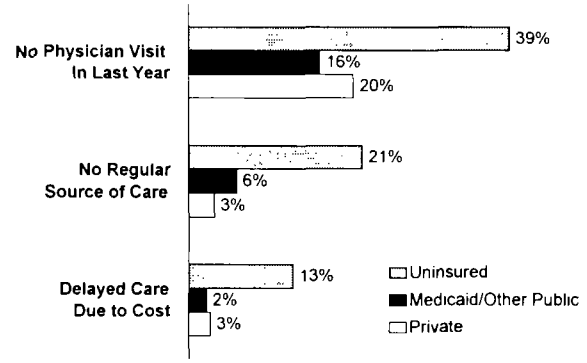
Federal guidelines require that Medicaid cover a comprehensive set of services with nominal or no cost-sharing for children. Access to these services is important because poor children experience more health problems than more affluent children. Children with Medicaid are eligible to receive physician and outpatient services, prescription drugs, inpatient hospital care, and long-term care services.

Medicaid coverage also entitles children to early and periodic screening, diagnostic, and treatment (EPSDT) services including a comprehensive health and developmental history and physical exam, immunizations, laboratory tests including blood lead levels, and health education. Children found to have conditions requiring further attention are covered for needed treatment.

The importance of health insurance in securing access to health care services is well documented. Despite their complex health and social needs, children with Medicaid coverage have access to care that is similar to higher income privately insured children (Figure 3).

Figure 3

Access to Care for Children by Insurance Status, 1993



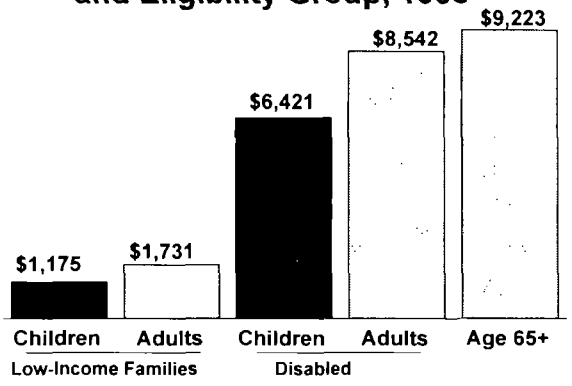
Source: National Center for Health Statistics,1997, Kaiser/Commonwealth Survey, 1997.

In 1995, Medicaid spent $25.4 billion on health care services for 17.5 million children in low-income families and about $7.1 billion for one million disabled children. The majority (93%) of the expenditures for non-disabled children are for acute care services, with one third for inpatient hospital care.

While low-income children represent half of the 35 million Medicaid beneficiaries, they account for only 16.7% of overall Medicaid spending. In 1995, Medicaid spent an average of $1,175 per low-income child enrolled in the program. On average, children cost less to care for than older Medicaid beneficiaries, but some disabled children have very costly health and long-term care needs. Medicaid spent an average of $6,421 per year per child qualifying on the basis of disability (Figure 4).

Figure 4

Medicaid Spending Per Enrollee By Age and Eligibility Group, 1995



SOURCE: The Kaiser Commission on the Future of Medicaid, 1997.

ISSUES AND CHALLENGES

Expanding Coverage. To broaden coverage of low-income uninsured children, Congress enacted the new State Child Health Insurance Program and included provisions to allow states to facilitate enrollment and continuity of coverage under Medicaid. Key issues facing state Medicaid agencies include how the new children's program will be structured, financed, and implemented, as well as how it will be integrated with or build on the state's existing Medicaid program.

Participation. An estimated 3 million of the 9.8 million uninsured children are eligible for but not enrolled in Medicaid. This is largely due to enrollment barriers or lack of awareness of the program. States can streamline the eligibility process and facilitate enrollment. For example, 25 states allow mail-in eligibility applications and 29 states have dropped the asset test. Medicaid eligibility policy has also changed markedly as a result of the 1996 welfare law, which eliminated the automatic link between cash assistance and Medicaid. Ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible for assistance under Medicaid are enrolled.

Managed Care. In 1996, 40% of beneficiaries were enrolled in managed care, mostly low-income children and their parents. The BBA of 1997 expands state flexibility by allowing states to mandate Medicaid managed care enrollment without requiring states to obtain a Section 1115 or 1915(b) waiver. States will still need a waiver to mandatorily enroll special needs children, but will be able to enroll other non-disabled children. Managed care has the potential to improve access to preventive and primary care, but given the vulnerable nature of the Medicaid population, it requires careful implementation and monitoring to assure quality and access.

THE HENRY J. KAISER FAMILY FOUNDATION

LEGISLATIVE SUMMARY

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

December 1997

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

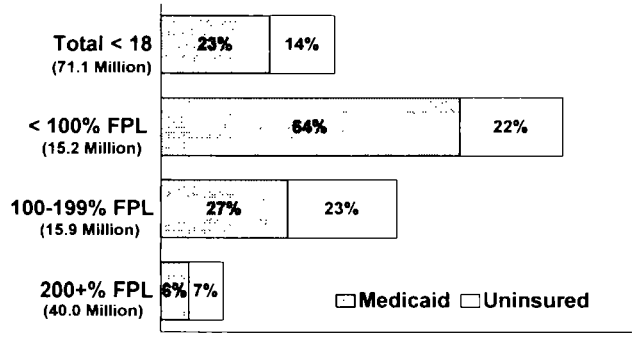
Nearly 10 million children are uninsured, often resulting in difficulties in obtaining needed health care. To expand coverage to low-income uninsured children, Congress enacted the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33). This new program allocates $20.3 billion in federal matching funds over five years to states to expand insurance for children. States can use the federal funds to expand coverage either through a separate state program or by broadening their Medicaid programs -- or both.

ELIGIBILITY

The intent of CHIP is to expand health insurance coverage to uninsured children under age 19 in families with incomes below 200% of poverty (Figure 1). Children with private insurance or who are covered by or qualify for Medicaid are ineligible for CHIP, as are those who are residents of public institutions or whose families are eligible for state employee health benefits.

Figure 1

Health Insurance Coverage of Children, by Poverty Level, 1995



Note: Federal Poverty Level (FPL) is $12,158 for a family of three.
Source: Employee Benefits Research Institute, 1996.

Undocumented children and legally resident children arriving in the U.S. after August 22, 1996 are ineligible for coverage but may qualify for emergency Medicaid assistance. States that implement their child health insurance programs through Medicaid may use federal funds to cover legally resident children in the country prior to August 22, 1996.

States that choose to operate a separate state child insurance program can establish eligibility based on geographic area, age, income and resources, residency, and disability status, as well as limit duration of coverage. States cannot exclude children based upon a preexisting condition or diagnosis, and cannot cover higher income children before lower income children.

If states use the Medicaid option, children become entitled to full Medicaid coverage. States that have already broadened Medicaid income eligibility levels above 150% of the federal poverty level (FPL) can expand coverage to children up to 50 percentage points above the current level. For example, a state with eligibility set at 175% FPL could expand to 225% FPL.

BENEFITS AND COST-SHARING

The benefit package options available to states fall into three general categories: Benchmark, benchmark-equivalent, or Medicaid.

- **Benchmark Packages:** States can offer one of three existing benefit packages: including the Federal Employees Blue Cross/Blue Shield PPO plan; coverage available to state employees; or coverage offered by the HMO with the state's largest commercially enrolled population.

- **Benchmark-Equivalent Coverage:** States can use a package with aggregate value greater than or equal to a benchmark plan. Hospital, physician, laboratory and x-ray, and well baby/child services must be included at a value at least actuarially equivalent to the benchmark benefit package. If prescription drugs, mental health, vision, and hearing services are included in the benchmark plan, then they must be part of the benchmark-equivalent coverage with a value of at least 75% of the benchmark plan's actuarial value.

- **Medicaid:** States that expand Medicaid must provide the complete benefit package, which includes well-child care, immunizations, prescription drugs, doctor visits, hospitalization, and EPSDT, as well as long-term care for disabled children. The Medicaid benefit package for children is broad and should satisfy the benchmark requirement in a state that administers a separate CHIP program.

The Secretary has the authority to approve a different benefit package that is determined to be appropriate for low-income children. The existing New York, Florida, and Pennsylvania child health programs are deemed to satisfy federal requirements for benefits.

Under the new CHIP program, states cannot impose cost-sharing for preventive services including well-baby and well-child care and immunizations. For children with family incomes at or below 150% FPL, cost-sharing must be "nominal" as under the Medicaid statute. Medicaid currently permits premiums of $15 to $19 per month per family and co-payments of up to $3 per service.

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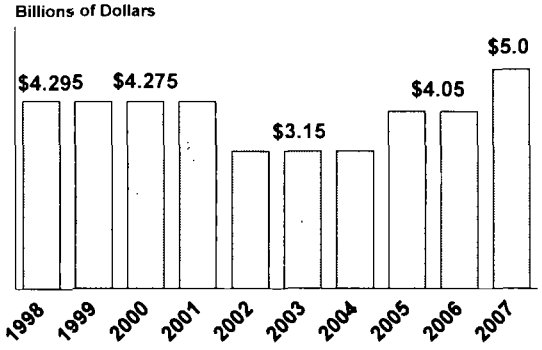
Cost-sharing for children with incomes above 150% FPL can be imposed based on an income-related sliding scale, but total cost sharing cannot exceed 5% of family income. Coverage can be provided directly by the state Medicaid program, an insurer, or any other entity qualified by the state.

FINANCING

The BBA authorizes $20.3 billion in federal funds from FY 1998 through FY 2002 and $19.4 billion over the second five years. Over the ten-year period, the funds are allocated as follows: $4.295 billion in FY 1998, $4.275 billion per year in FY 1999-2001, falling to $3.15 billion annually in FY 2002 through 2004, and then rising to $4.05 billion from FY 2005 through 2006, and reaching $5 billion for 2007, for a total of $40 billion.

Figure 2

Federal Allocations for SCHIP, FY 1998-2007



Source: Federal Register, 1997.

Annual federal allocations to states are based on the states' share of low-income and uninsured children using estimates from the Current Population Survey, conducted by the U.S. Census Bureau. The allotment formula changes over time to adjust for reductions in the number of uninsured children.

States do not receive their allotments automatically. States must have their child health plan approved by HHS and are required to contribute state funds in order to draw down, or "match" their federal allotment. The state share cannot include beneficiary cost-sharing and is subject to the same provider tax and donation limitations specified in the Medicaid statute.

Under the new state program, states receive an "enhanced" federal matching rate based on their Medicaid matching rate. The CHIP enhanced rate essentially reduces by 30 percent the share states pay as compared to what they would contribute under their Medicaid match. For example, a state with a federal match of 60% under Medicaid would receive an "enhanced" rate of 72% under the new program. In essence, the state would pay 28 cents of every dollar spent under the new children's program. No state may receive a matching rate greater than 85% and the minimum annual payment for a state is $2 million.

States can receive an enhanced matching rate for providing Medicaid coverage to an expanded group of children. All Medicaid rules, including the entitlement to coverage, would apply to the newly covered group of children. States would continue to receive the regular Medicaid matching rate after their CHIP allotment was depleted.

While the states have considerable latitude in designing and structuring their CHIP programs, there are some limits on what federal CHIP payments can be used for:

- No more than 10 percent of federal and state spending can be used for outreach, administrative costs or direct service payments to clinics or hospitals. The Secretary can authorize waivers to allow states to create community-based programs or to purchase family coverage.

- If states create a new program, they cannot adopt Medicaid eligibility criteria that are more restrictive than those in effect as of June 1, 1997. If states expand coverage under Medicaid, they must maintaintain eligibility standards in effect as of March 31, 1997.

- Maintenance of effort is also required in state-only programs in New York, Pennsylvania, and Florida.

- Abortions cannot be covered by federal or state funds except to save the life of the mother or in the case of rape or incest.

CHILD-RELATED MEDICAID PROVISIONS

In addition to the creation of the new state child health insurance program, several changes to Medicaid were made to strengthen coverage for children under the Balanced Budget Act of 1997. States can now opt to:

- **Extend presumptive eligibility to children** -- This means that services provided to uninsured children will be covered by Medicaid before eligibility determination is complete. For children who are determined to be eligible for the new program, the costs will be paid through new program funds.

- **Offer 12 month continuous eligibility to children** -- States can choose to provide up to one year of continuous eligibility for children under Medicaid, regardless of any changes in family income during that period.

- **Accelerate the phase-in to cover poor children born before September 30, 1983.** In the past, states could cover these children under Section 1902(r)(2) at state option or through a Section 1115 waiver. The BBA of 1997 clarifies this option. Some 27 states have used these options to expand coverage to older children.

States must also restore Medicaid eligibility to disabled children who lost SSI under the 1996 welfare reform legislation. The Balanced Budget Act also includes numerous provisions that grant states increased flexibility over their Medicaid programs. These include the ability to mandate managed care enrollment without a waiver, greater control over provider payment through the repeal the Boren Amendment, and a phase-out of cost-based reimbursement for Federally Qualified Health Centers.

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION

November 1997

MEDICAID'S FINANCIAL PROTECTIONS FOR MEDICARE'S POOR AND NEAR-POOR

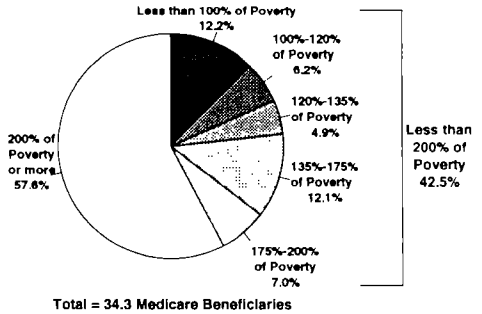
Medicare offers nearly universal coverage to the nation's elderly population and is an important source of coverage for persons with disabilities. Despite the significance of Medicare's protections, gaps in the scope of benefits and beneficiary financial obligations can result in significant out-of-pocket expenses for Medicare's poor and near poor. Medicaid helps to supplement Medicare by paying premiums and cost-sharing for some low-income beneficiaries, but participation is limited with less than half of the eligible population covered.

INCOME, HEALTH STATUS, AND HEALTH SPENDING

Nearly 15 million elderly and disabled Medicare beneficiaries (42.5%) are poor or near-poor with incomes below 200 percent of the federal poverty level (Exhibit 1). An even greater share of Medicare's beneficiaries who are women (48%), age 80 and older (52%), and African American (63%) have an income below twice the poverty level.

Exhibit 1

Medicare Population by Poverty Level, 1995



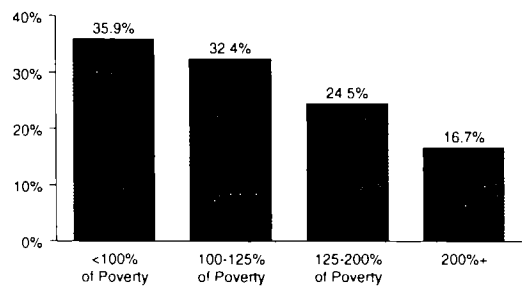
Total = 34.3 Medicare Beneficiaries

Note. 1995 federal poverty level was $7,470 for individuals; $10,030 for couples
SOURCE: M. Moon estimates of non-institutionalized population based on analysis of March 1996 *Current Population Survey*.

Low-income Medicare beneficiaries are more likely to be in poor health and have problems that require medical attention than their higher income counterparts (Exhibit 2). Because of their low-incomes, poor and near-poor beneficiaries are less able to afford basic medical services and prescription drugs.

Exhibit 2

Percent of Elderly Medicare Beneficiaries Reporting Fair or Poor Health, 1992

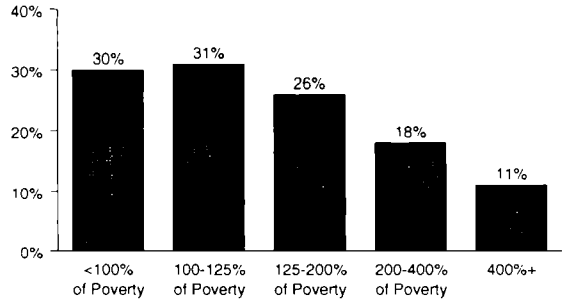


SOURCE: D. Rowland and B. Lyons, "Medicare, Medicaid, and the Elderly Poor," *Health Care Financing Review* 1996

Health expenses consume nearly one-third of the family income of Medicare's poor and near poor beneficiaries compared to about 21% of family income for all beneficiaries (Exhibit 3). High out-of-pocket costs are due to the financial requirements of the Medicare program, the limited coverage of

Exhibit 3

Health Spending by the Elderly as a Percent of Family Income, 1996



Note. Excludes institutionalized population.
SOURCE M. Moon, C. Kuntz, and L. Pounder, *Protecting Low-Income Medicare Beneficiaries*. The Commonwealth Fund, December 1996.

certain benefits, and lack of coverage for outpatient prescription drugs. The 1998 Medicare financial obligations for beneficiaries include a $764 hospital deductible, a $100 Part B deductible, 20% co-insurance for physician services, and Part B premium of $43.80 per month ($525.60 per year).

Although the majority of Medicare beneficiaries have Medigap or retiree health benefits to fill the gaps in the Medicare benefit package, lower income beneficiaries are much more likely than their higher income counterparts to rely solely on Medicare. Beneficiaries without any supplemental coverage experience the greatest access and financial barriers to care. Thus, Medicaid is an important source of supplemental health coverage for the low-income Medicare population.

MEDICAID'S BUY-IN PROTECTIONS

Medicaid, the federal/state health financing program for the poor, provides benefits which vary based on income and assets for about 6 million Medicare beneficiaries,.

- **Full Medicaid Benefits**: The majority of Medicare beneficiaries eligible for Medicaid qualify because they are entitled to SSI or have incurred large health expenses. These "dual eligibles" receive full Medicaid benefits (such as prescription drugs) as defined under each state's program. Medicaid also pays Medicare's premiums, deductibles, and cost-sharing requirements, known as QMB benefits (5.4 million beneficiaries in 1995).

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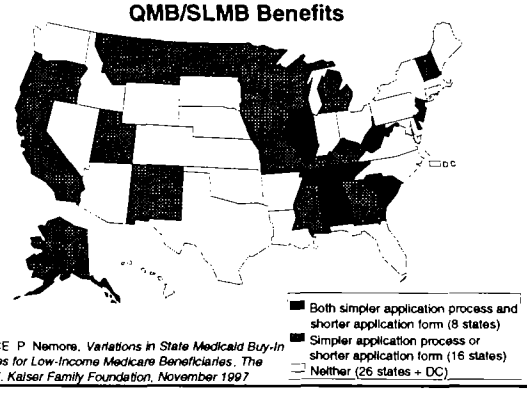
- **Qualified Medicare Beneficiaries (QMBs):** For Medicare beneficiaries with incomes below 100% of the poverty level and limited assets (less than $4,000 per individual), Medicaid pays Medicare's premiums, deductibles, and cost-sharing (367,000 QMB-only beneficiaries in 1995).

- **Specified Low-income Medicare Beneficiaries (SLMBs):** For Medicare beneficiaries with incomes between 100-120% of poverty and limited assets, Medicaid pays only the Medicare Part B premium (195,000 beneficiaries in 1995).

In 1996, only 63 percent of those eligible for QMB benefits and only 10 percent of those eligible for SLMB benefits received financial assistance under Medicaid (Moon, 1996). While some, but not most states, have taken steps to ease the QMB/SLMB enrollment process, requirements to apply in person at Medicaid and welfare offices, lengthy application forms, and the lack of effective outreach are barriers to Medicaid participation (Exhibit 4).

Exhibit 4

States Using Simplified Application Processes for QMB/SLMB Benefits



SOURCE P Nemore, *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries, The Henry J. Kaiser Family Foundation, November 1997*

The emerging role of managed care under Medicare and Medicaid offers the promise of coordinated care for dual eligibles. However, few states have systems in place to coordinate Medicare and Medicaid benefits for beneficiaries enrolled in HMOs (Nemore, 1997). Lack of coordination limits the capacity of states to pay cost-sharing benefits for low-income beneficiaries in Medicare HMOs. Medicaid programs are often unable to determine if beneficiaries are enrolled in Medicare HMOs and may be paying for benefits already included in the Medicare capitation rate. Finally, for beneficiaries, enrollment in Medicaid managed care plans may limit access to Medicare-covered services outside the Medicaid HMO (Feder, 1997).

BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA 97) increases financial obligations for beneficiaries under Medicare by raising the monthly Part B premiums. The new law is expected to increase Medicare Part B premiums from $43.80 per month in 1997 to $67 in 2002 and to $105.40 per month in 2007.

To help offset these costs for low-income beneficiaries, the BBA 97 established a new block grant to states ($1.5 billion over 5 years) to cover the premium for those with incomes between 120 and 135% of poverty and a portion of the premium for those with incomes between 135 and 175% of poverty (Exhibit 5). In contrast to the QMB/SLMB programs, the block grant is not an individual entitlement and states are not required to contribute matching funds. Thus, the block grant is estimated to cover only one-third of those eligible (Moon, 1997).

Exhibit 5

LEGISLATIVE HISTORY OF MEDICAID BUY-IN PROGRAMS

1965: (P.L. 89-97) Medicare and Medicaid enacted. States permitted to enroll certain eligible Medicaid recipients in Medicare Part B by paying their Part B premium.

1968: (P.L. 90-248) Federal payments prohibited for Medicaid services that could have been paid for by Medicare Part B if the recipient had been enrolled.

1986: (P.L. 99-509) States *permitted* to pay Medicare premiums and cost-sharing for Medicare beneficiaries with incomes up to 100% of poverty who are "not otherwise eligible" for Medicaid.

1988: (P.L. 100-360) States *required* to pay Medicare premiums and cost-sharing for Medicare beneficiaries up to 100% of poverty (QMB).

1989: (P.L. 101-239) States required to pay Medicare Part A premiums for certain qualified disabled working individuals (QDWI) with incomes up to 200% of poverty.

1990: (P.L. 101-508) States are required to pay the Part B premium for Medicare beneficiaries with incomes up to 120% of poverty (SLMB).

1997: (P.L. 105-33) States provided a $1.5 billion block grant (100% federal dollars) to pay the Part B premium, beginning in 1998, for individuals with incomes to 135% of poverty and a portion of the Part B premium for those with incomes up to 175% of poverty. States permitted to pay cost-sharing based on the Medicaid payment rate instead of the Medicare rate.

Source: Adapted from P. Nemore, *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries,* The Henry J. Kaiser Family Foundation, November 1997.

The BBA 97 also permits states to limit their QMB cost-sharing contributions to providers if the Medicaid rates are lower than the Medicare rates. This provision may result in access problems because Medicaid reimbursement rates are generally lower than Medicare rates and may not be accepted by some providers.

ISSUES AND CHALLENGES

While federal policymakers have historically relied on Medicaid to provide financial protections for low-income Medicare beneficiaries, state Medicaid programs have multiple responsibilities and may lack the capacity to absorb rising premiums and cost-sharing expenses for Medicare's poor and near-poor. At the same time, a significant share of the Medicare population (more than 4 in 10) have incomes below 200% of poverty ($15,780 in 1997) and already incur high financial burdens for their health expenses. The challenge facing policymakers is to make Medicaid work more effectively for low-income Medicare beneficiaries, minimize Medicare's financial burdens on the poor and near-poor, and preserve the Medicare program for future generations.

THE HENRY J KAISER FAMILY FOUNDATION

The Kaiser Commission on

THE FUTURE OF MEDICAID

December 1997

Dear Interested Party:

Today, Medicaid continues to provide important health and long-term care assistance to more than 35 million low-income Americans. The Balanced Budget Act of 1997 (BBA) made many important changes to the Medicaid program, including broadening state discretion to mandate enrollment in managed care organizations and reducing federal Disproportionate Share Hospital (DSH) payments. The BBA also creates a new option for states to expand coverage for children through the State Children's Health Insurance Program.

To assist policymakers and others concerned about the Medicaid program and the low income people it serves, we are pleased to send you the following new Commission publications: 5 fact sheets, the third edition of *Medicaid Expenditures and Beneficiaries*, and a background paper on the provisions in the BBA relating to Medicaid managed care.

Fact sheets

- ***Medicaid At A Glance* (update)** (#2004);
- ***Medicaid and Managed Care* (update)** gives an overview of enrollment in Medicaid managed care and reviews the major models of managed care delivery (#2068);
- ***Medicaid's Role for Children* (update)** provides an overview of the eligibility, benefits and financing of coverage for children and a summary of recent legislative changes (#2078);
- NEW! ***State Children's Health Insurance Program: Legislative Summary*** reviews the new child health legislation enacted as part of the BBA (#1345);
- NEW! ***Medicaid's Financial Protections for Medicare's Poor and Near-Poor*** reviews Medicaid's role in providing financial assistance to Medicare's low-income beneficiaries (#1334).

Data book and Background paper

- NEW! ***Medicaid Expenditures & Beneficiaries: National and State Profiles and Trends 1990-1995* (update)** revises earlier editions and presents a comprehensive overview of Medicaid spending and enrollment both nationally and at the state level (#2045).
- NEW! ***Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997*** reviews the provisions in the BBA relating to Medicaid managed care, prepared by Andy Schneider of the Center on Budget and Policy Priorities (#2102).

For more information, contact Lynda Bogatz at the Commission's office at (202) 347-5270. Additional copies of these publications are available by publication number at (800) 656-4KFF.

Sincerely,

Diane Rowland

Diane Rowland
Executive Director

1450 G Street, NW, Suite 250, Washington, DC 20005
tel (202) 347-5270 • fax (202) 347-5274

① Abby Steele
See when started getting each 12 month period is new

If work 1,250 hrs in past 12 months even if last time off can still have new 12 month period for 12 weeks off next

Kathy Hadden
Family & Medical Leave Act Regional Coordinator
312-353-4998
Fax # 312-353-2539

Pres- see 24 hr addition to be added to

for - school visitation - take relatives to visit medical providers

③ Fam med Leave who work for wage & hour in Dept of Labor - single call
Katherine Hadden
counsels people
(312) 353-4998
She's great

Republicans looking for comp time.
Hem & Haw over comp time.

Cynthia -
Proposed change has to do w/ additional 24 hr. period.
ask Katherine Hadden

Legislative Alert -
Abby will get back.

From Joe Lake Children's Miracle Network - WH visit 5/29 (312) Hyatt greeted. did a good job.

Ann

Robyn Bachman
6-6237 Staff Ast
→ Ricardo Te
Chief Economists office
at Labor

Commission
on
FMLA at
the Labor
- ~~Christa~~ ~~miller~~
Liz
→ 219-6611
Exec Director
Ann
Bookman

Texas Workforce Commission

Basics of the Family & Medical Leave Act

FAMILY AND MEDICAL LEAVE ACT SIGNED INTO LAW

After eight years of frequently bitter debate, Congress passed the Family and Medical Leave Act of 1993 (the Act) on February 4, 1993 and President Clinton signed the measure into law the following day.

The Act becomes effective on August 5, 1993 and requires employers with 50 or more employees within a 75-mile radius to offer eligible workers up to 12 weeks of unpaid leave during a 12-month period for birth or adoption, to care for a seriously ill parent, spouse or child or to undergo medical treatment for their own serious illness. State and local governments are covered by the Act under the same conditions as private employers. It is estimated the Act will affect five percent of America's employers and 40 percent of all employees.

Family Leave

To be eligible to take family leave, a worker must have been employed for at least 12 months and have worked a minimum of 1,250 hours (this an average of 25 hours per week). While the year of service to the employer does not have to be performed consecutively, the 1,250 hours of work must have been performed during the 12 calendar months immediately prior to the beginning of the leave. The Act does not cover seasonal or part-time employees working fewer than 1,250 hours per year, however they must be included when calculating the number of employees stationed at a particular worksite.

Employers are not required to provide family leave to the highest paid top 10 percent of their executive employees if granting such a leave would "create substantial and grievous injury to the business operations."

The right to take leave applies equally to male and female workers: fathers and mothers will be eligible to take family leave for the birth of a child. While the Senate Report does not specifically mention a father taking leave when a child is adopted or a foster child is placed in a home, because the right to take leave applies equally to the sexes, it appears a father is also entitled to take leave when a child is placed. While both parents may be eligible to take leave, if both spouses work for the same employer, that employer may limit their combined total weeks of leave to 12 during any one-year period for the birth or adoption of a child. This provision is apparently designed to remove any disincentive to the hiring of married couples.

One of the most frequently asked questions is whether the 12 weeks of leave must be taken consecutively; this was also one of the most hotly debated issues in Congress. While a number of large businesses already have some sort of family leave policy in place, many smaller employers asserted that allowing frequent intermittent periods of leave was much more disruptive in the workplace than longer periods of leave. Apparently, the compromise Congress reached here is that intermittent leave cannot be taken for the birth or adoption of a child; however, medical leave can be taken on an intermittent basis or on a "reduced leave schedule" if it is "medically necessary."

Eligible employees may take up to 12 weeks of unpaid leave during a one-year period to care for a son, daughter, spouse or parent if that individual has a "serious health condition" which is defined as an "illness, injury, impairment or any physical or mental condition that requires inpatient medical care or continuing treatment by a health care provider." The Senate Report on the Act cites as examples of such serious health conditions emphysema, appendicitis, severe respiratory distress conditions, heart conditions requiring bypass or valve operations, back conditions requiring surgery or extensive therapy and severe nervous disorders. The Report also makes it clear this is not to be considered an exhaustive list of "serious health conditions."

An eligible employee may take up to 12 weeks of unpaid leave during any one year period for that

An eligible employee may take up to 12 weeks of unpaid leave during any one year period for that employee's own "serious health condition." While a worker is allowed to take leave to care for a family member who simply has a "serious health condition," it is clear a higher standard must be met before an employee qualifies to take leave for a personal health condition: a worker must be able to demonstrate he or she is medically unable to perform the functions of their job before being eligible to take leave.

As previously mentioned, Congress has provided for intermittent leave in cases of "serious health conditions" if it is "medically necessary." This means a worker could take off for short periods of leave not to exceed 12 weeks in the aggregate during a one year period. The Senate Report defines "intermittent leave" as taking off for several hours, a single day or a week as a worker's medical needs require. A "reduced leave" schedule might include working only in the morning or adopting a regular three-day work week.

The Act also provides that the two types of leave - family and medical - may be combined. For example, if a woman takes six weeks of leave when her child is born, she would still be eligible to take leave that same year if her child experiences intermittent health problems. Under certain narrow circumstances, an employer can temporarily transfer an employee to another job with equivalent benefits and pay if granting intermittent leave would be inordinately disruptive to the workplace.

An employer can require medical certification regarding the need to take leave and of the worker's release to return to work after the leave. Such certification should include the date the serious health condition began and the estimated duration of the condition. If the employee is taking the leave to care for a family member, the certification should include a statement indicating it is necessary for that worker to care for the child, spouse or parent. If an employer doubts the validity of a worker's medical certification, it may require the eligible employee to get a second opinion from an independent health care provider of the employer's choosing. This is done at the employer's expense. If the two physicians do not agree on the prognosis, the employer and the eligible employee together must agree on a third physician whose opinion will be binding on the parties.

Other Important Provisions of the Act

The Act also provides that:

1. When an employee returns to work after taking leave, an employer must guarantee the employee can return to the job they held before the leave or a comparable position. While there is certain to be debate regarding the interpretation of these terms, the Senate Report indicates the job reinstatement requirement is to be strictly construed: a "similar" or "comparable" position is probably not an "equivalent" position. To be an "equivalent" position, all privileges, duties, terms and conditions of the worker's previous job must arguably correspond.

2. Employers may force an employee to use vacation, sick or other accumulated leave before granting a leave under this Act.

3. Employers must continue providing health care coverage while an employee is on leave. Taking such a leave does not constitute a qualifying event which would trigger the continuation of health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, a qualifying event triggering COBRA coverage could occur when an employer learns an employee will not be returning to work and therefore ceases to be entitled to leave under the Act. The Act also permits employers to require employees to pay for any health care benefits the employer paid for during the leave if the worker does not return to work. However, if the failure to return from leave is caused by factors beyond the worker's control, repayment is not required.

4. An employer may require a worker on leave to periodically report their status and intent to return to work. The Report states this provision is to allow the employer to require such reports at "reasonable intervals."

5. Employees must give their employers 30 days' notice of their intent to take leave for foreseeable events such as childbirth, adoption or necessary medical treatment. However, if the birth or placement of

a child or medical treatment requires leave to begin in less than 30 days, the employee must provide notice "as practicable."

6.The 12 weeks of leave provided under the Act is cumulative of whatever leave an employer already allows. For example, if an employer currently provides six weeks of paid leave, the new Act only requires the addition of six weeks of unpaid leave.

7. The penalties for violating the Act include an employee claim for lost wages and benefit costs plus interest and an additional 100 percent penalty for lost wages, benefits and interest. Reasonable attorneys fees and various costs (including payment of expert witnesses) are also allowed. The penalties are quite similar to those prescribed under the Fair Labor Standards Act.

8. The Office of Personnel Management of the Department of Labor (DOL) will enforce the Act. DOL has set a June 4, 1993 deadline for accepting public comment on the regulations which will be drafted to implement the Act. Hopefully, guidelines and regulations will be available before that Act goes into effect on August 5, 1993.

Those in favor of a national standard for family leave have argued for years that employers who have adopted family and medical leave policies have already experienced cost savings through reduced employee turnover and decreased hiring and training expenses. Such policies are viewed as a way to protect a company's investment of time and money in its most valuable commodity: its workers. Supporters have also argued the Act will be cost effective from a public policy standpoint and the benefits outweigh the problems because society as a whole often pays the price for failed, fragmented family units. On the other hand, many smaller employers see the new law as just the latest in a series of expensive, bureaucratic nightmares that will disrupt the workplace and result in lost productivity.

Which of these arguments proves valid on a national basis remains to be seen. The only thing that can be said with certainty at this time is that millions of American employers and employees are hopeful the Act can be implemented in a manner that maximizes benefits and minimizes burdens on both employers and employees.

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Texas Workforce Commission
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Ms. Hadden

OF (Organization)

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General Services Administration

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PRESIDENT CLINTON IS MEETING AMERICA'S CHALLENGES:
A REPORT ON THE SUCCESS OF THE FAMILY AND MEDICAL LEAVE ACT

May 1, 1996

"The law guarantees the right of up to twelve weeks of unpaid leave per year when it's urgently needed at home to care for a newborn child, or an ill family member. This bill will strengthen our families, and I believe it will strengthen our businesses and our economy as well."

- President Clinton, signing ceremony, February 5, 1993

Strengthening America's families, achieving economic security. Today's report shows that the Family and Medical Leave Act, which was the first bill President Clinton signed into law, has been a tremendous success in helping America's families find security in today's economy. By allowing working Americans to take leave of up to twelve weeks to care for sick relatives or new children without fear of losing their jobs, the FMLA provides the peace of mind that Americans will never have to choose between work and their family's health again.

A clear report. The Family and Medical Leave Act of 1993 established the bi-partisan Commission on Leave to study the impact of the Act. Their comprehensive, national survey concludes that **the FMLA is helping families without causing significant hardship to most businesses.**

* **Helping our families cope with serious illness.** Almost 80 percent of leave is taken to care for a seriously ill child, spouse or parent, or for one's own serious health condition.

* **Easy to administer.** More than nine out of ten employers find it "very" or "somewhat easy" to administer the FMLA.

* **Not costly to business.** For 89.2 to 98.5 percent of worksites, complying with the FMLA entails either little or no costs.

* **Helping America's businesses.** The vast majority of leave-takers (84 percent) return to their same employer, leading some businesses to testify that the new law has **helped them reduce employee turnover, enhance productivity and improve the morale of their workforce.**

* **A significant effect.** More than half of America's workers are eligible to take leave under the FMLA, and more than one in six of all employees have taken leave for a reason covered by the Act.

Helping Americans meet our challenges. The Family and Medical Leave Act takes a significant step with its signature features of guaranteed job protection and maintenance of health benefits. The Act is helping a larger cross-section of working Americans meet their medical and family caregiving needs while still maintaining their jobs and economic security, achieving the workable balance the President, and the nation, intended.

President Clinton Announces New Family-Friendly Workplace Proposals: Expanded Family & Medical Leave and Employee-Choice Flex-Time

June 24, 1996

"Family and medical leave is a matter of pure common sense and a matter of common decency. It will provide Americans what they need most: peace of mind. Never again will parents have to fear losing their jobs because of their families."

-- President Clinton, Family and Medical Leave Act Signing
February 5, 1993

Today, President Clinton attends the Vice President's annual Family Conference in Nashville to announce two new proposals to help parents care and provide for their families. A company's success in the new global economy depends on smart, flexible and committed workers. These days, a company loses half its workers every five years. In creating a family-friendly workplace, companies build loyalty, increase productivity and attract the workers they need to stay competitive.

Family and Medical Leave Act of 1993. In his first month in office, President Clinton delivered on his promise and signed the Family and Medical Leave Act into law. The law allows workers at businesses with 50 or more employees to take up to 12 weeks of unpaid, job-protected leave to care for a newborn or adopted child, to attend to their own serious health needs, or to care for a seriously ill parent, child or spouse.

* More than 12 million eligible workers have taken leave since its enactment.
* More than 85% of companies covered by the Act found that it neither adds to their costs nor takes away from their profits.
* 40% of all workers believe they will need to take leave under the Act at some time in the next five years.

Building on and expanding the Family and Medical Leave Act. President Clinton proposes expanding the law to cover more family obligations to better help workers care for their children and elderly relatives without sacrificing their work obligations. Under the proposed expansion, workers could take up to 24 hours of leave each year to meet additional specified family obligations, including the following:

* Attending parent-teacher conferences.
* Accompanying a child, spouse or elderly parent for routine medical and dental care.

New employee-choice flex-time. The President also proposes a flex-time initiative that will give workers the opportunity to receive extra paid time-off -- "flex-time" -- rather than working overtime for cash pay. Under this proposal, workers would get time-and-a-half in flex-time for each hour of overtime and could choose to use their flex-time for family and medical leave purposes whenever they need it. Workers would maintain ultimate control of when to use flex-time, as long as they provide two weeks notice to their employers.

To protect against the potential of abuse, the President's proposal includes explicit protections against coercion:

* Employees and employers would have a written flex-time agreement.
* Private-sector workers can get cash for their accumulated flex-time within two weeks of notice.
* Workers from businesses that go bankrupt would be protected by special safeguards for unpaid flex-time in bankruptcy proceedings.

TALKING IT OVER
BY HILLARY RODHAM CLINTON
FOR IMMEDIATE RELEASE

For years, Sarah Clay supported her two children with low-wage jobs in child care and retail sales, relying occasionally on food stamps to make ends meet. Again and again, she was turned down for better-paying jobs because she didn't have a college degree. "I was running into a brick wall as far as being able to make a livable income," she said.

So, at the age of 42, the single mother decided to go back to school. Pell grants, student loans and academic scholarships covered the cost of her tuition. But there was still the issue of transportation. She lived more than an hour away from campus and had no money for gas.

Then, Clay heard about the Single Parent Scholarship Fund, a privately supported Arkansas program that offers grants of up to $500 a semester to single parents living at or near the poverty level who are also enrolled in college or vocational training programs. She applied for and received a scholarship that covered the cost of gas and maintenance on her car. While modest, the scholarship made a huge difference in her ability to do well in class and be a good mother to her young son and teen-age daughter. Clay graduated from the University of Central Arkansas in 1994 and earned a master's in social work two years later. She now works with children and families through the Arkansas Department of Human Services.

I met Sarah and four other women helped by the fund at a dinner earlier this week in Little Rock. The fund got its start in a northwest Arkansas county more than 10 years ago. Its founder, a man named Ralph Nesson, noticed that many poor, single parents were having difficulty going to college or vocational school to earn the degrees they needed to find better jobs.

Nesson, who worked in a community-action agency, discovered that a number of factors conspired against these single parents: the high cost of tuition and books, the absence of extended family or friends to help with child care, a lack of transportation and a lack of information about available scholarships and other assistance. So, Nesson and his colleagues raised a scholarship fund to help single parents meet the challenges of raising children and going to college.

I first heard of the Single Parent Scholarship Fund in 1989, when its founders invited me to help introduce the program throughout Arkansas. Over the past seven years, local scholarship committees across the state have awarded 3,148 grants worth

$1.2 million and have posted success rates that are the envy of many institutions of higher learning. Seventy-five percent of the scholarship recipients have remained in school or graduated from college, and 72 percent now have careers in fields such as nursing, education, engineering and social work.

I have met dozens of scholarship recipients like Sarah Clay who just needed the helping hand provided by the fund to keep them on the road to greater economic independence. They weren't people looking for a handout or a free ride but women eager to make the sacrifices and commitments necessary to further their education, acquire the skills they needed to succeed and improve conditions for themselves and their families.

The only thing standing in their way was the ability to go back to or stay in school.

Today, education is critical to every citizen's economic security. We live in an Information Age -- an age when education can mean the difference between having a job or no job; between a decent job or a dead-end job; between a sense of fulfillment or a sense of futility.

Nearly one-third of all American families are headed by single parents. And at a time when a woman with a college degree can earn more than double what a woman without one earns, single parent scholarships are needed more than ever. They can be important tools in our efforts to help the many single mothers who are striving to free themselves from welfare dependence. For many of these women, a scholarship can offer not only much needed financial help on the long, hard road to independence but also a vote of confidence in their ability to learn and succeed.

There is no reason that this wonderful idea can't work in places beyond Arkansas. Single parent scholarships can be replicated in communities all across the country. Local businesses, foundations, churches, civic organizations and private citizens can join together to form their own scholarship funds and committees to help single parents in their communities lift themselves and their families out of poverty and off public assistance

The investment is minimal. But the rewards for the recipient and our communities are great. "I feel self-sufficient. I don't have to depend on anyone anymore," Clay said. "I've got the tools I need to be productive and to make a contribution to society. I have a real sense of freedom because of that."

March 11, 1997

PRESIDENT CLINTON ANNOUNCES ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

March 26, 1997

Today, President Clinton will announce the members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The President will call on the Commission to develop a "Consumer Bill of Rights" to promote and assure patient protections and health care quality. The Advisory Commission was created through an Executive Order signed by President Clinton in September, 1996 to build on the Clinton Administration's commitment to improve the quality of the nation's health care system.

The 32-member Commission will review rapid changes in the health care financing and delivery systems and make recommendations, where appropriate, on how best to preserve and improve the quality of the nation's health care system. The purpose of the Commission is to advise the President on how unprecedented changes in the health care delivery system are affecting quality, consumer protection and the availability of needed services. Through a series of public meetings, it will collect and evaluate information and develop recommendations on improving quality in the health care system. The Commission will be co-chaired by the Secretary of Health and Human Services and the Secretary of Labor.

Acting Labor Secretary Cynthia Metzler will make opening remarks. Secretary Shalala will then make remarks and introduce the President.

Attached is a fact sheet on the Commission and brief bios on the members. In addition to those members named today, three additional individuals selected to serve on the Commission are expected to be named shortly.

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THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY

REPRESENTING BROAD-BASED INTERESTS AND EXPERTISE

Co-chaired by the Secretaries of Health and Human Services and Labor, the Advisory Commission has broad-based representation from consumers, businesses, labor, health care providers, insurers, and quality and financing experts. The Advisory Commission members have vast expertise on a wide range of health issues including the unique challenges facing rural and urban communities, children, women, older Americans, minorities, people with disabilities, mental illness and AIDS. There are also members with extensive backgrounds in privacy rights and ethics. Advisory Commission members come from all parts of the country and reflect America's diverse population.

FOCUSING ON CONSUMER RIGHTS AND QUALITY

The President charged the Commission with developing a "Consumer Bill of Rights" to ensure that patients have adequate appeals and grievance processes. In developing the "Consumer Bill of Rights," the Commission will study and make recommendations on consumer protections, quality, and the availability and treatment of services. Using the best research to measure real outcomes and consumer satisfaction across all providers of health care, the Commission will work to give Americans the tools they need to measure and compare health care quality. It will submit a final report by March 30, 1998. The Vice President will review the final report before it is submitted to the President. In addition, the Advisory Commission will play a consultative role should relevant legislative initiatives move through the Congress prior to the due date of the final report.

BUILDING ON THE ADMINISTRATION'S COMMITMENT TO HEALTH CARE QUALITY

The Clinton Administration has a long history of strong support for consumer protection in health plans, including executive actions and legislative initiatives barring gag rules; limiting physician incentive arrangements; increasing choice and consumer information; and requiring health plans to allow women to stay in the hospital for 48 hours after a mastectomy or after the delivery of a child. The President has called for this Commission to develop a broader understanding of the numerous issues facing a rapidly evolving health care delivery system and to help build consensus on ways to assure and improve quality health care.

work and live, I believe we must expand family leave so that workers can take time off for teacher conferences and a child's medical checkup. We should pass flex-time, so workers can choose to be paid for overtime in income or trade it in for time off to be with their families. (Applause.)

We must continue -- we must continue, step by step, to give more families access to affordable, quality health care. Forty million Americans still lack health insurance. Ten million children still lack health insurance -- 80 percent of them have working parents who pay taxes. That is wrong. (Applause.)

My balanced budget will extend health coverage to up to 5 million of those children. Since nearly half of all children who lose their insurance do so because their parents lose or change a job, my budget will also ensure that people who temporarily lose their jobs can still afford to keep their health insurance. No child should be without a doctor just because a parent is without a job. (Applause.)

My Medicare plan modernizes Medicare, increases the life of the trust fund to 10 years, provides support for respite care for the many families with loved ones afflicted with Alzheimer's. And for the first time, it would fully pay for annual mammograms. (Applause.)

Just as we ended drive-through deliveries of babies last year, we must now end the dangerous and demeaning practice of forcing women home from the hospital only hours after a mastectomy. (Applause.) I ask your support for bipartisan legislation to guarantee that a woman can stay in the hospital for 48 hours after a mastectomy. With us tonight is Dr. Kristen Zarfos, a Connecticut surgeon whose outrage at this practice spurred a national movement and inspired this legislation. I'd like her to stand so we thank her for her efforts. Dr. Zarfos, thank you. (Applause.)

In the last four years, we have increased child support collections by 50 percent. Now we should go further and do better by making it a felony for any parent to cross a state line in an attempt to flee from this, his or her most sacred obligation. (Applause.)

Finally, we must also protect our children by standing firm in our determination to ban the advertising and marketing of cigarettes that endanger their lives. (Applause.)

To prepare America for the 21st century, we must build stronger communities. We should start with safe streets. Serious crime has dropped five years in a row. The key has been community policing. We must finish the job of putting 100,000 community police on the streets of the United States. (Applause.) We should pass the Victims Rights Amendment to the Constitution.

And I ask you to mount a full-scale assault on juvenile crime, with legislation that declares war on gangs, with new prosecutors and tougher penalties; extends the Brady Bill so violent teen criminals will not be able to buy handguns; requires child safety locks on handguns to prevent unauthorized use; and helps to keep our schools open after hours, on weekends, and in the summer, so our young people will have someplace to go and something to say yes to. (Applause.)

This balanced budget includes the largest antidrug effort ever: to stop drugs at their source, punish those who push them, and teach our young people that drugs are wrong, drugs are illegal, and drugs will kill them. I hope you will support it. (Applause.)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
Director,
Office of Managed Care

FEB 20 1997

Dear State Medicaid Director:

The purpose of this letter is to clarify Federal law and regulations regarding physicians' and other health care providers' advice and counsel to beneficiaries enrolled in Medicaid managed care plans. A similar letter was sent in November 1996, to Medicare-contracting health maintenance organizations (HMOs) and competitive medical plans (CMPs).

Federal law and regulations state clearly that beneficiaries enrolled in Medicaid HMOs must have access to the same services available to Medicaid beneficiaries in the fee-for-service (FFS) program. Medicaid contracting HMOs must make the services they provide under their contracts "accessible . . . to the same extent as such services are made accessible to individuals . . . not enrolled with the organization." (See Section 1903(m)(1)(A) of the Social Security Act.) In addition, relevant regulations require Medicaid managed care plans with risk contracts to make services accessible to Medicaid HMO enrollees to the same extent that those services are available to Medicaid beneficiaries not enrolled in an HMO.

Beneficiaries are entitled to the full range of their health care providers' opinions and counsel about the availability of medically necessary services under Medicaid FFS or managed care programs. Any contractual provisions -- including so-called gag rules -- that restrict a health care provider's ability to advise patients about medically necessary treatment options violate Federal law and regulations.

In order to ensure that all Medicaid beneficiaries have access to the same advice and counsel from their health care providers, I encourage you to review relevant contract provisions, as well as the policies and procedures of HMOs contracting with the State, to ensure that health care providers' advice and counsel regarding medically necessary treatment are unrestricted.

Thank you for your attention to this important matter. Please contact Rachel Block, Director of the Medicaid Managed Care Team, if you require additional information.

Sincerely,

Bruce Merlin Fried
Director

2/20/97 10:00 A.M.

PRESIDENT WILLIAM J. CLINTON
STATEMENT ON MEDICAID GAG-RULE
THE WHITE HOUSE
FEBRUARY 20, 1997

Acknowledgments: [By V.P.]

Today, I am pleased to announce that we are taking steps to see to it that Medicaid beneficiaries continue to get access to the fullest possible range of high-quality medical care.

In recent years, the medical community and the insurance industry have joined with us to reform and improve American health care. Much of this progress has come through managed care plans, which emphasize prevention, provide better care, and at the same time control costs.

The growth of managed care has been a good thing for America. At the same time, we must make absolutely sure that this rapid transformation does not lead to a decline in the quality of health care. That is why I have been concerned about so-called gag-rules in some HMOs and other health care plans. These rules restrict the ability of health-care professionals to administer proper medical care. They prevent doctors and nurses from telling patients about alternate, sometimes more expensive treatments, that are not covered by the plans.

That is unacceptable. Patients in HMOs and other health care plans should know that their doctors will give them the best information, the most complete information, the widest possible range of information when it comes to their treatment. On this, there should be not a shadow of a doubt.

In December, as Secretary Shalala just pointed out, we took action to give Medicare beneficiaries the right to know about all their treatment options. Today, we will take the next step. We will act to protect 13 million Medicaid beneficiaries -- children, the disabled and elderly Americans. I am directing Secretary Shalala to inform all state Medicaid directors that it is illegal for health care plans to prohibit doctors from discussing any treatment options with their patients.

Families facing illness should not have to worry that the doctor they trust does not have the freedom to tell them what they need to know. Patients have the fundamental right to know they are getting the best medical treatment -- not just the cheapest.

This must only be the beginning. We can act today to protect Medicare and Medicaid beneficiaries because they are federal programs -- and because the government is the largest purchaser of managed care in the country. But to protect the 130 million Americans enrolled in managed care plans through the private sector, Congress must act. That is why I am so pleased that members of Congress, from both parties, have come together, with the support of doctors,

nurses, health-care professionals, and consumers to craft legislation that will ban all gag-rules, for all Americans, in all HMOs and other health-care plans. I urge Congress to send me this legislation, and when they do, I will sign it into law.

This bipartisan legislation shows how we can work together as we continue, step by step, to give more families access to quality, affordable health care. I hope we will build on t his record of accomplishment, and that Congress will join with me to pass a balanced budget that extends health coverage to children...helps people who temporarily lose their jobs to keep their health insurance...and reforms Medicare for the next decade.

Together, we have built a strong foundation for the health of American families. With these efforts, we will make sure that foundation lasts a good long time.