

## HEALTH CARE REFORM

*"Our families will never be secure, our businesses will never be strong, and our government will never again be fully solvent until we tackle the health care crisis."* [President Clinton, Joint Session of Congress, 2/17/93]

### THE CLINTON ADMINISTRATION CONTINUES TO FIGHT FOR REAL HEALTH CARE REFORM.

- As you know, last year the Clinton Administration fought hard for health care reform. While we could not reach agreement on legislation, there can be little disagreement that the problems remain. Nearly forty million Americans have no health insurance and millions more are just one pink slip or illness away from losing it. Eighty-four percent of the uninsured in 1993 were in working families, and more than 55 percent lived in families headed by full-time workers. And while health care costs have begun to slow down, they are continuing to rise at three times the rate of inflation.
- As the President said in his State of the Union address and in his December letter to the Congressional Leadership, we remain firmly committed to guaranteeing health security to all Americans and to containing health care costs for families, businesses and Federal, state and local governments.
- The President believes that we should take a step-by-step approach. This year, we can take the first steps. The Congress can and should:
  - Reform the insurance market -- so that people don't lose their insurance when they lose their job or change jobs or a family member falls ill, and so that small businesses can afford to buy insurance for their workers.
  - Make coverage affordable for and available to children.
  - Help workers who lose their jobs keep their health insurance.
  - Level the playing field for the self-employed by giving them the same tax treatment as other businesses.
  - Help families provide long-term care for a sick parent or a disabled child.
- Because their constituents are demanding action, some Republicans have begun to respond to the President's challenge by coming forward with proposals and bills. We look forward to working with them to take the first steps this year.

## **THE CLINTON ADMINISTRATION IS FIGHTING BACK TO PROTECT HEALTH CARE FOR MOTHERS, CHILDREN, THE DISABLED AND AGED AMERICANS.**

- Unfortunately, for too many Republicans in Congress, "health reform" has turned into the code word for slashing Medicare and Medicaid to pay for tax cuts for the wealthy. Republicans in the House and the Senate have talked about cutting both Medicare and Medicaid by hundreds of billions of dollars.
  - Republicans have signaled their intention to cut Medicare by about \$300 billion between now and 2002.
  - Republicans have suggested cutting Federal Medicaid spending by at least \$180 to \$190 billion between now and 2002.
- It's not hard to figure out what that means for the doctors and hospitals who treat patients receiving benefits under these programs, and for the patients themselves.
  - It means shifting a staggering financial burden to elderly and disabled Medicare beneficiaries. Or to small businesses and families who will pay higher premiums and fees if these programs are slashed without overall reform.
  - It means dropping coverage or shrinking benefits for mothers and children on Medicaid. Or it means asking States to pick up the tab to preserve the Medicaid program, and in doing so, forcing them to raise taxes or slash spending for services like education and public safety.
  - It means significant cuts in payments to hospitals, physicians and other providers.
- The President presented a responsible budget to Congress -- a budget that made tough choices to get our rising deficit under control, but a budget that protected hard-working Americans and investments in our children. Now it is Congress' turn to act. To detail where they will get the cuts they need to pay for their tax cuts for the wealthy. To step forward with *their* plan for deficit reduction.
- The President has consistently said that we cannot get a hold of the deficit without passing meaningful health reform. Over the next five years alone, almost 40 percent of the growth in total Federal spending will come from rising costs in Federal health care programs. We must contain costs in these programs. But we must do it as we reform our health care system as a whole -- not by arbitrarily cutting programs that serve the most vulnerable Americans.

March 6, 1995

Staff Contact: Jennifer Klein (6-2599)

## MEMORANDUM

TO: Political Strategy Group  
FR: Chris Jennings  
RE: Short/Long-Range Health Care Challenges  
cc: Carol Rasco, Pat Griffin, Janet Murgia

March 3, 1995

Attached is a one-month calendar that outlines some immediate (predominantly) legislative events, which will refocus attention on the health care issue. Understandably enough, it starts with yesterday's balanced budget vote and the attention it focuses on health care entitlements (Medicare & Medicaid), the deficit, and our position on health reform.

### **Background on Politics of Health Care and the Budget**

The President has consistently said we cannot get a hold of the deficit without enacting meaningful health reform. As such, we oppose "Medicare cuts outside the context of health reform."

Until we make a more specific statement on the health reform issue, the Administration will be pressed extremely hard by Republicans and the elite media to provide our definition of health reform, with specifics on how much -- if any -- deficit reduction such reform entails. Moreover, a number of very visible Democrats on the Hill (e.g., Ranking Budget House/Senate Chairmen Sabo/Exon), responding to this pressure, will almost certainly produce their own deficit reduction proposals. There is little doubt that these visible Democrats' proposals will contain significant Medicare and Medicaid cuts.

The Administration's current position is that we stand firm on challenging the Republicans to produce their budget BEFORE we engage in talking about any specific health reform package that the Administration might support. (This is consistent with the President's position of not wanting to push a health reform proposal down the Republicans' throats and inviting them to work with him to jointly produce a "meaningful" health reform proposal). Although everyone within the Administration understands and supports our position, the outside pressures will make it very difficult to implement and will require enormous discipline.

## **Short-Term Strategy Recommendation**

During the pre-Republican budget resolution mark-up period, we need to continue to coordinate any necessary responses with the President's health policy development team chaired by Carol Rasco and Laura Tyson. As the calendar illustrates, the Republicans are already starting to hold hearings and mark-ups on health bills. Leon, George, Pat, Harold, Erskine, Alice, Gene, Bill, the primary health care jurisdiction Department Secretaries and others are represented in this work group and, so far, our clearance and policy position process has worked quite well.

In addition, we must understand the importance of being better prepared to define our health care reform/deficit reduction position. Even if we can avoid being specific for now, it will become almost impossible to not further expand on our current position after the Republican budget resolution mark-up. There is no question that the longer we remain silent on this issue, the more vulnerable we become to criticism that we are being fiscally irresponsible and playing politics with the health care and deficit reduction issue.

Similar to our short, short-term strategy, the DPC/NEC working group needs to continue to be the focal point of our political/policy deliberations around a specific health policy position. We must ensure, however, that its work is running at a parallel and consistent track to the strategy being discussed in the political and budget groups that are now being formed within the White House.

# DRAFT

- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission on the Future of Medicaid finds that if the growth in federal Medicaid payments to states is capped at 5% per year, states would lose over \$84 billion in federal funds between 1996 and 2000.
- New York, California, Texas and Florida would lose the largest amount. New York would lose almost \$9 billion; California almost \$7 billion; Texas \$5.5 billion; and Florida \$5 billion.
- States in the South and Mountain regions would have the biggest percentage reductions in federal payment. Reductions will average over 18% in states such as Florida, Georgia, ~~Arkansas~~, Montana, West Virginia and North Carolina.
- The study suggests that it is very unlikely that cuts of this magnitude could be offset through managed care, provider payment reductions or elimination of optional benefits -- states would very likely be forced to reduce coverage or increase their own spending to offset the substantial reduction in federal Medicaid contributions.

Note: Ark is 17.5%

DRAFT

## The Impact of a Five Percent Medicaid Expenditure Growth Cap

John Holahan  
David Liska  
March 15, 1995

Controlling the growth in Medicaid spending is a pivotal part of Congressional efforts to reduce the federal deficit. One proposal that has emerged is a 5% cap on the growth in federal Medicaid expenditures. This would be a uniform cap applied to all states on all Medicaid spending including acute care, long term care, disproportionate share payments and administrative costs. It would give states amounts equal to their current federal spending plus 5% for each year beginning in 1995 on into the indefinite future. We have discussed the distributional effects of these policies elsewhere.<sup>1</sup> This report addresses the aggregate spending impacts.

The most important findings in this analysis are:

- Federal Medicaid spending would fall as a result of a 5% expenditure growth cap by 20.1% in the year 2000. Cumulative reductions in federal expenditures would amount \$84.2 billion over the 1996 to 2000 period. If state spending also grew by 5% over the period, total Medicaid expenditures would fall by \$51.0 billion relative to the baseline projection of \$254.9 billion.
- The impact of a 5% cap is greatest for states in the South and Mountain regions. This is because these states are expected to grow faster than the national average in the absence of an expenditure cap.
- States with high levels of disproportionate share hospital (DSH) payments will grow more slowly than average, all else being equal; as a result, expenditure caps will have less of an effect on these states. This is because these states are already subject to caps on DSH spending resulting from federal legislation enacted in 1991 and 1993.
- A 5% expenditure growth cap also has more serious implications for lower income states because of the structure of federal matching contributions. Because federal Medicaid payments can amount to over 70% of total expenditures in low income

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<sup>1</sup>Holahan, John and David Liska. "State Variations in Medicaid: Implications for Block Grants and Expenditure Growth Caps." (Washington, D.C.: The Kaiser Commission of the Future of Medicaid, Policy Brief, March 1995).

states, replacing any lost federal funds would require greater percentage increases in state spending in these states. For example, while states on average would have to increase spending by 27.2% in order to replace all federal funds, Mississippi and West Virginia would need to increase state spending by more than 80%, assuming they attempted to maintain current spending levels.

To estimate the impact of a 5% cap we project Medicaid beneficiary and expenditure growth from 1993 to the year 2002. We make separate projections for growth in different beneficiary groups and for changes in spending per beneficiary for acute and long term care services for different groups, e.g., the aged, disabled, adults and children. We also use regional adjusters to account for differences across geographic areas in the rate of growth of beneficiaries and of spending per beneficiary.<sup>2</sup> This allows us to develop estimates of beneficiary and spending growth that are state specific and more likely to reflect actual growth patterns that will vary considerably across states. The results of our spending projections are shown in Tables 1 through 3.

We estimate that under current law, the number of beneficiaries will grow from 36.3 million in 1995 to 43.4 million in 2000 and 45.7 million in 2002. We estimate that spending will grow from \$159.8 billion in 1995 to \$254.9 billion in the year 2000, and \$304.0 billion in 2002. Both of these projections are within the range forecast by the Congressional Budget Office and the Health Care Financing Administration's Office of the Actuary.

Table 1 projects that Medicaid expenditures would experience an average annual increase of 9.8% in the absence of any change in policy. This includes increases in benefits (10.4% per

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<sup>2</sup>These adjustments allow us to account for much of the differentials in beneficiary and spending growth across states in the recent past (1988-1993). States of course differ somewhat within regions in their past experience and future policies adopted by specific states could result in different patterns than we have projected. It is, of course, not possible to know all of the likely events that could impact any state's future expenditures. We have little choice but to assume the past is the best guide to the future. (More detail on the estimation methods is available from the authors.)

year), disproportionate share payments (5.0% per year), and administration (8.4% per year).

Table 1 also shows that acute care spending is likely to grow faster than long term care.

Between 1993 and 2002 acute care services are projected to increase by 11.4% per year; while long term care is expected to increase by 8.9% annually. These differences are consistent with growth rates in the recent past and reflects increases in those beneficiaries likely to be heavier users of acute care services as well as slow growth in long term care spending per beneficiary.

Table 2 suggests that spending on the blind and disabled (11.1% per year) and adults and children (11.3% per year) will grow more rapidly than spending on the elderly (8.9% per year). This reflects larger increases in enrollment among the former groups as well as more use of faster growing acute care services. The smaller increases in spending on the elderly reflects the impact of the projected slower growth in long term care.

Table 3 shows that expenditures in the South Atlantic, West South Central, Mountain, and Pacific (excluding California) regions will grow more rapidly than in the New England, West North Central and East North Central regions. We have also made separate adjustments for California and New York because of their size and impact on overall spending growth in the program. California is expected to experience growth roughly in line with the national average while New York is projected to grow somewhat more slowly. Finally, states with high disproportionate share expenditures are affected by 1991 and 1993 legislation that limits growth in these payments. State whose disproportionate share payments exceed 12% of their Medicaid expenditures are essentially frozen. Other states are permitted to grow at the same rate as their Medicaid expenditures.

Table 4 shows the impact of a 5% cap on changes in federal expenditures over the 1996-2000 period as well as for the year 2000. The results show that federal spending would decline



by \$84.2 billion or 13.7% over the 1996 to 2000 period, relative to baseline projections. The results also show that a 5% cap would mean a 20.1% reduction (\$29.5 billion) in federal expenditures in the year 2000. The higher percentage reduction reflects the growing impact of a 5% cap over time.

The distribution of federal spending reductions across states is uneven, reflecting three factors. First, states where expenditures for acute care are substantially greater than long term care will experience greater reductions from a 5% cap because those states are estimated to have had more rapid growth. Second, states in the South and Mountain regions, in part related to more beneficiary growth and the greater importance of acute care, have greater percentage reductions in federal spending under a 5% cap. For example, Florida, Georgia, Montana, North Carolina and West Virginia will have the largest percentage reductions, over 18% between 1996-2000. Reductions in federal Medicaid spending in these states in the year 2000 will exceed 25%.

States with high disproportionate share payments in 1993 will have lower reductions in spending because current restrictions on use of disproportionate share payments constrain their overall rates of growth in the absence of the cap. For example, states with large disproportionate share payments, such as New Hampshire (1.5%), Kansas (8.4%), Missouri (6.3%), Connecticut (8.4%), or Alabama (9.5%) will experience smaller effects from the 5% cap than other states in their regions because of the importance of disproportionate share payments.

In terms of absolute dollars, the states with the largest reductions in federal payments (1996-2000) are New York (\$8.9 billion), California (\$6.9 billion), Texas (\$5.5 billion) and Florida (\$5.0 billion).

Table 5 shows reductions in state spending, assuming that states only allow their spending to increase by 5%. If states successfully reduce spending by this amount, cumulative savings would amount to \$60.9 billion over the 1996 - 2000 period or a reduction of 13.3%. In the year 2000 savings would be \$21.5 billion (19.8%).

The pattern of reductions across states are the same as described above. States in the South and Mountain regions would have the largest percentage reductions. States with high disproportionate share payments would have the smallest reductions. Since many of the latter states (high DSH) have financed disproportionate share payments with provider taxes and donations, which in many cases do not involve transfers of real resources these savings are really "on paper."

Table 6 shows that total (federal and state) expenditures would be reduced by \$51.0 billion in the year 2000 relative to the baseline of \$254.9 billion, or by 20%. Unfortunately, states may have a very difficult time reducing Medicaid spending by these amounts. Reductions in Medicaid spending of 20% or more are very likely not achievable simply by enrolling people in managed care or otherwise controlling utilization, reducing provider payment rates or eliminating optional services. States would most likely have to reduce enrollment in order to achieve these savings.

Because of the difficulties in making these kinds of reductions, many states will end up using their own revenues to replace some of the lost federal revenues. In Table 6 we show estimates under the assumption that states will replace all federal dollars. This table allows us to ask the question "How much will states have to increase spending if they were to replace all funding no longer coming from the federal government?" We do not presume that states will, in fact, replace all lost federal dollars; we only estimate the effect if they wished to do so.

The results show that states would have to increase their own spending by \$84.2 billion (1996-2000) or by 18.5% to replace all federal funds that would have been spent without the cap. In the year 2000, states would have to increase spending by 27.2% (\$29.5 billion) in order to replace all federal funds.

The states that would have to increase their spending the most (1996 - 2000) in absolute dollars again include New York, California, Florida and Texas. However, the states that would have increase their spending the most in percentage terms over this period would be West Virginia (62.7%), New Mexico (49.2%), Mississippi (57.2%) and Arkansas (51.0%). The percentage increases for these states are substantially larger in the year 2000. For example, spending increases would exceed 80% in Mississippi and West Virginia in 2000 relative to the baseline if these states attempted to maintain current spending levels. They clearly would not do so, but these estimates indicate the kinds of program impacts that could result.

The large impacts on these states occurs because these states have very high matching rates--federal contributions would amount to over 70% of their Medicaid spending. Reductions in federal dollars therefore require large increases in spending relative to their current outlays. In contrast, states such as New York and California which have very large increases in absolute dollars have relatively small increases in percentage terms (11.5% and 12.2% respectively in 1996 - 2000). As before, states with large disproportionate share payments would have to make much smaller increases in state expenditures to offset the reduction in federal dollars. This follows from the fact that their rates of growth in the baseline are already low; consequently, their reductions from the 5% federal cap would be substantially smaller as well.

Tables 7 and 8 show our projected growth in beneficiaries from 1993 - 2002 by eligibility group and by region, respectively. Tables 9 - 11 provide estimates of changes in federal and state spending for the 1996 - 2002 period.

**Table 1**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Type of Service**

Expenditures (billions)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Total</b>	131.2	144.8	159.8	176.3	193.9	213.3	233.8	254.9	278.3	304.0	
Growth	-	10.3%	10.3%	10.3%	10.0%	10.0%	9.6%	8.0%	9.2%	9.2%	9.6%
<b>Benefits*</b>	109.5	122.6	136.9	152.2	168.5	186.1	204.9	223.9	244.8	267.7	
Growth	-	12.0%	11.7%	11.2%	10.6%	10.5%	10.1%	9.3%	9.3%	9.4%	10.4%
<b>Benefits by Service</b>											
Acute Care	64.0	72.5	81.8	92.0	102.7	114.5	126.9	139.6	153.6	169.0	
Growth	-	13.2%	12.9%	12.4%	11.7%	11.5%	10.9%	10.0%	10.0%	10.0%	11.4%
Long-term Care	44.2	48.6	53.5	58.5	63.8	69.5	75.5	81.7	88.3	95.5	
Growth	-	10.1%	9.9%	9.4%	9.0%	8.9%	8.8%	8.1%	8.1%	8.2%	8.9%
<b>DSH</b>	16.9	17.2	17.7	18.3	19.2	20.3	21.4	22.7	24.4	26.3	
Growth	-	1.6%	2.7%	3.6%	4.8%	5.4%	5.5%	6.2%	7.5%	7.7%	5.0%
<b>Administration</b>	4.8	5.0	5.2	5.7	6.3	6.9	7.5	8.3	9.1	10.0	
Growth	-	3.9%	3.9%	9.7%	9.7%	9.7%	9.7%	9.8%	9.8%	9.8%	8.4%

Beneficiaries (thousands)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Total</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth	-	6.1%	5.2%	4.5%	4.1%	3.8%	3.1%	2.6%	2.6%	2.6%	3.8%

\*totals include Arizona

**Table 2**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Beneficiary Group**

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Expenditures (billions)</b>											
<b>Total</b>	131.2	144.8	159.8	176.3	193.9	213.3	233.8	254.9	270.3	304.0	
Growth	-	10.3%	10.3%	10.3%	10.0%	10.0%	9.8%	9.0%	9.2%	9.2%	9.6%
<b>Benefits*</b>	109.5	122.6	136.8	152.2	168.5	186.1	204.9	223.9	244.8	267.7	
Growth	-	12.0%	11.7%	11.2%	10.6%	10.5%	10.1%	9.3%	9.3%	9.4%	10.4%
<b>Benefits by Beneficiary Group</b>											
<b>Elderly</b>	34.3	37.8	41.6	45.4	49.4	53.8	58.4	63.1	68.3	73.9	
Growth	-	10.3%	10.0%	9.3%	8.8%	8.7%	8.6%	8.1%	8.2%	8.2%	8.9%
<b>Blind &amp; Disabled</b>	39.5	44.3	49.7	55.8	62.1	69.1	76.8	84.4	92.8	102.0	
Growth	-	11.8%	12.3%	12.3%	11.3%	11.2%	11.1%	9.9%	9.9%	9.9%	11.1%
<b>Adults &amp; Children</b>	28.6	32.1	36.0	40.4	45.3	50.6	55.9	61.6	67.8	74.7	
Growth	-	12.4%	12.1%	12.1%	12.1%	11.7%	10.5%	10.2%	10.2%	10.2%	11.3%
<b>Pregnant Women &amp; Children</b>	5.8	7.0	8.0	8.8	9.6	10.5	11.4	12.2	13.0	14.0	
Growth	-	19.6%	15.0%	10.0%	9.0%	8.9%	8.6%	7.2%	7.2%	7.2%	10.2%
<b>DSH</b>	16.9	17.2	17.7	18.3	19.2	20.3	21.4	22.7	24.4	26.3	
Growth	-	1.6%	2.7%	3.8%	4.8%	5.4%	5.5%	6.2%	7.5%	7.7%	5.0%
<b>Administration</b>	4.8	5.0	5.2	5.7	6.3	6.9	7.5	8.3	9.1	10.0	
Growth	-	3.9%	3.9%	9.7%	9.7%	8.7%	8.7%	9.8%	9.8%	9.8%	8.4%
<b>Beneficiaries (thousands)</b>											
<b>Total</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth	-	6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.6%

\*totals include Arizona

**Table 3**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Region**

											Average 1993- 2002
Expenditures (billions)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	
<b>Total</b>	131.2	144.8	159.8	176.3	193.9	213.3	233.8	254.9	278.3	304.0	
Growth	-	10.3%	10.3%	10.3%	10.0%	10.0%	9.6%	9.0%	9.2%	9.2%	9.8%
<b>Benefits*</b>	109.5	122.6	136.9	152.2	168.5	186.1	204.9	223.9	244.8	267.7	
Growth	-	12.0%	11.7%	11.2%	10.6%	10.5%	10.1%	9.3%	9.3%	9.4%	10.4%
<b>Benefits by Region</b>											
New England	7.5	8.2	9.0	9.9	10.8	11.8	13.0	14.2	15.5	16.9	
Growth	-	10.3%	9.9%	9.7%	9.4%	9.6%	9.5%	9.1%	9.1%	9.1%	9.5%
Middle Atlantic	11.2	12.4	13.8	15.3	16.8	18.5	20.4	22.3	24.4	26.6	
Growth	-	11.2%	11.0%	10.6%	10.2%	10.2%	9.9%	9.3%	9.3%	9.4%	10.1%
South Atlantic	13.7	15.8	18.2	20.7	23.2	26.0	28.8	31.5	34.4	37.6	
Growth	-	15.3%	14.8%	13.6%	12.5%	11.8%	10.8%	9.4%	9.4%	9.4%	11.8%
East South Central	6.2	7.0	7.9	8.9	9.9	10.9	12.0	13.1	14.4	15.7	
Growth	-	13.0%	12.6%	11.8%	11.1%	10.8%	10.2%	9.2%	9.2%	9.2%	10.8%
West South Central	10.2	11.7	13.4	15.2	17.0	19.0	21.0	22.9	25.1	27.4	
Growth	-	14.7%	14.3%	13.2%	12.2%	11.5%	10.6%	9.4%	9.4%	9.4%	11.6%
East North Central	18.2	20.2	22.5	24.8	27.3	30.1	33.1	36.2	39.6	43.3	
Growth	-	11.4%	11.0%	10.5%	10.1%	10.1%	9.9%	9.4%	9.4%	9.4%	10.1%
West North Central	6.5	7.1	7.8	8.6	9.4	10.2	11.2	12.2	13.3	14.5	
Growth	-	10.2%	9.8%	9.5%	9.2%	9.3%	9.3%	9.0%	9.0%	9.0%	9.4%
Mountain	3.1	3.5	4.0	4.5	5.0	5.5	6.1	6.6	7.2	7.9	
Growth	-	13.6%	13.1%	12.2%	11.4%	11.0%	10.3%	9.3%	9.3%	9.3%	11.0%
Pacific	3.6	4.1	4.6	5.2	5.8	6.4	7.1	7.7	8.4	9.2	
Growth	-	13.9%	13.5%	12.5%	11.5%	11.0%	10.1%	9.0%	9.1%	9.1%	11.1%
California	11.0	12.3	13.7	15.2	16.9	18.7	20.7	22.7	24.9	27.3	
Growth	-	11.5%	11.5%	11.4%	11.0%	10.8%	10.4%	9.7%	9.7%	9.8%	10.6%
New York	17.1	18.7	20.4	22.3	24.3	26.6	29.2	31.9	34.8	38.0	
Growth	-	9.3%	9.2%	9.3%	9.2%	9.5%	9.5%	9.2%	8.2%	9.2%	9.3%
<b>DSH</b>	16.9	17.2	17.7	18.3	19.2	20.3	21.4	22.7	24.4	26.3	
Growth	-	1.6%	2.7%	3.8%	4.8%	5.4%	5.5%	6.2%	7.5%	7.7%	5.0%
<b>Administration</b>	4.8	5.0	5.2	5.7	6.3	6.9	7.5	8.3	9.1	10.0	
Growth	-	3.9%	3.9%	9.7%	9.7%	9.7%	9.7%	9.8%	9.8%	9.8%	8.4%

*totals include Arizona*

Table 4

## Medical Expenditure Projections, 1996-2000

## Federal Expenditures

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Federal Cap			Baseline	5% Federal Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	615,975	531,782	(84,193)	-13.7%	146,462	118,979	(29,483)	-20.1%
Alabama	9,142	8,273	(869)	-9.5%	2,121	1,820	(301)	-14.2%
Alaska	1,278	1,064	(215)	-16.8%	307	234	(73)	-23.7%
Arizona	7,786	6,612	(1,175)	-15.1%	1,889	1,454	(414)	-22.2%
Arkansas	7,219	5,953	(1,266)	-17.5%	1,739	1,309	(429)	-24.7%
California	56,287	49,408	(6,879)	-12.2%	13,356	10,869	(2,488)	-18.6%
Colorado	5,271	4,426	(845)	-16.0%	1,265	974	(291)	-23.0%
Connecticut	8,649	7,925	(724)	-8.4%	2,004	1,743	(260)	-13.0%
Delaware	1,127	961	(166)	-14.7%	269	211	(58)	-21.5%
District of Columbia	2,945	2,516	(429)	-14.6%	706	553	(153)	-21.6%
Florida	26,390	21,394	(4,996)	-18.9%	6,389	4,706	(1,683)	-26.3%
Georgia	16,846	13,703	(3,144)	-18.7%	4,077	3,014	(1,062)	-26.1%
Hawaii	1,772	1,474	(298)	-16.8%	425	324	(101)	-23.8%
Idaho	1,916	1,639	(277)	-14.5%	457	361	(96)	-21.1%
Illinois	21,731	18,670	(3,060)	-14.1%	5,194	4,107	(1,087)	-20.9%
Indiana	15,105	12,971	(2,133)	-14.1%	3,608	2,853	(754)	-20.8%
Iowa	5,151	4,530	(621)	-12.1%	1,218	997	(221)	-18.2%
Kansas	3,963	3,632	(331)	-8.4%	919	799	(120)	-13.0%
Kentucky	11,923	10,023	(1,901)	-15.9%	2,869	2,205	(664)	-23.1%
Louisiana	22,461	19,722	(2,739)	-12.2%	5,255	4,338	(917)	-17.4%
Maine	3,976	3,647	(329)	-8.3%	925	802	(122)	-13.2%
Maryland	8,767	7,422	(1,345)	-15.3%	2,105	1,633	(472)	-22.4%
Massachusetts	16,576	14,421	(2,155)	-13.0%	3,946	3,172	(773)	-19.6%
Michigan	20,656	17,730	(2,927)	-14.2%	4,943	3,900	(1,043)	-21.1%
Minnesota	9,705	8,625	(1,080)	-11.1%	2,293	1,897	(396)	-17.3%
Mississippi	8,189	6,945	(1,244)	-15.2%	1,954	1,528	(427)	-21.8%
Missouri	9,943	9,314	(629)	-6.3%	2,277	2,049	(229)	-10.0%
Montana	2,268	1,832	(436)	-19.2%	546	403	(143)	-26.2%
Nebraska	2,923	2,560	(363)	-12.4%	692	563	(129)	-18.6%
Nevada	1,887	1,636	(251)	-13.3%	449	360	(89)	-19.8%
New Hampshire	2,538	2,500	(38)	-1.5%	565	550	(16)	-2.7%
New Jersey	18,527	16,669	(1,858)	-10.0%	4,321	3,667	(654)	-15.1%
New Mexico	3,943	3,257	(687)	-17.4%	951	716	(234)	-24.7%
New York	77,313	68,385	(8,928)	-11.5%	18,339	15,043	(3,296)	-18.0%
North Carolina	18,781	15,119	(3,662)	-19.5%	4,542	3,326	(1,216)	-26.8%
North Dakota	1,643	1,448	(195)	-11.9%	388	319	(69)	-17.8%
Ohio	26,707	23,061	(3,645)	-13.6%	6,380	5,073	(1,287)	-20.2%
Oklahoma	7,249	6,069	(1,180)	-16.3%	1,735	1,335	(400)	-23.0%
Oregon	5,825	4,845	(980)	-16.8%	1,393	1,066	(327)	-23.5%
Pennsylvania	25,165	22,189	(2,975)	-11.8%	5,983	4,881	(1,102)	-18.4%
Rhode Island	3,584	3,137	(447)	-12.5%	850	690	(160)	-18.9%
South Carolina	10,072	8,871	(1,201)	-11.9%	2,355	1,951	(404)	-17.1%
South Dakota	1,559	1,364	(195)	-12.5%	370	300	(70)	-18.9%
Tennessee	15,807	13,395	(2,412)	-15.3%	3,789	2,947	(842)	-22.2%
Texas	39,767	34,284	(5,482)	-13.8%	9,390	7,542	(1,848)	-19.7%
Utah	3,329	2,812	(516)	-15.5%	797	619	(178)	-22.3%
Vermont	1,307	1,146	(161)	-12.3%	310	252	(58)	-18.8%
Virginia	8,506	7,010	(1,496)	-17.6%	2,048	1,542	(506)	-24.7%
Washington	11,910	9,947	(1,963)	-16.5%	2,855	2,188	(666)	-23.3%
West Virginia	8,919	7,180	(1,739)	-19.5%	2,165	1,579	(585)	-27.0%
Wisconsin	10,840	9,359	(1,482)	-13.7%	2,583	2,059	(524)	-20.3%
Wyoming	831	705	(126)	-15.2%	198	155	(43)	-21.8%

Table 8

## Medical Expenditure Projections, 1996-2000

## State Expenditures, Without States Maintaining Total Baseline Spending

## Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	456,180	395,316	(60,864)	-13.3%	108,428	86,860	(21,469)	-19.8%
Alabama	3,653	3,306	(347)	-9.5%	848	727	(120)	-14.2%
Alaska	1,278	1,064	(215)	-16.8%	307	234	(73)	-23.7%
Arizona	4,031	3,423	(608)	-15.1%	967	753	(214)	-22.2%
Arkansas	2,483	2,047	(435)	-17.5%	598	450	(148)	-24.7%
California	58,287	49,408	(8,879)	-12.2%	13,356	10,869	(2,488)	-18.6%
Colorado	4,415	3,707	(707)	-16.0%	1,059	816	(244)	-23.0%
Connecticut	8,849	7,925	(724)	-8.4%	2,004	1,743	(260)	-13.0%
Delaware	1,127	961	(166)	-14.7%	269	211	(58)	-21.5%
District of Columbia	2,945	2,516	(429)	-14.6%	706	553	(153)	-21.6%
Florida	21,565	17,483	(4,082)	-18.9%	5,221	3,846	(1,375)	-26.3%
Georgia	10,290	8,370	(1,920)	-18.7%	2,490	1,841	(649)	-26.1%
Hawaii	1,772	1,474	(298)	-16.8%	425	324	(101)	-23.8%
Idaho	775	663	(112)	-14.5%	185	146	(39)	-21.1%
Illinois	21,731	18,870	(3,060)	-14.1%	6,194	4,107	(1,087)	-20.9%
Indiana	8,791	7,550	(1,242)	-14.1%	2,100	1,661	(439)	-20.9%
Iowa	3,059	2,690	(369)	-12.1%	723	592	(131)	-18.2%
Kansas	2,848	2,610	(238)	-8.4%	680	574	(86)	-13.0%
Kentucky	4,706	3,956	(750)	-15.9%	1,132	870	(262)	-23.1%
Louisiana	8,011	7,034	(977)	-12.2%	1,874	1,547	(327)	-17.4%
Maine	2,458	2,253	(203)	-8.3%	571	496	(76)	-13.2%
Maryland	8,787	7,422	(1,365)	-15.3%	2,105	1,633	(472)	-22.4%
Massachusetts	16,576	14,421	(2,155)	-13.0%	3,946	3,172	(773)	-19.6%
Michigan	18,336	14,021	(2,314)	-14.2%	3,909	3,084	(825)	-21.1%
Minnesota	7,963	7,077	(886)	-11.1%	1,882	1,557	(325)	-17.3%
Mississippi	2,175	1,845	(331)	-15.2%	519	406	(113)	-21.8%
Missouri	6,557	6,142	(415)	-6.3%	1,502	1,351	(151)	-10.0%
Montana	930	751	(179)	-19.2%	224	165	(59)	-26.2%
Nebraska	1,844	1,615	(229)	-12.4%	436	355	(81)	-18.6%
Nevada	1,723	1,493	(230)	-13.3%	410	328	(81)	-19.8%
New Hampshire	2,538	2,500	(38)	-1.5%	565	550	(16)	-2.7%
New Jersey	18,527	16,669	(1,858)	-10.0%	4,321	3,667	(654)	-15.1%
New Mexico	1,396	1,153	(243)	-17.4%	337	254	(83)	-24.7%
New York	77,313	68,385	(8,928)	-11.5%	18,339	15,043	(3,296)	-18.0%
North Carolina	9,710	7,817	(1,893)	-19.5%	2,348	1,719	(629)	-26.8%
North Dakota	632	557	(75)	-11.9%	149	123	(27)	-17.8%
Ohio	17,620	15,215	(2,405)	-13.6%	4,196	3,347	(849)	-20.2%
Oklahoma	3,156	2,642	(514)	-16.3%	755	581	(174)	-23.0%
Oregon	3,511	2,921	(591)	-16.8%	840	643	(197)	-23.5%
Pennsylvania	20,193	17,806	(2,388)	-11.8%	4,801	3,917	(884)	-18.4%
Rhode Island	3,098	2,711	(386)	-12.5%	735	596	(139)	-18.9%
South Carolina	4,058	3,574	(484)	-11.9%	949	786	(163)	-17.1%
South Dakota	660	577	(83)	-12.5%	157	127	(30)	-18.9%
Tennessee	7,587	6,429	(1,158)	-15.3%	1,818	1,414	(404)	-22.2%
Texas	21,944	18,919	(3,025)	-13.8%	5,182	4,162	(1,020)	-19.7%
Utah	1,092	923	(169)	-15.5%	261	203	(58)	-22.3%
Vermont	875	768	(108)	-12.3%	208	189	(39)	-18.8%
Virginia	8,508	7,010	(1,498)	-17.6%	2,048	1,542	(506)	-24.7%
Washington	9,737	8,132	(1,605)	-16.5%	2,334	1,789	(545)	-23.3%
West Virginia	2,772	2,232	(540)	-19.5%	873	491	(182)	-27.0%
Wisconsin	7,101	6,131	(971)	-13.7%	1,692	1,349	(343)	-20.3%



**Table 6**  
**Medicaid Expenditure Projections, 1996-2000**  
**Federal and State Expenditures**  
**Total Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	1,072,155	927,098	(145,057)	-13.5%	264,891	203,939	(50,952)	-20.0%
Alabama	12,795	11,578	(1,216)	-9.5%	2,969	2,547	(422)	-14.2%
Alaska	2,557	2,127	(430)	-16.8%	614	468	(146)	-23.7%
Arizona	11,817	10,035	(1,783)	-15.1%	2,836	2,207	(628)	-22.2%
Arkansas	9,701	8,000	(1,702)	-17.5%	2,337	1,760	(577)	-24.7%
California	112,575	98,817	(13,758)	-12.2%	26,712	21,737	(4,975)	-18.6%
Colorado	9,688	8,134	(1,552)	-16.0%	2,324	1,789	(535)	-23.0%
Connecticut	17,289	15,851	(1,448)	-8.4%	4,008	3,487	(521)	-13.0%
Delaware	2,254	1,922	(331)	-14.7%	539	423	(116)	-21.5%
District of Columbia	6,890	5,031	(858)	-14.6%	1,412	1,107	(305)	-21.6%
Florida	47,955	38,877	(8,078)	-18.9%	11,610	8,552	(3,058)	-26.3%
Georgia	27,138	22,073	(5,064)	-18.7%	6,567	4,855	(1,711)	-26.1%
Hawaii	3,544	2,848	(596)	-16.8%	851	648	(202)	-23.8%
Idaho	2,692	2,302	(390)	-14.5%	642	508	(135)	-21.1%
Illinois	43,461	37,341	(6,121)	-14.1%	10,388	8,214	(2,174)	-20.9%
Indiana	23,896	20,521	(3,375)	-14.1%	5,707	4,514	(1,193)	-20.9%
Iowa	8,210	7,221	(990)	-12.1%	1,941	1,588	(353)	-18.2%
Kansas	6,811	6,242	(568)	-8.4%	1,579	1,373	(206)	-13.0%
Kentucky	16,630	13,979	(2,651)	-15.9%	4,001	3,075	(926)	-23.1%
Louisiana	30,472	26,756	(3,716)	-12.2%	7,130	5,886	(1,244)	-17.4%
Maine	6,431	5,900	(531)	-8.3%	1,486	1,298	(188)	-13.2%
Maryland	17,535	14,844	(2,691)	-15.3%	4,209	3,265	(944)	-22.4%
Massachusetts	33,162	28,843	(4,309)	-13.0%	7,892	6,345	(1,547)	-19.6%
Michigan	36,992	31,751	(5,241)	-14.2%	8,853	6,984	(1,869)	-21.1%
Minnesota	17,669	15,703	(1,968)	-11.1%	4,175	3,454	(721)	-17.3%
Mississippi	10,364	8,790	(1,575)	-15.2%	2,474	1,934	(540)	-21.8%
Missouri	16,500	15,458	(1,045)	-8.3%	3,778	3,400	(379)	-10.0%
Montana	3,199	2,583	(615)	-19.2%	770	568	(202)	-26.2%
Nebraska	4,766	4,176	(591)	-12.4%	1,128	918	(210)	-18.8%
Nevada	3,610	3,129	(481)	-13.3%	858	688	(170)	-19.8%
New Hampshire	5,077	5,000	(77)	-1.5%	1,131	1,100	(31)	-2.7%
New Jersey	37,054	33,338	(3,716)	-10.0%	8,642	7,334	(1,309)	-15.1%
New Mexico	5,339	4,410	(930)	-17.4%	1,287	970	(317)	-24.7%
New York	154,628	136,771	(17,855)	-11.5%	36,878	30,086	(6,591)	-18.0%
North Carolina	28,491	22,936	(5,555)	-19.5%	6,890	5,045	(1,845)	-26.8%
North Dakota	2,275	2,005	(270)	-11.9%	537	441	(96)	-17.8%
Ohio	44,328	38,276	(6,050)	-13.8%	10,555	8,420	(2,136)	-20.2%
Oklahoma	10,405	8,711	(1,694)	-16.3%	2,490	1,916	(574)	-23.0%
Oregon	9,336	7,768	(1,570)	-16.8%	2,233	1,708	(525)	-23.5%
Pennsylvania	45,358	39,995	(5,363)	-11.8%	10,784	8,798	(1,986)	-18.4%
Rhode Island	6,681	5,848	(833)	-12.5%	1,585	1,286	(299)	-18.9%
South Carolina	14,130	12,446	(1,684)	-11.9%	3,304	2,738	(567)	-17.1%
South Dakota	2,219	1,941	(278)	-12.5%	527	427	(100)	-18.9%
Tennessee	23,394	19,824	(3,569)	-15.3%	5,607	4,361	(1,246)	-22.2%
Texas	61,711	53,204	(8,507)	-13.8%	14,572	11,704	(2,868)	-19.7%
Utah	4,421	3,736	(686)	-15.5%	1,058	822	(236)	-22.3%
Vermont	2,182	1,914	(268)	-12.3%	518	421	(97)	-18.8%
Virginia	17,013	14,021	(2,992)	-17.6%	4,096	3,084	(1,012)	-24.7%
Washington	21,647	18,080	(3,568)	-16.5%	5,188	3,977	(1,211)	-23.3%
West Virginia	11,691	8,412	(2,279)	-19.5%	2,837	2,070	(767)	-27.0%
Wisconsin	17,942	15,490	(2,452)	-13.7%	4,274	3,407	(867)	-20.3%

Table 43

## Medical Expenditure Projections, 1996-2002

## State Expenditures, With States Maintaining Total-Baseline Spending

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2002				2002			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	703,947	870,809	166,862	23.7%	129,359	174,982	45,624	35.3%
Alabama	5,552	7,255	1,704	30.7%	985	1,445	460	46.6%
Alaska	1,980	2,393	413	20.8%	366	475	108	29.6%
Arizona	6,255	8,594	2,339	37.4%	1,163	1,806	643	55.3%
Arkansas	3,852	6,280	2,429	63.1%	715	1,351	636	88.9%
California	87,038	101,273	14,235	16.4%	16,092	20,201	4,109	25.5%
Colorado	6,841	8,487	1,646	24.1%	1,268	1,708	440	34.7%
Connecticut	13,200	14,722	1,522	11.5%	2,371	2,820	449	18.9%
Delaware	1,744	2,071	327	18.8%	322	411	89	27.6%
District of Columbia	4,568	5,428	861	18.8%	849	1,087	239	28.1%
Florida	33,543	43,067	9,524	28.4%	8,261	8,735	2,474	39.5%
Georgia	16,003	22,012	6,009	37.5%	2,987	4,553	1,566	52.4%
Hawaii	2,745	3,318	573	20.9%	508	658	151	29.6%
Idaho	1,197	1,741	544	45.4%	220	367	147	66.6%
Illinois	33,641	39,772	6,131	18.2%	6,225	7,922	1,697	27.3%
Indiana	13,602	17,859	4,257	31.3%	2,514	3,686	1,173	46.7%
Iowa	4,705	5,953	1,248	26.5%	858	1,205	347	40.4%
Kansas	4,335	5,014	679	15.7%	773	968	195	25.2%
Kentucky	7,308	11,055	3,746	51.3%	1,361	2,377	1,016	74.7%
Louisiana	12,220	17,422	5,202	42.6%	2,186	3,532	1,346	61.6%
Maine	3,755	4,456	703	18.7%	678	891	213	31.4%
Maryland	13,800	16,263	2,463	19.6%	2,526	3,253	726	28.8%
Massachusetts	25,605	29,961	4,356	17.0%	4,716	5,935	1,219	25.8%
Michigan	25,315	31,202	5,888	23.3%	4,896	6,333	1,638	34.9%
Minnesota	12,255	14,481	2,226	18.2%	2,239	2,876	637	28.4%
Mississippi	3,359	5,771	2,412	71.8%	618	1,258	640	103.7%
Missouri	9,903	11,195	1,292	13.1%	1,733	2,102	369	21.3%
Montana	1,440	2,253	813	56.4%	268	470	204	76.8%
Nebraska	2,837	3,583	726	25.6%	518	719	201	38.7%
Nevada	2,661	3,167	505	19.0%	491	631	141	28.7%
New Hampshire	3,772	3,861	89	2.3%	635	664	29	4.6%
New Jersey	28,258	31,954	3,696	13.1%	5,058	6,074	1,016	20.1%
New Mexico	2,169	3,496	1,327	61.2%	404	755	351	86.8%
New York	119,220	137,674	18,454	15.5%	21,879	27,172	5,294	24.2%
North Carolina	15,075	21,956	6,881	45.6%	2,801	4,552	1,751	62.5%
North Dakota	871	1,360	389	40.1%	176	283	107	60.7%
Ohio	27,209	34,468	7,260	26.7%	5,006	7,001	1,995	39.9%
Oklahoma	4,877	7,138	2,261	46.4%	898	1,489	591	65.8%
Oregon	5,422	7,276	1,854	34.2%	996	1,473	477	47.9%
Pennsylvania	31,170	37,318	6,148	19.7%	5,731	7,492	1,761	30.7%
Rhode Island	4,775	5,677	902	18.9%	875	1,128	252	28.8%
South Carolina	6,188	8,474	2,286	36.9%	1,108	1,699	593	53.6%
South Dakota	1,017	1,412	395	38.8%	187	297	110	59.1%
Tennessee	11,736	16,452	4,715	40.2%	2,166	3,430	1,264	58.4%
Texas	33,814	44,571	10,757	31.8%	8,202	9,125	2,924	47.1%
Utah	1,690	2,696	1,006	59.5%	312	581	269	86.2%
Vermont	1,351	1,678	328	24.3%	248	341	93	37.3%
Virginia	13,190	16,051	2,861	21.7%	2,446	3,192	746	30.5%
Washington	15,067	18,841	3,773	25.0%	2,783	3,774	991	35.6%
West Virginia	4,317	7,629	3,312	76.7%	808	1,667	859	106.3%
Wisconsin	10,971	13,928	2,957	27.0%	2,021	2,835	815	40.3%
Wyoming	628	872	244	38.8%	115	180	65	56.0%

Table 7

## Medicaid Expenditure Projections, 1996-2000

## State Expenditures, With States Maintaining Total Baseline Spending

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	456,180	540,373	84,193	18.5%	108,429	137,912	29,483	27.2%
Alabama	3,653	4,522	869	23.8%	848	1,149	301	35.6%
Alaska	1,278	1,493	215	16.8%	307	380	73	23.7%
Arizona	4,031	5,205	1,175	29.1%	967	1,381	414	42.8%
Arkansas	2,483	3,749	1,266	51.0%	598	1,027	429	71.8%
California	56,287	63,166	6,879	12.2%	13,358	15,844	2,488	18.6%
Colorado	4,415	5,259	845	19.1%	1,059	1,350	291	27.5%
Connecticut	8,849	9,373	724	8.4%	2,004	2,264	260	13.0%
Delaware	1,127	1,293	166	14.7%	269	328	58	21.5%
District of Columbia	2,945	3,374	429	14.6%	706	859	153	21.6%
Florida	21,585	26,561	4,996	23.2%	5,221	8,904	1,683	32.2%
Georgia	10,290	13,434	3,144	30.6%	2,490	3,552	1,062	42.7%
Hawaii	1,772	2,070	298	16.8%	425	527	101	23.8%
Idaho	775	1,053	277	35.8%	185	281	96	52.1%
Illinois	21,731	24,791	3,060	14.1%	5,194	6,281	1,087	20.9%
Indiana	8,791	10,925	2,133	24.3%	2,100	2,854	754	35.9%
Iowa	3,059	3,680	621	20.3%	723	945	221	30.6%
Kansas	2,848	3,179	331	11.6%	660	780	120	18.1%
Kentucky	4,706	6,607	1,901	40.4%	1,132	1,796	664	58.6%
Louisiana	8,011	10,750	2,739	34.2%	1,874	2,791	917	48.9%
Maine	2,456	2,784	328	13.4%	571	694	122	21.4%
Maryland	8,787	10,113	1,345	15.3%	2,105	2,577	472	22.4%
Massachusetts	16,576	18,730	2,155	13.0%	3,946	4,719	773	19.6%
Michigan	16,336	19,262	2,927	17.9%	3,909	4,953	1,043	26.7%
Minnesota	7,963	9,043	1,080	13.6%	1,882	2,277	396	21.0%
Mississippi	2,175	3,420	1,244	57.2%	519	946	427	82.2%
Missouri	6,557	7,187	629	9.6%	1,502	1,731	229	15.2%
Montana	930	1,355	436	48.9%	224	367	143	64.0%
Nebraska	1,844	2,206	363	19.7%	436	565	129	29.5%
Nevada	1,723	1,974	251	14.6%	410	499	89	21.7%
New Hampshire	2,538	2,577	38	1.5%	565	581	16	2.7%
New Jersey	18,527	20,385	1,858	10.0%	4,321	4,975	654	15.1%
New Mexico	1,396	2,083	687	49.2%	337	571	234	69.6%
New York	77,313	86,241	8,928	11.5%	18,339	21,635	3,296	18.0%
North Carolina	8,710	13,372	3,662	37.7%	2,348	3,564	1,218	51.8%
North Dakota	632	827	195	30.8%	149	218	69	46.3%
Ohio	17,620	21,265	3,645	20.7%	4,196	5,482	1,287	30.7%
Oklahoma	3,156	4,338	1,180	37.4%	755	1,155	400	52.9%
Oregon	3,511	4,491	980	27.9%	840	1,167	327	39.0%
Pennsylvania	20,193	23,189	2,975	14.7%	4,801	5,903	1,102	23.0%
Rhode Island	3,098	3,544	447	14.4%	735	885	160	21.8%
South Carolina	4,058	5,259	1,201	29.6%	949	1,353	404	42.6%
South Dakota	660	855	195	29.6%	157	227	70	44.7%
Tennessee	7,587	9,998	2,412	31.8%	1,818	2,680	842	46.3%
Texas	21,944	27,427	5,482	25.0%	5,182	7,030	1,848	35.7%
Utah	1,092	1,609	516	47.3%	261	439	178	68.1%
Vermont	875	1,036	181	18.4%	208	288	58	28.0%
Virginia	8,508	10,002	1,496	17.6%	2,048	2,554	506	24.7%
Washington	9,737	11,700	1,963	20.2%	2,334	3,000	666	28.6%
West Virginia	2,772	4,511	1,739	62.7%	673	1,258	585	87.0%
Wisconsin	7,101	8,583	1,482	20.9%	1,692	2,216	524	31.0%
Wyoming	407	500	93	22.8%	100	125	25	25.0%

**Table 8  
 Medicaid Beneficiary Projections, 1994-2002  
 by Beneficiary Group**

Beneficiaries (thousands)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Total*</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth	-	6.1%	5.2%	4.5%	4.1%	3.8%	3.1%	2.6%	2.6%	2.6%	3.8%
<b>Beneficiaries by Group</b>											
Elderly	3,687	3,818	3,942	4,052	4,164	4,276	4,383	4,484	4,590	4,701	
Growth	-	3.5%	3.3%	2.8%	2.8%	2.7%	2.5%	2.3%	2.4%	2.4%	2.7%
Blind & Disabled	4,968	5,249	5,555	5,879	6,159	6,444	6,731	6,950	7,175	7,408	
Growth	-	5.7%	5.8%	5.3%	4.8%	4.6%	4.5%	3.2%	3.2%	3.2%	4.5%
Adults & Children	19,108	19,975	20,798	21,656	22,528	23,360	23,962	24,512	25,075	25,651	
Growth	-	4.5%	4.1%	4.1%	4.0%	3.7%	2.6%	2.3%	2.3%	2.3%	3.3%
Pregnant Women & Children	4,367	5,035	5,567	5,883	6,157	6,436	6,712	6,914	7,121	7,335	
Growth	-	15.3%	10.6%	5.7%	4.7%	4.5%	4.3%	3.0%	3.0%	3.0%	5.8%

*Totals include Arizona*

**Table 9**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Region**

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Beneficiaries (thousands)</b>											
<b>Total*</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth		6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.8%
<b>Beneficiaries by Region</b>											
<b>New England</b>	1,610	1,700	1,781	1,853	1,921	1,991	2,050	2,102	2,156	2,212	
Growth	-	5.6%	4.7%	4.0%	3.7%	3.6%	3.0%	2.6%	2.6%	2.6%	3.6%
<b>Middle Atlantic</b>	2,635	2,741	2,845	2,947	3,052	3,163	3,264	3,349	3,437	3,528	
Growth	-	4.0%	3.8%	3.6%	3.6%	3.6%	3.2%	2.6%	2.6%	2.6%	3.3%
<b>South Atlantic</b>	4,983	5,512	6,027	6,472	6,874	7,239	7,522	7,717	7,917	8,123	
Growth	-	10.6%	9.4%	7.4%	6.2%	5.3%	3.9%	2.6%	2.6%	2.6%	5.6%
<b>East South Central</b>	2,549	2,713	2,857	2,978	3,091	3,205	3,306	3,390	3,476	3,566	
Growth	-	6.4%	5.3%	4.2%	3.8%	3.7%	3.2%	2.5%	2.6%	2.6%	3.8%
<b>West South Central</b>	3,743	4,069	4,372	4,634	4,878	5,101	5,280	5,413	5,550	5,691	
Growth	-	8.7%	7.4%	6.0%	5.2%	4.6%	3.5%	2.5%	2.5%	2.5%	4.6%
<b>East North Central</b>	5,077	5,230	5,339	5,441	5,556	5,698	5,837	5,991	6,149	6,312	
Growth	-	3.0%	2.1%	1.9%	2.1%	2.5%	2.5%	2.6%	2.6%	2.6%	2.4%
<b>West North Central</b>	1,852	1,941	2,014	2,077	2,139	2,205	2,267	2,327	2,388	2,452	
Growth	-	4.8%	3.8%	3.1%	3.0%	3.1%	2.8%	2.6%	2.7%	2.7%	3.2%
<b>Mountain</b>	975	1,057	1,134	1,200	1,261	1,316	1,361	1,396	1,431	1,468	
Growth	-	8.5%	7.3%	5.8%	5.0%	4.4%	3.4%	2.5%	2.5%	2.6%	4.7%
<b>Pacific</b>	1,133	1,211	1,286	1,352	1,414	1,473	1,522	1,561	1,601	1,642	
Growth	-	6.9%	6.1%	5.1%	4.6%	4.2%	3.3%	2.6%	2.6%	2.6%	4.2%
<b>California</b>	4,834	5,060	5,269	5,477	5,685	5,886	6,054	6,206	6,363	6,525	
Growth	-	4.7%	4.1%	4.0%	3.8%	3.5%	2.9%	2.5%	2.5%	2.5%	3.4%
<b>New York</b>	2,740	2,844	2,939	3,038	3,139	3,241	3,328	3,408	3,491	3,577	
Growth	-	3.8%	3.4%	3.4%	3.3%	3.3%	2.7%	2.4%	2.4%	2.4%	3.0%

\*Totals include Arizona

**Table 10**  
**Medical Expenditure Projections, 1996-2002**  
**Federal Expenditures**  
**Federal Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2002				2002			
	Baseline	5% Federal Cap			Baseline	8% Federal Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	950,442	783,580	(166,862)	-17.6%	174,593	128,970	(45,624)	-26.1%
Alabama	13,894	12,190	(1,704)	-12.3%	2,466	2,006	(460)	-18.6%
Alaska	1,980	1,567	(413)	-20.8%	388	268	(108)	-28.6%
Arizona	12,082	9,743	(2,339)	-19.4%	2,247	1,604	(643)	-28.8%
Arkansas	11,200	8,771	(2,429)	-21.7%	2,080	1,444	(636)	-30.6%
California	87,038	72,803	(14,235)	-16.4%	18,092	11,983	(4,109)	-25.5%
Colorado	8,168	6,522	(1,646)	-20.1%	1,514	1,074	(440)	-29.1%
Connecticut	13,200	11,678	(1,522)	-11.5%	2,371	1,822	(449)	-18.9%
Delaware	1,744	1,418	(327)	-18.8%	322	233	(89)	-27.6%
District of Columbia	4,568	3,707	(861)	-18.8%	849	610	(239)	-28.1%
Florida	41,047	31,624	(9,524)	-23.2%	7,662	5,189	(2,474)	-32.3%
Georgia	26,200	20,191	(6,009)	-22.9%	4,889	3,323	(1,566)	-32.0%
Hawaii	2,745	2,172	(573)	-20.9%	508	357	(151)	-29.6%
Idaho	2,959	2,415	(544)	-18.4%	544	398	(147)	-26.9%
Illinois	33,641	27,511	(6,131)	-18.2%	6,225	4,528	(1,697)	-27.3%
Indiana	23,370	19,113	(4,257)	-18.2%	4,319	3,146	(1,173)	-27.2%
Iowa	7,923	6,875	(1,248)	-15.7%	1,445	1,099	(347)	-24.0%
Kansas	6,030	5,351	(679)	-11.3%	1,076	881	(195)	-18.1%
Kentucky	18,515	14,768	(3,746)	-20.2%	3,447	2,431	(1,016)	-29.5%
Louisiana	34,262	29,060	(5,202)	-15.2%	6,129	4,783	(1,346)	-22.0%
Maine	6,077	5,373	(703)	-11.6%	1,098	884	(213)	-19.4%
Maryland	13,800	10,936	(2,863)	-19.6%	2,526	1,800	(726)	-28.8%
Massachusetts	25,805	21,250	(4,358)	-17.0%	4,716	3,498	(1,219)	-25.8%
Michigan	32,011	26,125	(5,886)	-18.4%	5,937	4,300	(1,638)	-27.6%
Minnesota	14,936	12,710	(2,226)	-14.9%	2,729	2,092	(637)	-23.3%
Mississippi	12,645	10,233	(2,412)	-19.1%	2,325	1,884	(640)	-27.6%
Missouri	15,016	13,724	(1,292)	-8.8%	2,628	2,259	(369)	-14.1%
Montana	3,512	2,700	(813)	-23.1%	549	444	(204)	-31.5%
Nebraska	4,498	3,772	(726)	-16.1%	822	621	(201)	-24.4%
Nevada	2,916	2,410	(505)	-17.3%	537	397	(141)	-26.2%
New Hampshire	3,772	3,684	(89)	-2.3%	635	606	(29)	-4.6%
New Jersey	28,258	24,562	(3,696)	-13.1%	5,058	4,043	(1,016)	-20.1%
New Mexico	6,125	4,799	(1,327)	-21.7%	1,141	790	(351)	-30.8%
New York	119,220	100,766	(18,454)	-15.5%	21,879	16,585	(5,294)	-24.2%
North Carolina	29,159	22,278	(6,881)	-23.6%	5,418	3,667	(1,751)	-32.3%
North Dakota	2,523	2,134	(389)	-15.4%	468	351	(107)	-23.4%
Ohio	41,241	33,981	(7,260)	-17.6%	7,588	5,593	(1,995)	-26.3%
Oklahoma	11,204	8,943	(2,261)	-20.2%	2,063	1,472	(591)	-28.7%
Oregon	8,994	7,140	(1,854)	-20.6%	1,652	1,175	(477)	-28.9%
Pennsylvania	38,843	32,696	(6,148)	-15.8%	7,142	5,381	(1,761)	-24.7%
Rhode Island	5,525	4,622	(902)	-16.3%	1,013	761	(252)	-24.9%
South Carolina	15,358	13,072	(2,286)	-14.9%	2,745	2,151	(593)	-21.6%
South Dakota	2,404	2,010	(395)	-16.4%	441	331	(110)	-25.0%
Tennessee	24,454	19,738	(4,715)	-19.3%	4,513	3,249	(1,264)	-28.0%
Texas	61,275	50,518	(10,757)	-17.6%	11,239	8,315	(2,924)	-26.0%
Utah	5,150	4,144	(1,006)	-19.5%	951	682	(269)	-28.3%
Vermont	2,016	1,888	(328)	-16.2%	370	278	(93)	-25.0%
Virginia	13,190	10,330	(2,861)	-21.7%	2,446	1,700	(746)	-30.5%
Washington	18,431	14,657	(3,773)	-20.5%	3,404	2,412	(991)	-29.1%
West Virginia	13,892	10,580	(3,312)	-23.8%	2,600	1,741	(859)	-33.0%
Wisconsin	16,747	13,790	(2,957)	-17.7%	3,085	2,270	(815)	-26.4%

**Table 11**  
**Medicaid Expenditure Projections, 1996-2002**  
**State Expenditures, Without States Maintaining Total Baseline Spending**  
**Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2002				2002			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	703,947	582,497	(121,449)	-17.3%	129,359	95,873	(33,485)	-25.9%
Alabama	5,552	4,871	(681)	-12.3%	985	802	(184)	-18.6%
Alaska	1,980	1,567	(413)	-20.8%	366	258	(108)	-29.6%
Arizona	6,255	5,044	(1,211)	-19.4%	1,163	830	(333)	-28.6%
Arkansas	3,852	3,016	(835)	-21.7%	715	496	(219)	-30.6%
California	87,038	72,803	(14,235)	-16.4%	16,092	11,983	(4,109)	-25.5%
Colorado	6,841	5,463	(1,378)	-20.1%	1,268	899	(369)	-29.1%
Connecticut	13,200	11,578	(1,522)	-11.6%	2,371	1,922	(449)	-18.9%
Delaware	1,744	1,416	(327)	-18.8%	322	233	(89)	-27.6%
District of Columbia	4,568	3,707	(861)	-18.8%	849	610	(239)	-28.1%
Florida	33,543	25,761	(7,783)	-23.2%	6,261	4,240	(2,021)	-32.3%
Georgia	16,003	12,333	(3,670)	-22.9%	2,887	2,030	(857)	-29.7%
Hawaii	2,745	2,172	(573)	-20.9%	508	357	(151)	-29.6%
Idaho	1,197	977	(220)	-18.4%	220	161	(59)	-26.8%
Illinois	33,641	27,511	(6,131)	-18.2%	6,225	4,528	(1,697)	-27.3%
Indiana	13,602	11,124	(2,478)	-18.2%	2,514	1,831	(683)	-27.2%
Iowa	4,705	3,964	(741)	-15.7%	858	653	(205)	-24.0%
Kansas	4,335	3,846	(488)	-11.3%	773	633	(140)	-18.1%
Kentucky	7,308	5,829	(1,479)	-20.2%	1,361	959	(401)	-29.5%
Louisiana	12,220	10,365	(1,855)	-15.2%	2,188	1,708	(480)	-22.0%
Maine	3,755	3,320	(435)	-11.6%	678	546	(132)	-19.4%
Maryland	13,600	10,936	(2,663)	-19.6%	2,526	1,800	(726)	-28.8%
Massachusetts	25,605	21,250	(4,356)	-17.0%	4,718	3,498	(1,219)	-25.8%
Michigan	25,315	20,660	(4,655)	-18.4%	4,698	3,400	(1,295)	-27.6%
Minnesota	12,255	10,428	(1,826)	-14.9%	2,239	1,716	(523)	-23.3%
Mississippi	3,359	2,719	(641)	-19.1%	618	447	(170)	-27.6%
Missouri	9,903	9,050	(852)	-8.6%	1,733	1,490	(244)	-14.1%
Montana	1,440	1,107	(333)	-23.1%	266	182	(84)	-31.5%
Nebraska	2,837	2,380	(458)	-16.1%	518	392	(127)	-24.4%
Nevada	2,661	2,200	(461)	-17.3%	491	362	(128)	-26.2%
New Hampshire	3,772	3,684	(89)	-2.3%	635	606	(29)	-4.6%
New Jersey	28,258	24,562	(3,696)	-13.1%	5,058	4,043	(1,016)	-20.1%
New Mexico	2,169	1,699	(470)	-21.7%	404	280	(124)	-30.8%
New York	119,220	100,766	(18,454)	-15.5%	21,879	16,585	(5,294)	-24.2%
North Carolina	15,075	11,518	(3,557)	-23.6%	2,801	1,896	(905)	-32.3%
North Dakota	971	821	(150)	-15.4%	176	135	(41)	-23.4%
Ohio	27,209	22,419	(4,790)	-17.6%	5,006	3,690	(1,316)	-26.3%
Oklahoma	4,877	3,893	(984)	-20.2%	898	641	(257)	-28.7%
Oregon	5,422	4,304	(1,118)	-20.6%	896	708	(188)	-21.0%
Pennsylvania	31,170	26,237	(4,933)	-15.8%	5,731	4,318	(1,413)	-24.7%
Rhode Island	4,775	3,995	(780)	-16.3%	875	658	(218)	-24.8%
South Carolina	6,188	5,267	(921)	-14.9%	1,108	857	(239)	-21.6%
South Dakota	1,017	850	(167)	-16.4%	187	140	(47)	-25.0%
Tennessee	11,736	9,473	(2,263)	-19.3%	2,166	1,559	(607)	-28.0%
Texas	33,814	27,877	(5,936)	-17.6%	6,202	4,588	(1,613)	-26.0%
Utah	1,690	1,360	(330)	-19.5%	312	224	(88)	-28.3%
Vermont	1,351	1,131	(219)	-16.2%	248	188	(62)	-25.0%
Virginia	13,190	10,330	(2,861)	-21.7%	2,446	1,700	(746)	-30.5%
Washington	15,067	11,983	(3,085)	-20.5%	2,783	1,972	(810)	-29.1%
West Virginia	4,317	3,288	(1,029)	-23.8%	808	541	(267)	-33.0%
Wisconsin	10,971	9,034	(1,937)	-17.7%	2,021	1,487	(534)	-26.4%

Table 12

## Medicaid Expenditure Projections, 1996-2002

## Federal and State Expenditures

Total Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2002				2002			
	Baseline	Expend.	5% Cap Change	%Change	Baseline	Expend.	5% Cap Change	%Change
Total	1,654,389	1,366,077	(288,312)	-17.4%	303,952	224,843	(79,109)	-26.0%
Alabama	19,445	17,061	(2,384)	-12.3%	3,451	2,808	(643)	-18.6%
Alaska	3,950	3,135	(825)	-20.8%	733	516	(217)	-29.6%
Arizona	18,336	14,788	(3,550)	-19.4%	3,410	2,434	(976)	-28.6%
Arkansas	15,051	11,788	(3,264)	-21.7%	2,798	1,940	(858)	-30.6%
California	174,076	145,606	(28,470)	-16.4%	32,184	23,965	(8,219)	-25.5%
Colorado	15,009	11,985	(3,024)	-20.1%	2,781	1,973	(809)	-29.1%
Connecticut	28,400	23,358	(5,044)	-17.8%	4,742	3,844	(898)	-18.9%
Delaware	3,487	2,833	(655)	-18.8%	644	466	(178)	-27.6%
District of Columbia	9,135	7,414	(1,722)	-18.8%	1,897	1,220	(677)	-35.5%
Florida	74,591	57,285	(17,306)	-23.2%	13,923	9,429	(4,495)	-32.3%
Georgia	42,203	32,524	(9,679)	-22.9%	7,876	5,353	(2,523)	-32.0%
Hawaii	5,489	4,343	(1,146)	-20.9%	1,018	715	(303)	-29.8%
Idaho	4,156	3,392	(764)	-18.4%	764	558	(206)	-26.9%
Illinois	67,283	55,021	(12,262)	-18.2%	12,450	9,056	(3,394)	-27.3%
Indiana	36,972	30,237	(6,735)	-18.2%	6,832	4,977	(1,855)	-27.2%
Iowa	12,628	10,640	(1,988)	-15.7%	2,304	1,751	(553)	-24.0%
Kansas	10,365	9,193	(1,172)	-11.3%	1,849	1,514	(335)	-18.1%
Kentucky	25,823	20,598	(5,225)	-20.2%	4,808	3,390	(1,418)	-29.5%
Louisiana	46,482	39,425	(7,057)	-15.2%	8,315	6,489	(1,826)	-22.0%
Maine	9,831	8,693	(1,138)	-11.6%	1,776	1,431	(345)	-19.4%
Maryland	27,199	21,873	(5,326)	-19.6%	5,053	3,800	(1,253)	-24.8%
Massachusetts	51,211	42,500	(8,711)	-17.0%	8,432	6,995	(1,437)	-17.0%
Michigan	57,328	46,785	(10,543)	-18.4%	10,833	7,700	(3,133)	-28.9%
Minnesota	27,190	23,138	(4,052)	-14.9%	4,968	3,808	(1,160)	-23.3%
Mississippi	16,004	12,951	(3,053)	-19.1%	2,942	2,132	(810)	-27.5%
Missouri	24,919	22,774	(2,145)	-8.6%	4,361	3,748	(613)	-14.1%
Montana	4,952	3,807	(1,145)	-23.1%	915	627	(288)	-31.5%
Nebraska	7,335	6,152	(1,183)	-16.1%	1,340	1,013	(327)	-24.4%
Nevada	5,577	4,610	(967)	-17.3%	1,028	759	(269)	-26.2%
New Hampshire	7,545	7,368	(177)	-2.3%	1,270	1,213	(57)	-4.5%
New Jersey	58,515	49,123	(9,392)	-16.1%	10,116	8,085	(2,031)	-20.1%
New Mexico	8,294	8,498	(1,798)	-21.7%	1,545	1,069	(476)	-30.8%
New York	238,440	201,532	(36,908)	-15.5%	43,757	33,170	(10,587)	-24.2%
North Carolina	44,234	33,796	(10,438)	-23.6%	8,219	5,582	(2,637)	-32.1%
North Dakota	3,493	2,955	(538)	-15.4%	635	486	(149)	-23.4%
Ohio	68,450	56,400	(12,050)	-17.6%	12,594	9,283	(3,311)	-26.3%
Oklahoma	16,081	12,836	(3,245)	-20.2%	2,961	2,113	(848)	-28.7%
Oregon	14,415	11,444	(2,972)	-20.6%	2,648	1,883	(765)	-28.9%
Pennsylvania	70,013	58,932	(11,081)	-15.8%	12,874	9,700	(3,174)	-24.7%
Rhode Island	10,300	8,617	(1,683)	-16.3%	1,888	1,418	(470)	-24.9%
South Carolina	21,546	18,338	(3,208)	-14.9%	3,851	3,018	(833)	-21.6%
South Dakota	3,422	2,860	(562)	-16.4%	628	471	(157)	-25.0%
Tennessee	36,190	29,211	(6,979)	-19.3%	6,678	4,808	(1,870)	-28.0%
Texas	95,089	78,396	(16,693)	-17.6%	17,440	12,903	(4,537)	-26.0%
Utah	6,840	5,504	(1,336)	-19.5%	1,263	908	(355)	-28.3%
Vermont	3,367	2,820	(547)	-16.2%	619	464	(155)	-25.0%
Virginia	26,381	20,659	(5,722)	-21.7%	4,892	3,400	(1,492)	-30.5%
Washington	33,498	26,640	(6,858)	-20.5%	6,186	4,385	(1,801)	-29.1%
West Virginia	18,209	13,868	(4,341)	-23.8%	3,408	2,283	(1,125)	-33.0%
Wisconsin	27,718	22,824	(4,894)	-17.7%	5,105	3,757	(1,348)	-26.4%



## Concerns about Gregg Proposal

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### MEDICARE

- Proposes over \$100 billion reduction in spending on Medicare -- with no reinvestment in health care coverage.
  - o Cuts will fall disproportionately on seniors, who will continue to spend over three times as much of their income on health care as the younger population.
- The proposal promises beneficiaries more choice of plans without limiting access to the current program. But it also promises savings to the government. Where will the savings come from if seniors' current choices are truly protected?
- The Clinton proposal, rather than mandating managed care for seniors, in fact promoted choice while retaining seniors' access to the current program at no extra cost. This proposal offers a similar promise, but no specifics on how to achieve it.
- The "Look Back" savings in this proposal would bring Medicare per capita growth rates below private sector per capita growth rates (6.0% versus 7.2%).
  - o How could these savings be achieved without further burdening seniors or forcing providers -- already pressed to provide uncompensated care to growing numbers of uninsured -- to shift costs or reduce access to health care?

### MEDICAID

- The proposed block grant for Medicaid freezes the growth rate so low that there is little room for price or utilization growth.
  - o CBO projects recipient growth rate of 3.0%.
  - o Under the 4% cap, price and utilization could grow at only 1% -- far below CPI projections of 3% and MCPI projections of 5.3%.
- This low growth in the block grant would force states to cut coverage.



## NATIONAL CONFERENCE OF STATE LEGISLATURES

444 NORTH CAPITOL STREET, N.W. SUITE 515 WASHINGTON, D.C. 20001  
202-624-5400 FAX: 202-737-1069

March 14, 1995

The Honorable Richard Armeý  
U.S. House of Representatives  
Washington, DC 20515-4326

JANE L. CAMPBELL  
ASSISTANT MINORITY LEADER  
OHIO  
PRESIDENT, NCSL

TED FERRIS  
DIRECTOR, JOINT LEGISLATIVE  
BUDGET COMMITTEE  
ARIZONA  
STAFF CHAIR, NCSL

WILLIAM POUND  
EXECUTIVE DIRECTOR

Dear Representative Armeý:

On behalf of the National Conference of State Legislatures, we are writing to share the states' ideas and concerns regarding block grants. NCSL has long supported a reasonable sorting out of functions among the different levels of government. We also believe the devolution of certain federal responsibilities to the states should not simply be a way to deal with the federal deficit, but, following the lead of the unfunded mandates legislation, constitute a serious attempt at restoring balance to and productive partnerships within our federal system. To that end the NCSL has developed the set of enclosed principles to be considered with regard to any block grant proposal. Because state legislatures are the bodies that are most involved in the decision-making process with respect to program delivery in the states, we urge you to consider the following issues when constructing any block grant plan.

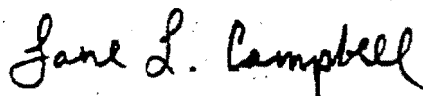
1. **Federal block grant funds should be expended "according to state law."** This is of vital importance to the proper allocation of funds within a state and allows for the most appropriate form of oversight. Failure to include such a clause in any block grant proposal is tantamount to a wide preemption of state laws governing the appropriation of funds and could lead to unnecessary disputes.

Proposals that grant the authority to the governor of each jurisdiction are not conducive to achieving a balanced distribution of funds across the state and are basically the same as ceding congressional authority over the appropriations process to the President. Block grants, by their nature, include minimal amounts of guidance over the distribution of funds within a state, and the legislative process is needed in order to best allocate the funds once they reach the state treasury. State legislators also hold the power of the purse over state revenues and are uniquely equipped to leverage state funds in conjunction with federal funds in order to create the most efficient and powerful programs.

2. **The maximum level of flexibility in the use of the block grant funds should be granted.** Cuts in projected funding levels, if sought, require greater flexibility if the states are to have any opportunity to achieve program goals.
3. **Certain entitlement programs should not be changed into non-entitlement block grants.** For example, programs involving child nutrition and food stamps should not be treated as capped entitlement programs. We believe that the resources necessary to ensure that eligible children continue to receive benefits should not be limited.
4. **State legislatures will need transition and lead time to address these potential changes in a deliberate and comprehensive manner.** Since many state legislatures meet part-time or biennially, we ask your consideration that we work together to develop implementation timetables that are most conducive to a timely but thorough transition of program management.

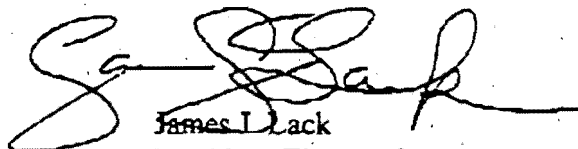
Thank you for your consideration of these views when making your decisions with regard to any block grant proposal. Members of the National Conference of State Legislatures would be pleased to discuss these issues with you and/or testify with regard to any block grant proposal. Please contact Scott DeFife or Michael Bird in our Washington office at 202/624-5400 if you have any questions or need additional assistance.

Sincerely,



Jane L. Campbell  
President, NCSL  
Assistant Minority Leader, Ohio

Sincerely,



James I. Lack  
President-Elect, NCSL  
New York State Senate

DRAFT - for discussion only

payment accuracy Quality Control system to a broader system focused on self-sufficiency and program improvement.

*The existing QC system requires an evaluation of all factors of eligibility and payment, except a few that are specifically excluded by the Statute, e.g., monthly reporting. The new system would focus on only error prone factors with significant dollar effects (e.g. earned income, filing unit, deprivation, etc.), or only on factors viewed as critical to public confidence in the program.*

- Revise the regulations to reduce the verification and documentation required to substantiate a review finding.

*The current system requires a detailed description and calculation of all errors found in a case review, and that a specified amount of verification be obtained to substantiate the error finding. Under this option, documentation/verification standards would be relaxed by establishing new minimum standards and the payment error determination process will be simplified.*

- Revise the regulations to change the sample design.

*The current system requires each state (or jurisdiction) to select a minimum of 300 to 1200 review cases each year. The Federal staff examines a portion of each state's sample to validate the review findings. The precision (confidence level) of the payment errors is primarily a function of the sizes of the State and Federal samples and the expected frequency with which the attribute being measured occurs in the population being sampled. They have been tested and judged adequate for holding States accountable for prescribed payment accuracy standards. Commitment of resources to achieve this level of precision may not be necessary in an incentive/technical assistance response to State performance. It should be noted that smaller sample sizes will reduce the amount and degree of reliability of performance data on the transitional system. We can study the potential impact of various reduced sample size models on the precision of payment error estimates and other process measures.*

#### OPTION 2: Operational Design

*States would be required to conduct periodic, internal audits of their JOBS and WORK processes to ensure the accuracy of reported data and annual audits to establish payment accuracy rates. The Federal government would specify the minimum sample sizes to achieve 90 or 95 percent confidence at the lower limit (the method generally used by OIG). States would also be permitted to use current QC resources to conduct special studies to test and improve the current system. To ensure that State data and procedures are valid and reliable, the Federal government would conduct periodic, targeted, and unannounced audits for that purpose.*

#### 4. Incentives vs. Penalties

- States would be eligible for performance-based incentive payments -- for example, a 1-10 percent increase in FFP (administrative costs, or JOBS, or WORK).
- Sanctions for unacceptable performance could also be included, if needed to foster appropriate behavior.
- The incentive/sanction formula would be developed by the Secretary taking into consideration and appropriately weighting desired results, including payment accuracy.

DRAFT 3/15/95 1PM

**PRESIDENT WILLIAM JEFFERSON CLINTON**  
**REMARKS ON REGULATORY REFORM** 95 MAR 15 P2:15  
**CUSTOM PRINT PLANT, ARLINGTON, VA**  
March 16, 1995

We are here at the Custom Print Plant, because these are the people on whose behalf we work. Stu McMichael owns this plant; he's been in business for [x] years and employs [x] workers. He works hard, he wants to minimize the inevitable pollution produced by his plant, and he wants to play by the rules. But like too many other small businesses, the many rules governing printing are so dense and so complex that it is literally impossible for him to know if he is complying or not.

Last month, I called together the heads of the federal regulatory agencies and ordered them to begin a root-and-branch reexamination of the way they do business. I asked Vice-President Gore to take charge of this process. Today I am announcing the first fruit of this process -- government-wide regulatory reforms that will cut back on paperwork and treat honest businesspeople as partners, not adversaries. And we will put in place significant reforms in the way we protect our environment and the way we assure safe and high quality drugs and medical devices. The reforms we implement today are real; they have teeth. And they show that you can reform regulation without hurting the environment, workers, or consumers.

Our philosophy is simple: Protecting people, not protecting bureaucracy. Results, not rules. Action, not rhetoric. Common sense. And when it comes to regulation, a little bit of common sense can be a revolutionary idea.

Look around us; a pressman of 50 years ago wouldn't recognize this as a printing plant. [ck] Technological and economic change constantly makes and remakes our world. Our government, if it is to remain a relevant and positive force in our lives, must change, too. Since I assumed office, I have been determined to replace yesterday's government with a new government that can help solve the problems of today and meet the challenges of tomorrow.

The government of tomorrow will discard volume after volume of detailed rules, and will, instead, set clear goals -- and challenge our people to come up with the ways to meet them. That's what I mean when I talk about a government that offers opportunity and demands responsibility, one that lives up to a New Covenant with the people. A government that is as flexible and innovative as the best private business. A government that uses the newest tools of technology and economics.

As you know, we are engaged in a great debate about the proper role and reach of

government. One-size-fits-all regulation didn't make sense. But one-size-fits-all deregulation doesn't make sense, either. I am determined to see a different approach -- a government that is leaner but not meaner, that protects consumers, workers, the environment without burdening business and choking innovation.

Yes, we need to cut paperwork, and we're doing it. But it doesn't make sense to freeze federal efforts to protect children from unsafe toys or unsound food. Yes, we need to carefully analyze the risks and benefits of what we do. But it doesn't make for better regulation to pile on dozens of new procedural requirements. That's not common sense -- that's nonsense. It's paralysis by process, and it won't help solve our problems. As I have said before, reform, yes -- bring it on. Rollback, no.

All Americans want the benefits of strong government protection: Air that you can't see; water that you can drink; a workplace that doesn't force workers to trade off a livelihood for safety; food that is unadulterated and healthy; banks that invest wisely and protect taxpayer money.

Over the past two years, we have made great strides in protecting the public in all these areas. But we all know that the way we seek these goals can frustrate the very goals we seek. And the way our regulatory system has grown -- a dense jungle of rules and regulations, precise lists of dos and don'ts, -- can trip up even the most well-intentioned businessperson, while unscrupulous competitors too often escape notice.

So we must cut through this jungle with a deep and abiding commitment to regulatory reform. It is time to stop the silliness, stop the behavior that makes no sense, accomplishes no ultimate goal, and drives people in the private sector up the wall. The American people want strong protections, but they want results, not rules; action, not more law. The tremendously popular book The Death of Common Sense makes a simple point: in our entirely understandable desire to protect the public, we have put in place a system that literally requires government regulators to act in ways that defy common sense. The author of that book, Philip Howard, is here with us today. [Introduce Philip Howard] The Vice-President gave me this book, and I'm reading it now -- it's very compelling.

Over the past two years, my administration has begun to change the way government does business. Already, we reduced federal spending by over a quarter of a trillion dollars, reduced the size of the federal payroll by over 100,000. We are on our way to a reduction in excess of 250,000 in the federal work force, which will give us by the end of this decade the smallest federal government since the Kennedy administration. Vice President Gore's leadership in the reinventing government initiatives have already saved taxpayers \$63 billion.

And we have begun to change the way government regulates. We eliminated rules that are obsolete, we have simplified rules that are too complicated, and we have cut paperwork wherever we could. We found that the government often stood in the way of our

very goals. We want economic development; the Commerce Department's Economic Development Administration is making life simpler by repealing outright over half its rules. We want nutritious food; USDA is making it easier to import fruits and vegetables. USDA has repealed rules under the stockyards act, and Interior has eliminated feather import quotas for exotic birds. The Education Department has rescinded its rule requiring both parents to sign financial aid application forms. And the FHA has [finish the e.g.].

Now we must take the next steps to bring common sense to regulation.

We must recognize that most businesses are small businesses, and that the overwhelming majority of them want to do the right thing. Unfortunately, today's rules and regulations can be so voluminous and arcane that a dry cleaner or printer simply can't know what they are doing wrong. And our inspectors are required by the rules to treat every violation as if it were another Love Canal.

First, we are going to get our enforcers out of the business of mindlessly writing traffic tickets, and into the business of achieving results. We are going to let these regulators apply common sense.

Today I am ordering a government-wide policy, so that a small business that tried to act properly but violated the rules can spend the money fixing the problem instead of paying a fine to the government. Our enforcers will be given authority to waive up to 100% of fines for small businesses so that a businessperson who acts in good faith can put his energy into correcting the problem, not fighting with a regulator. Similarly, regulators will be given the discretion to waive fines for small businesses altogether, if it's a first-time violation and the firms quickly and sincerely act to correct the condition that violates the rules.

Let me make clear: These initiatives are meant to cement a new era of partnership between the regulators and the regulated. They will not excuse those violating criminal laws, and they will not be an amnesty for businesses that harm public health and safety while their competitors are playing by the rules. But we will stop playing "gotcha" with people who want to be good citizens. Compliance, not punishment, will be our credo.

Second, we are going to curb the government's voracious appetite for paperwork. I am asking each agency to double the amount of time between regularly scheduled reports to the federal government, if it can be done without sacrificing important public purposes.

Common sense. Flexibility. Less paperwork. All of these are important. But we must do even more. Last fall, I asked Vice-President Gore to begin to systematically review the most significant areas of federal regulation, with an eye toward proposing deep and real reform.

Today we are announcing fundamental reforms in the areas of environmental protection and drug and medical devices.

Environmental regulation touches every part of our lives. And this is a moment of transition for our nation's environmental policy. The modern era of environmental protection began in 1970 with the first Earth Day, the passage of landmark legislation, and the creation of the Environmental Protection Agency. The results are a great American success story, envied and copied around the world.

But the methods that worked then aren't necessarily the right methods for today. To meet the challenges of the next 25 years, our environmental programs must work better and cost less. They must build on what we know.

We know that an overwhelming majority of the American people are deeply committed to a clean and healthy environment. We know that pollution is often a sign of economic inefficiency, and that business can make money by preventing it. We know that better decisions result when people work together as partners rather than as adversaries. And we know that standards that provide flexibility -- but demand accountability -- can provide greater protection at lower cost.

Today my administration is announcing a landmark package of 25 environmental reforms.

Some of these reforms will improve the current system.

For example, we recognize that market mechanisms make more sense than micromanagement. For example, letting utilities buy and sell their rights under the Clean Air Act has saved utilities and their customers \$2 billion while resulting in cleaner air. Today we will dramatically extend this market concept to other areas of clean air and water protection. This is good for business, and good for the environment.

Today, too many small businesses are afraid to come to EPA for help in cleaning up their act, because they are afraid they'll be punished. We will open compliance centers to help small business. And we will say to them: if we discover a problem, you will have 180 days to clean it up, with no penalty.

And because you shouldn't need a forestfull of paper to protect the environment, EPA will cut the paperwork requirements it imposes on businesses and communities by 25%.

And while these steps will improve the current system, others will move well beyond it -- a shift in the way we think about regulation. EPA will launch a pilot program -- "Project XL" -- which is simple but revolutionary. We will say to companies: Here is the pollution reduction goal. If you can figure out how to meet it, then you can throw out the EPA rulebook. If this works -- and we have every reason to believe it will -- then we have a chance to put the responsibility for protecting the environment squarely in the hands of people in the private sector.



These changes are good for business and good for the environment. That's why I'm pleased that the CEO of DuPont, [name], is here with us, as well as [other validators]. And that's why [name of EDF person] is here as well.

Consider how our reforms will make life easier for Stu McMichael. Today, a small printer has to fill out up to 20 forms about toxic emissions; we will replace that with one form. He can work with EPA's new compliance centers to identify problems and correct them, without facing a fine. The inspectors who visit his plant will come as partners, not prosecutors. And the help the agency gives will be in English.

The other major area examined by the Vice-President is the realm of drugs and medical devices. There was a time when consumers might find that their food was adulterated, their drugs were quackery or had dreadful side effects. Today, Americans don't have to worry about safety or effectiveness when they buy anything from cough syrup to the latest antibiotics or pacemakers. And the reason they don't have to worry is that the Food and Drug Administration does all the worrying. The FDA has made American drugs and medical devices the envy of the world and in demand all over the world. Believe me, we are sticking with the standards we have -- they're the best in the world.

But strong standards do not mean government business as usual. Today we are announcing a set of reforms that will make our high-quality drugs and devices available to consumers more quickly and cheaply.

Using the same common sense principles we are discussing today, FDA will stop doing a full-blown review every time a biotech drug company makes a minor, risk-free manufacturing change in an established drug.

FDA will stop requiring costly environmental assessments on drugs that obviously have no significant impact on the environment.

FDA will eliminate 600 pages of cumbersome regulations controlling the production of insulin and antibiotics, and other drug products

It will allow our firms to export products to the world without FDA preapproval, if those products are already tested and approved in other leading industrial countries.

And 140 categories of medical devices that pose low risk to patients -- from syringes to xx -- will no longer need preapproval by FDA before they are put on the market. *original needs to*

These FDA reforms and others we will announce in the next few weeks will keep quality at world class levels and save industry -- and consumers -- nearly a half billion dollars a year. And I am pleased that representatives of the drug and medical device industry are here, as well, and we appreciate your support.

***[NOTE: Financial institution reforms are also ready to be announced at this event. However, we recommend that these be announced at the first Economic Conference, where they will attract stand-alone attention.]***

All these changes, taken together, represent real, deep, fundamental reform. They lack the sledgehammer subtlety of a moratorium. But if we are going to be responsible, we must fix the problem -- not freeze it in place. To go from yesterday's government to tomorrow's, we need positive movement, not paralysis.

If we continue our commitment to create a government that works better, costs less, and reflects our values, it can make a real difference in the lives of businesspeople and workers. That's true common sense. And that is what I am committed to giving the American people.