Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note w/attach	Todd Stern, Helen Howell to POTUS Re: Secretary Shalala's Memo re: Health Coverage Needs of Young Adults (3 pages)	5/21/96	P5

COLLECTION:
Clinton Presidential Records
Domestic policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
May 1996 HSA [1]

gf123

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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May 9, 1996

Note to Chris Jennings, Jennifer Klein, Nancy-Ann Min

From: Jack Ebeler

The Secretary sent the attached memo to the WH yesterday on health coverage for young adults.

I am enclosing a background packet of information on the issue for your information. We are continuing to develop more specific data on marital status, parental coverage, etc., and will send you that as we get it.

Attachment
Memo
Background packet

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 8 1996

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Incremental Health Care Reform -- Covering the Class of '96

Summary

In one of your upcoming commencement speeches, you could call for a voluntary, private sector campaign to address better the health coverage needs of young adults – who often lose health coverage as dependents when they graduate from college.

Introduction

In the past year, you have effectively focused public and Congressional attention on the need for incremental health care reforms, with the centerpiece being insurance reforms. That effort, coupled with your strong stand in updating and preserving Medicare and Medicaid, is proving successful, and provides a model for future strategies -- a modular approach to health care reform.

We should continue to target our efforts on gaps that occur in the transitions among parts of the health care system -- as individuals move from job to job, as they age from one form of coverage to another, or as the system itself changes. I have been reviewing potential approaches, and one in particular suggests itself for immediate attention. That is to call on employers, insurers, and the National Association of Insurance Commissioners to develop model programs to address coverage needs for young adults.

As you may know, many young adults now lose health insurance coverage as they become independent; such as graduating from college. My own department's General Counsel discovered the problem first-hand shortly after her son's graduation. When her son went in to fill a prescription last June, he was informed that he was no longer covered by the family's health insurance policy, and his mother, while surprised, immediately took action to purchase supplemental insurance. Just weeks later, a serious bicycle accident put him in the hospital for two different surgical operations -- which would have cost the family thousands of dollars if he had not discovered that he was uninsured because of his college graduation.

Calling on insurance companies to design policies to address this gap in coverage would have special appeal to two important groups: young adults age 18-24, who either don't have health insurance or are realizing its cost for the first time, and their parents, who are increasingly concerned about their children's safe transition to independence. And it gives you the

opportunity to simultaneously address the high-profile issues of health care, corporate responsibility, and the government's role in supporting families, through a voluntary, non-regulatory approach.

The proposal could be announced in one of your upcoming commencement speeches, which would guarantee you a supportive audience and a visible platform. It could also be followed by a meeting with insurers, interviews with college newspapers, specialty press outreach to target media like MTV, and visits to college campuses this fall.

Background

Young adults are the population most likely to be uninsured: 27 percent of 18-24 year olds are uninsured, compared with 15 percent of the population as a whole. Health insurance gaps are the norm as these individuals make a transition from coverage as dependents to coverage in the work force.

In general, children are considered dependents through age 18-21, depending on state law. Full-time students are covered generally through age 22 or 23. Many states provide for a continuation of coverage option when dependency status ceases; certain provisions in the insurance reforms recently passed by the House and Senate, if enacted, will provide for the availability of individual policies for such individuals.

Proposal

You would call on employers and insurers, working with the National Association of Insurance Commissioners (NAIC), to create a campaign to better address the coverage needs of this population. The campaign would include:

- model family health insurance program(s) for states, with a uniform extended age through which young adults would be able to be carried as dependents;

- an educational campaign on the purchase of health insurance for young adults.

I have talked informally with some major insurers about this proposal. If you are interested in pursuing this matter, I will follow-up with more detailed discussions with the key parties to set the stage for an announcement during the spring graduation season.

Donna E. Shalala

Attachments

A Program to Increase Health Insurance Coverage for Young Adults, Persons Age 18-24

Issue

Young adults are the age group most likely to be uninsured. The percentage of those 18-24 without health insurance is 27 percent compared with 15 percent for the population as a whole. Almost 40 percent of 23 year old males are uninsured. The question is how best to enhance coverage for this population.

Background

The age of 18 is traditionally the age when children are considered to be adults. The age of 25 is the age when most young adults have jobs and are well on their way to longer-term living arrangements. Between those two ages, young adults undergo a number of transitions in family or living arrangements, occupation and educational status that traditionally change their health insurance status. The first transition is from high school to training, first job, or college. A second transition is from training or college to first job. A further transition is to a new family status, either living separately from parents or forming a new family.

Colleges and Universities. For the college bound, health insurance coverage is often required during the undergraduate years, optional during any years of graduate school, and then provided with a first job. Parents' policies often cover young adults who are full-time students until they reach 22 or 23. Problems arise for students whose health insurance plans -- most frequently managed care plans -- do not cover non-emergency care out of state, for those who are older than the cutoff age, and for those whose families cannot or do not have coverage. A recent newsletter of the American College Health Association estimates that "at least one-third" of students enrolled in American colleges or universities do not have health insurance coverage, a proportion which reflects graduate students, undergraduates older than the cutoff age, and those whose parents do not have coverage. For those who do not go on to higher education, health insurance coverage from a parent's policy typically ends between age 18 and 21, depending upon state law. Some HMOs and managed care plans are experimenting with policies that allow out of area coverage or portability for college students; Blue Cross-Blue Shield, for example, is expected to offer a program that allows coverage away from the home area for its 18.5 million members in July.

Health Insurance. Health insurance gaps between the ages of 18 to 25 are the norm. Many young adults find that their first full-time jobs don't have any health insurance coverage; others perceive the coverage as too expensive. There is also evidence that most young adults consider themselves healthy and unlikely to need much medical care, a further incentive not to purchase health insurance if the price of the policy is perceived as expensive and the person does not believe anything catastrophic could happen. For those not offered health insurance through their jobs or a parent's policy, individual policies may be available, but again may be expensive relative to income, perceived risk, or both.

State Laws. Coverage of dependents generally is defined in state law for insured persons, though it is unregulated for self-funded arrangements. The rules vary. Unmarried, non-disabled children are considered dependents through age 18 to 21, depending upon the state. Full-time students are covered generally through age 22 or 23. Many states provide for a continuation option (i.e., a "conversion" policy) for dependents no longer eligible under a parent's policy, but the terms of the conversion vary across states. Most states require a policy to be offered without regard to health status, but underwriting is permitted in at least one state. A quick survey of states did not find any cases where health status could be used as a rating factor. In some cases, carriers are permitted to segregate conversion policies into a separate rating pool, meaning that the policies would be quite expensive as a result of adverse risk selection. In other cases, it appears that rates are constrained based on the premium paid by the employee. There is also variation among insurers: some aggressively market individual policies; others provide only the minimum notice that such policies exist. Individual coverage is available from a number of carriers, with a high deductible policy (for example, $1,000 deductible) costing $40 to $80 per month for 20 to 30 year olds. The relatively low cost must be weighed against the widespread perception among young adults of low discretionary income and a relatively low priority for health insurance.

General facts about young adults and health insurance:

- The percent uninsured grows throughout the 18-24 year old bracket, peaking at age 23, where one-third of the young adults are uninsured. About 19 percent of 18 year olds lack health insurance, a percentage that increases to over 30 percent of the 23 and 24 year olds. The percentage then drops through the late 20s. At age 27, for example, it is 26 percent.

- Young men are more likely to be uninsured. The percentage of males 18-24 without health insurance is 30 percent; for females, 23 percent.

- Of the young adults who work full-time, 27 percent have no health coverage. Among part-time workers 18 to 24 years old, 23 percent are uninsured. Of those unemployed, 31 percent have no health coverage.

- The leading causes of death for 18-24 year olds are unintentional injuries, homicide, and suicide, followed by cancer, heart disease, and HIV infection.

- Data from the 1994 National Health Interview Survey and the 1995 Current Population Survey show that 43 percent of 18-24 year olds consider their own health to be "excellent," and 32 percent consider their health to be "very good." Only 4 percent consider their health to be "fair" or "poor."

Future Trends. Projections show that the number of 18-24 year olds will rise from 25.5 million in 1995 to 30.6 million in 2025. As a proportion of the population, however, 18-24 year olds will rise from 9.7 percent in 1995, to 10.1 percent in 2010, but then fall

slightly to 9.0 percent in 2025.

Recommended Options

Begin a campaign, in cooperation with employers, insurance companies and the National Association of Insurance Commissioners, to propose and adopt a model family health insurance program with a uniform extended age through which all young adults would be able to be carried on their parents' health insurance policies. To accomplish this end, we recommend calling a meeting of employers and major insurers to discuss the feasibility of making family coverage through a standard age in the mid-20s a national standard. We would also work with the National Association of Insurance Commissioners to propose and adopt a model family health insurance program. These proposals would be discussed during the next several weeks in several commencement addresses and in other forums.

Design an education campaign on the purchase of health insurance for young adults in transition. There is evidence that some young adults feel that health insurance is not needed. An education campaign through public service announcements, reminders on pay stubs, and a message on the new Social Security earnings statement would remind a group that has never purchased health insurance that its purchase can help with unforseen accidents and illnesses.

18-24 Year Olds

Persons (Millions) by Health Insurance (18-24 Year Olds Only)

This chart shows the types of health insurance for 18-24 year olds. Compared with the entire population.

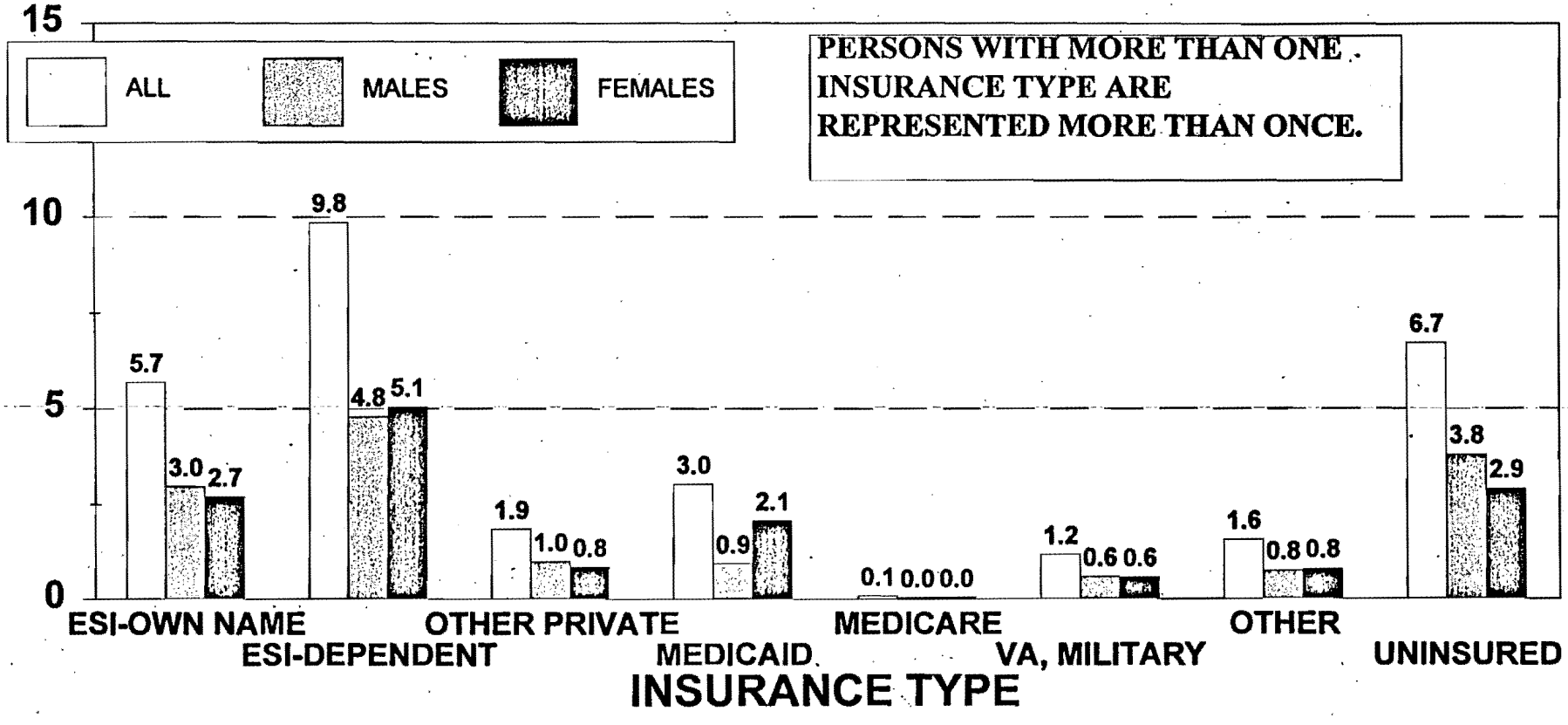
- 18-24 year olds have many more persons in the Employer Sponsored Insurance--Dependent category compared with Employer Sponsored Insurance in their own names. For the population as a whole these numbers are almost equal; for this population, there are many more covered as dependents than covered in their own names.

- As expected, relatively few have Medicare or VA/Military coverage.

- Relatively more are uninsured.

PERSONS (MILLIONS) BY HEALTH INSURANCE MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

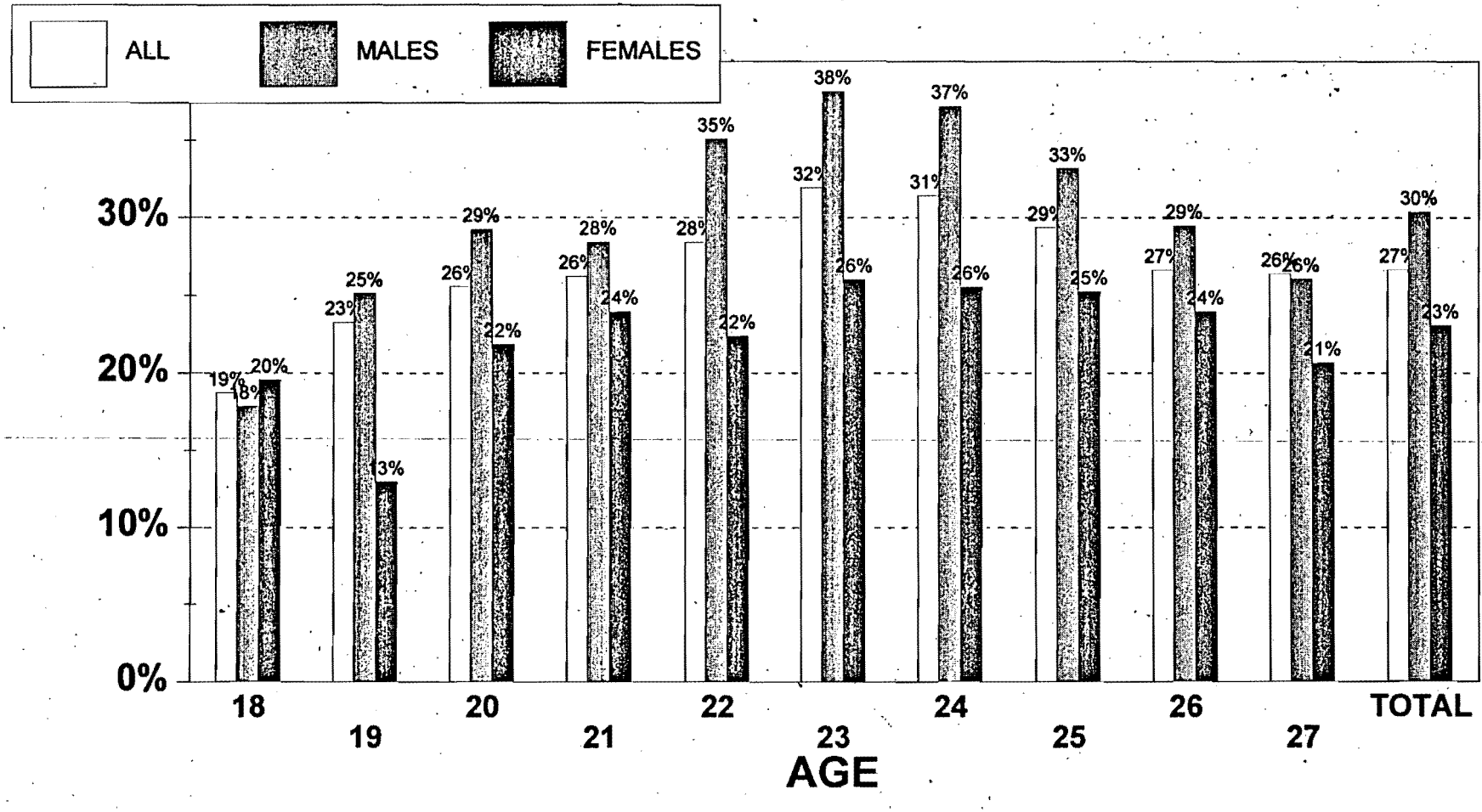
Percent Uninsured by Age: Aged 18-27

- The percent uninsured grows throughout the age bracket, peaking at age 23 where 32 percent are uninsured.

- The percent uninsured begins to decline at age 25.

% UNINSURED BY AGE: AGED 18-27

MARCH 1995 CURRENT POPULATION SURVEY



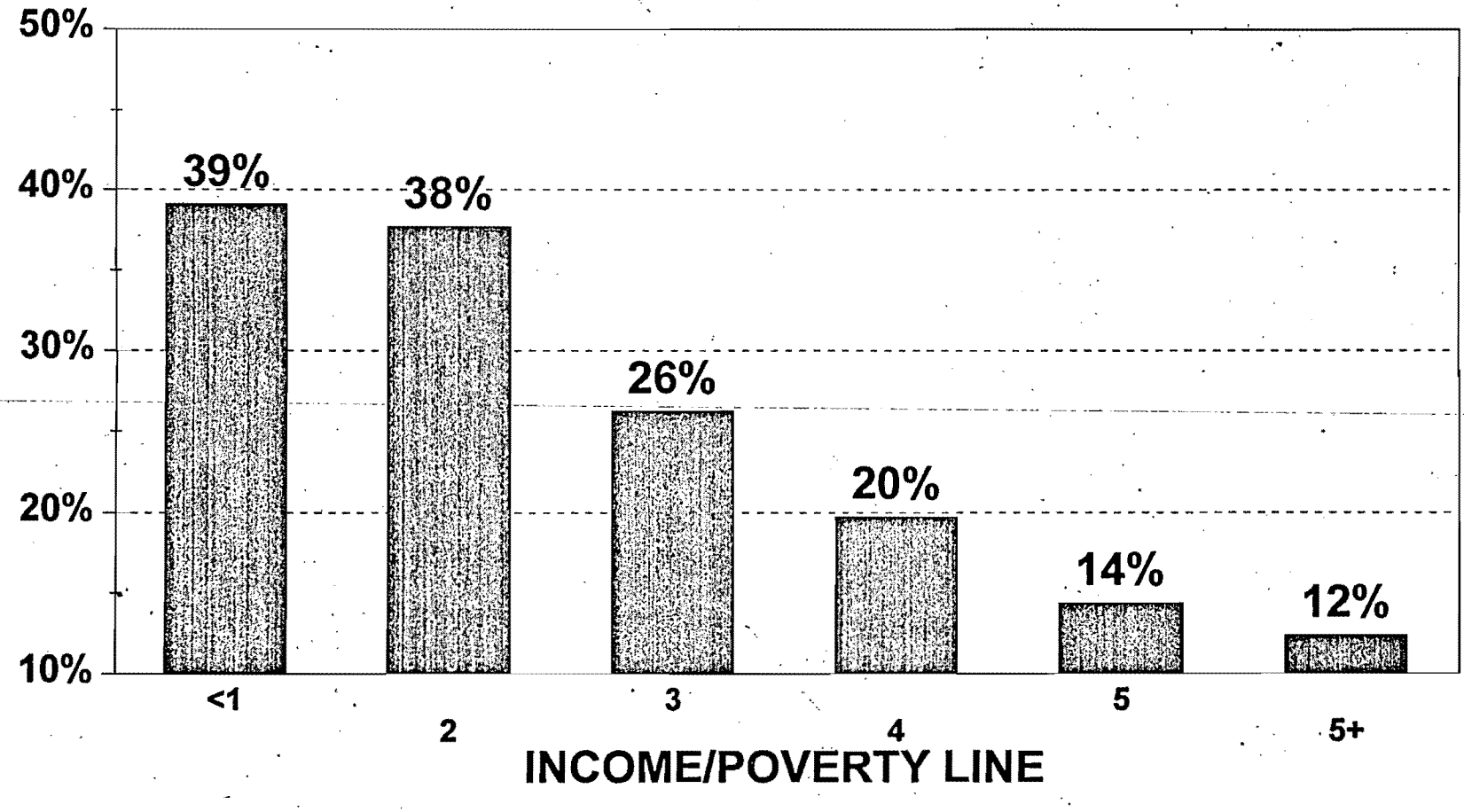
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY .

Percent Uninsured by Poverty Class (18-24 Year Olds Only)

- 39% of those below poverty are uninsured.
- This percentage drops as income rises until 12% are uninsured at 5 times or more of the poverty line..

% UNINSURED BY POVERTY CLASS
MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



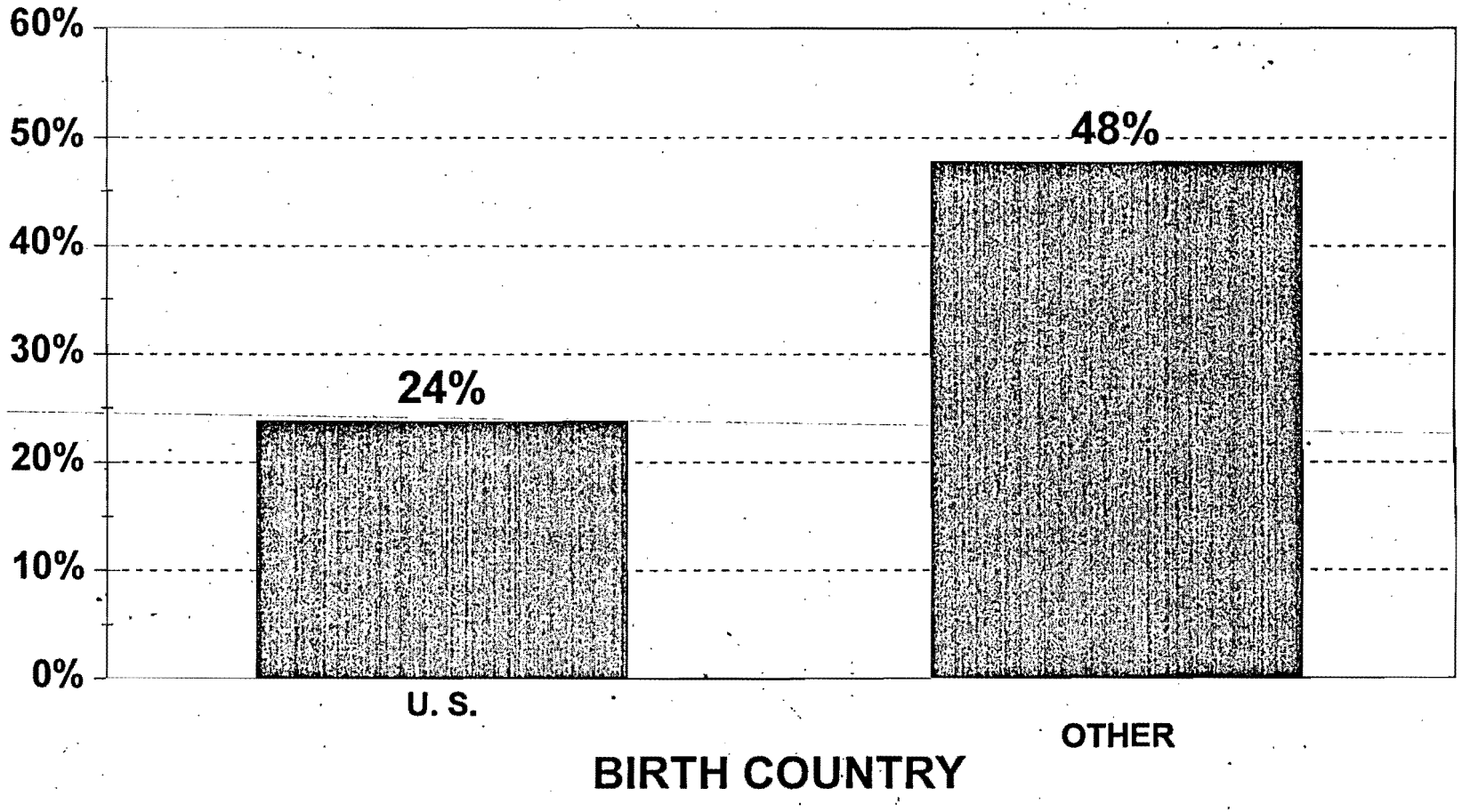
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

Percent Uninsured by Country of Birth (18-24 Year Olds Only)

- For the uninsured, the gap between those born in the U.S. vs. those born in other nations is even wider than it is for the entire population: 48% vs. 24% compared with 31% vs 13% for the population as a whole.

% UNINSURED BY COUNTRY OF BIRTH
MARCH 1995 CURRENT POPULATION SURVEY

18-24 YEAR OLDS ONLY



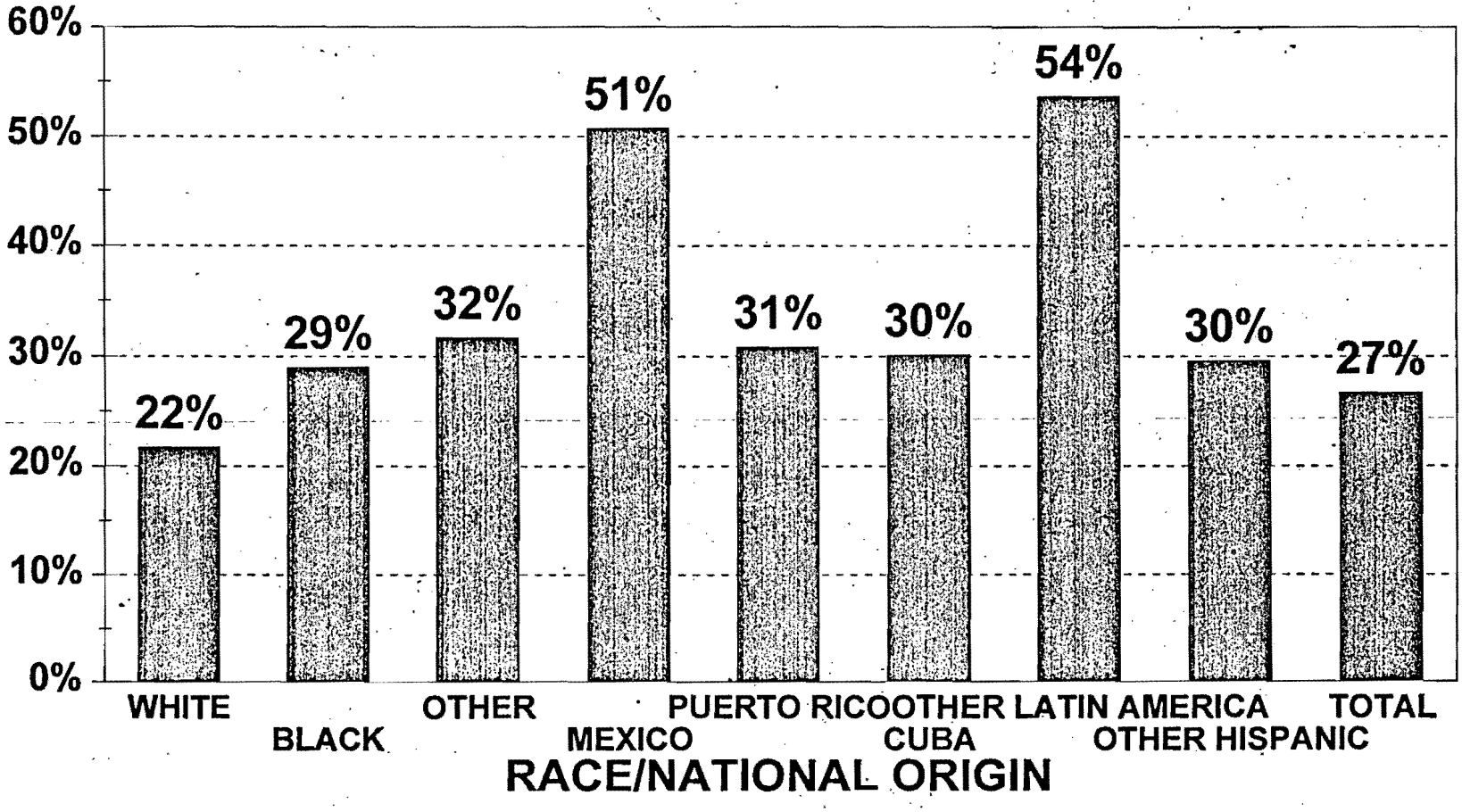
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

Percent Uninsured by Race/Origin: Aged 18-24

- More than half of young adults whose national origin is in Mexico and Other Latin American nations are uninsured.

% UNINSURED BY RACE/ORIGIN: AGED 18-24

MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY .
HISPANICS OF ANY RACE ARE COUNTED AS HISPANICS.

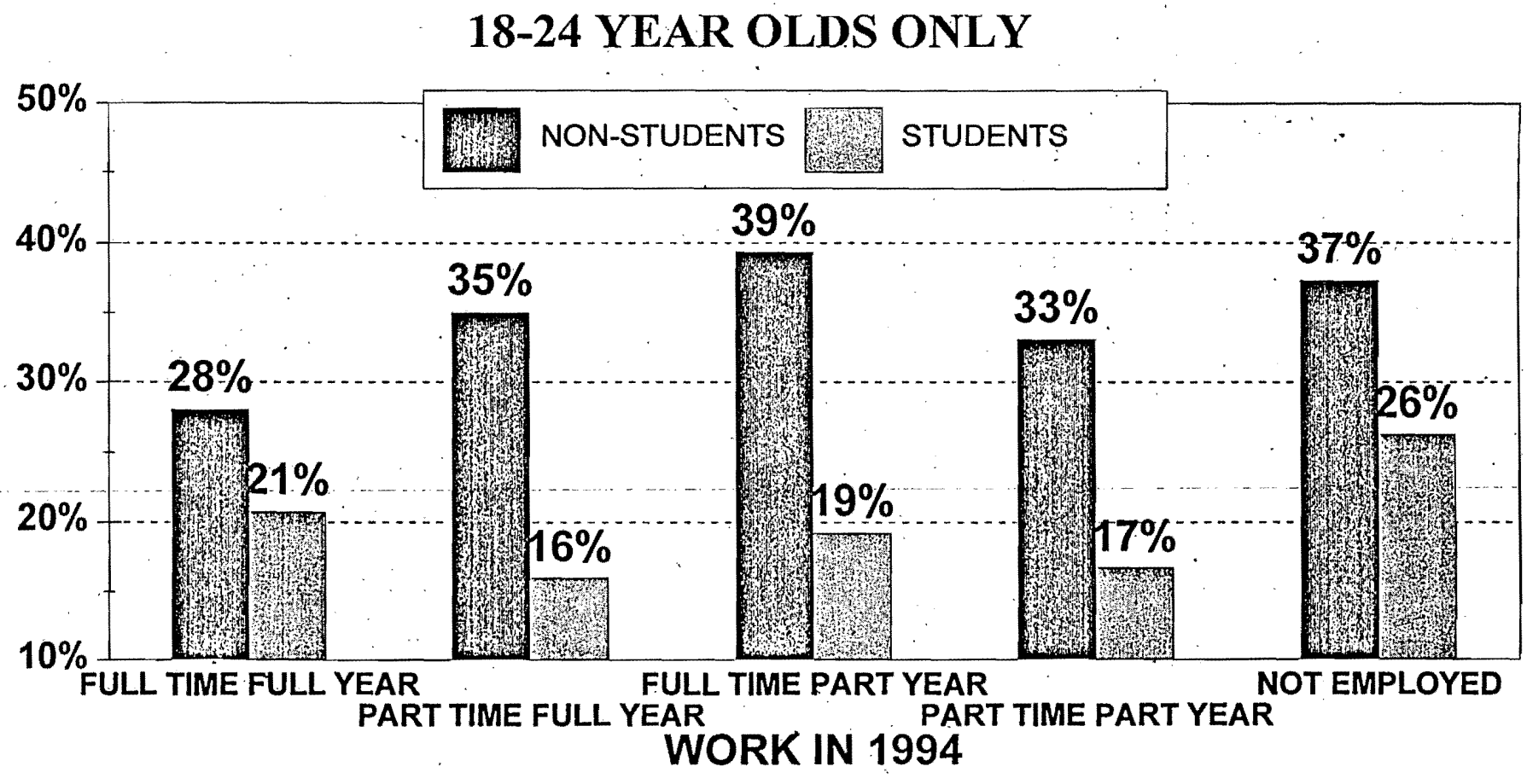
Percent Uninsured by Work and Student Status (18-24 Year Olds Only)

- This chart shows the percent without health insurance for various types of work status. For each, we show those whose predominant activity was work compared with those who were in school.

- In each case, the students were **less** likely to be **un**insured.

- Among those not in school, those who work full-time for the full year were least likely to be uninsured.

% UNINSURED BY WORK AND STUDENT STATUS
MARCH 1995 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

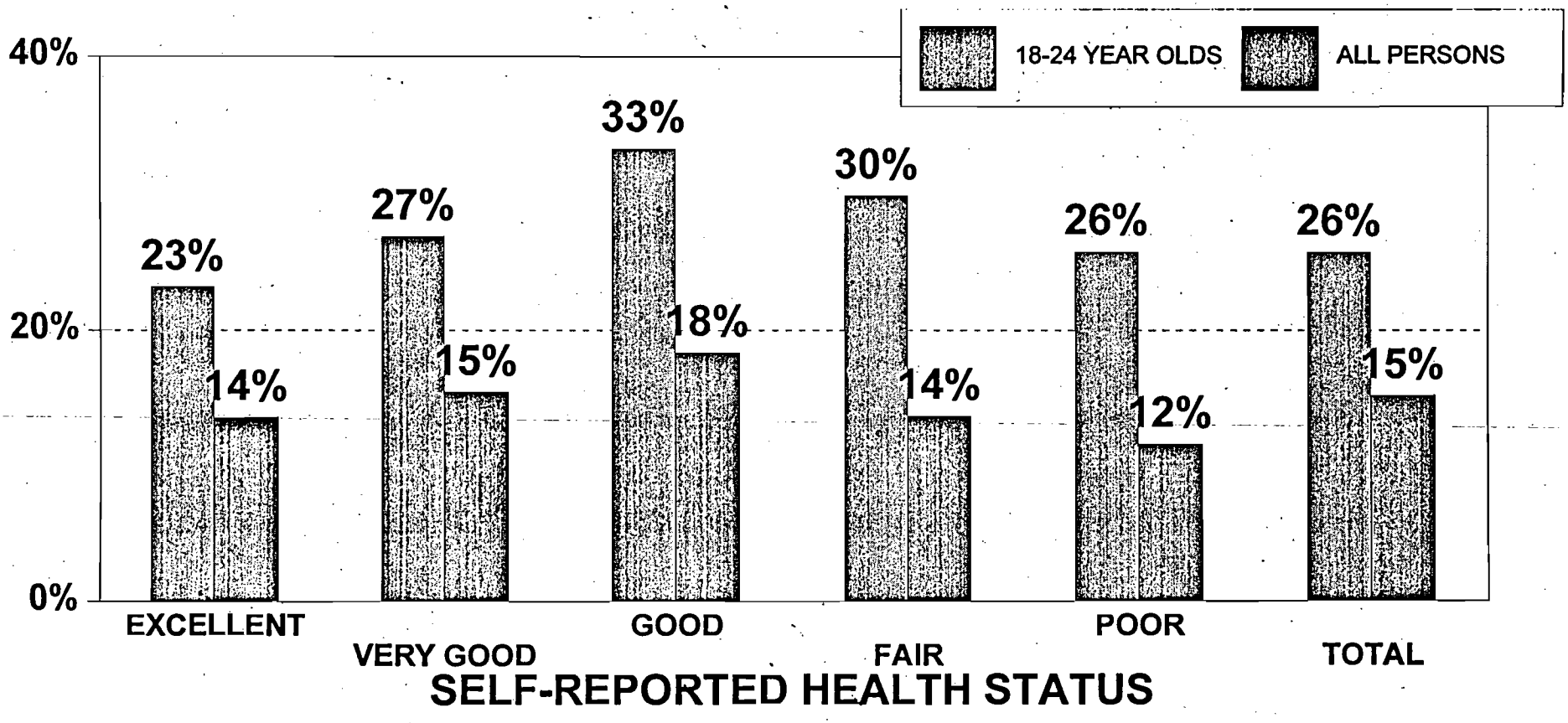
Percent Uninsured by Health Status (18-24 Year Olds and All Persons)

- This chart has both the total population and 18-24 year olds on it. 18-24 year olds are the bar to the left in each set.

- Again, health status is basically uncorrelated with having or not having health insurance.

% UNINSURED BY HEALTH STATUS

MARCH 1995 CURRENT POPULATION SURVEY



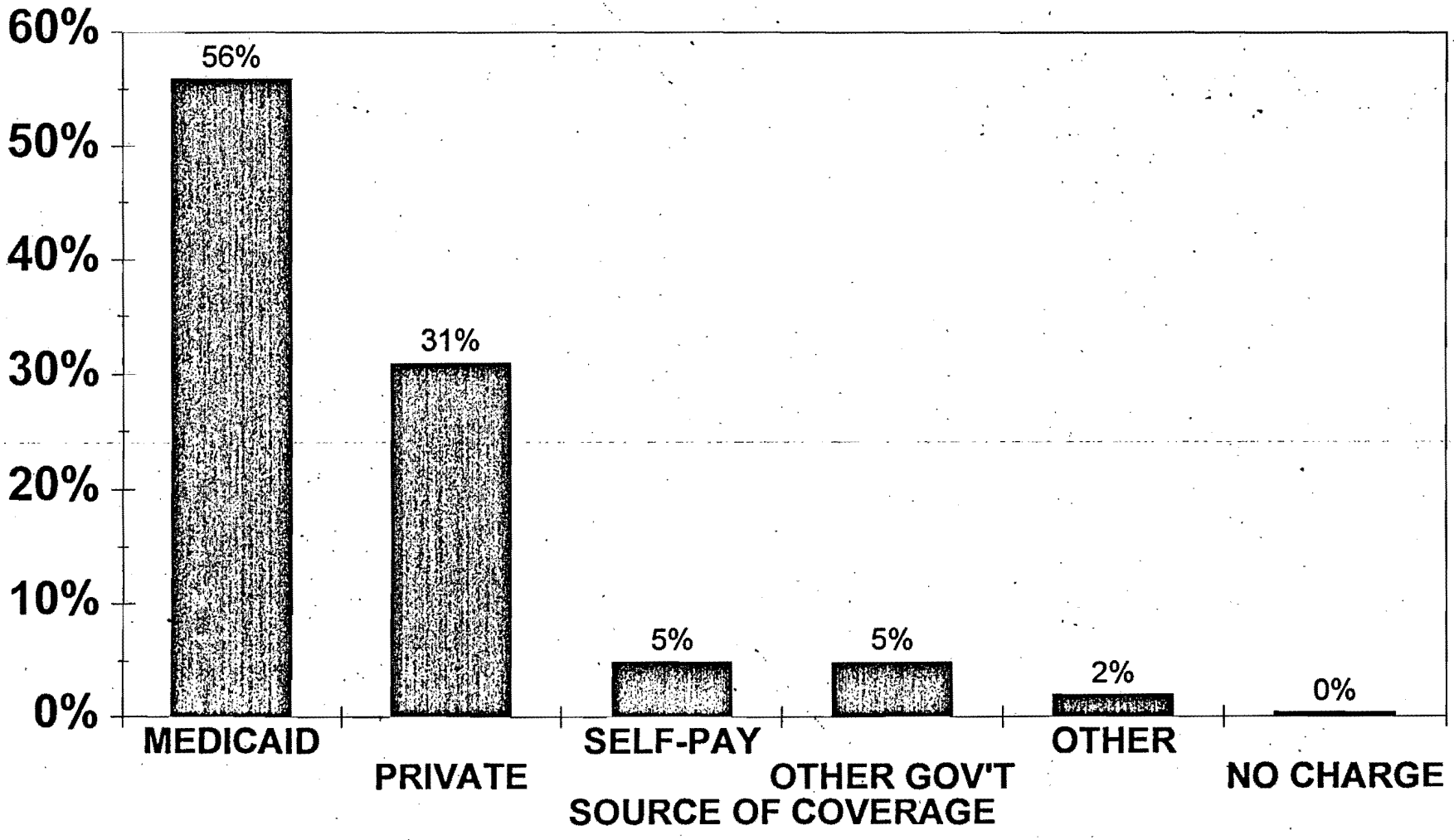
SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY.

Source of Coverage for Hospital Births (18-24 Years Old Only)

- Young women in this age group are more likely to bear children. However, most of the births are insured.
- Medicaid pays for 56% of all births in this age cohort, followed by 31% for private insurance.

SOURCE OF COVERAGE FOR HOSPITAL BIRTHS

18-24 YEARS OLD ONLY



SOURCE: NATIONAL HOSPITAL DISCHARGE SURVEY

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This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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May 30, 1996

TO: Ashley Files
Karen Pollitz

FROM: John Spiegel

SUBJECT: Materials to be cleared by OMB and the White House

The materials on the Republican Medicaid bill are ready for White House and OMB review and clearance. The documents listed in the Overview Materials section have either been sent to OMB and the White House for review (item A), or they have already been released by the White House (items B and C). Earlier today, I gave you copies of the side-by-side, section IV, which has been cleared for OMB and White House review. The documents in sections II and III, with the exceptions noted below, are now ready for OMB and White House review, and are attached for transmittal.

The following items are not included in the package because they are not yet cleared within the Department:

-- Welfare/Medicaid
-- State Employees and Increased Federal Medicaid Payments

If you have any questions please let me know.

MEDICAID ISSUES AND MATERIALS

I. Overview Materials

A. Administration summary of problems--(*THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S PRINCIPLES FOR MEDICAID REFORM)*

B. Democratic Governors problems--(*THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT--NOT BIPARTISAN NGA AGREEMENT)*--one pager from White House

C. Congressional problems--(*REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE*)--one pager from White House

II. Detailed problems: Administration perspective

A. Guarantee

1. Eligibility
   a. Children
   b. Definition of disability (including language on DA/A)
   c. Welfare/Medicaid

2. Benefits
   a. ADS, comparability, and statewideness
   b. EPSDT
   c. Cost Sharing/Family Protections ("balance billing" issues)
   d. Transfer of Assets/ Estate Recoveries
   e. VFC

3. Right of Action/Enforcement

B. Fiscal Accountability: Summary
1. Funding Formula
2. DSH
3. Donations and taxes
4. FMAP
5. Payer of last resort
6. Retaining Title XIX

C. Managed Care Quality

III. Cross cutting issues
A. Children
B. Disability
C. Accountability
D. Nursing Homes
E. Immigrants
F. American Indians

IV. Side-by-side comparison of Medicaid Plans

ELIGIBILITY OF CHILDREN

Summary: The 5/21 Republican bill would stop the phase-in of coverage for "Waxman kids" at its 1996 level, which is age 12.

- **"Waxman kids" -- children between ages 13 and 18 in families with incomes below 100% of poverty will not be guaranteed eligibility for Medicaid coverage under the Republican bill.**
- **In addition, children who are now covered would lose Medicaid eligibility once they turn 13 unless States decide to cover this population as an optional group.**

Current Law

In 1990, Congress expanded Medicaid eligibility for children under 100 percent of the federal poverty line. All children born after September 30, 1983 would have Medicaid coverage phased-in year by year, so that by 2002 all poor children under the age 19 would be eligible for Medicaid coverage.

In 1996, low-income children age 12 were phased-in for Medicaid coverage.

5/21 Republican Proposal

Guaranteed Medicaid eligibility for children ages 13-18 with family incomes below 100% FPL is eliminated. States will not be required to provide Medicaid coverage to this population. States could chose to cover these children as an optional eligibility group.

If the Republican proposal is enacted up to 2.5 million children ages 13-18 will lose the guarantee of Medicaid eligibility and perhaps their coverage, depending on state decisions.

Covering Children is a Wise Investment

Medicaid coverage for 13 to 18 year olds is important to ensure that this population carries its good health status into adulthood. Medicaid services for this population are predominately preventive health services provided through the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) under Medicaid. Periodic health exams and screens under EPSDT assist in the early detection and treatment of disease.

Medicaid expenditures for periodic screening and diagnosis of this population are small in comparison to service expenditures for other Medicaid populations -- however, they are an investment in the health of this population as they enter adulthood.

To protect the health of poor children, the phase-in of coverage should be maintained.

DEFINITION OF DISABILITY

Current Law

Generally, people who meet the federal SSI standards for disability are entitled to Medicaid coverage. States have the option to use the Medicaid disability definition they used prior to 1972; eleven states have elected this "209(b)" option, with four limiting eligibility to people over age 18, three using a more restrictive disability definition, and nine using more restrictive income and asset standards.

May 21 Republican Proposal

The May 21 Republican proposal would allow each state to either continue to use the SSI definition of disability or to develop its own disability definition for Medicaid eligibility. In the first year, the umbrella fund would be available for the disabled population in cases where the state opted to continue to use the SSI definition; if the state were to develop its own definition, the umbrella fund could not be tapped. The May 21 Republican proposal would also require states choosing to use their own disability definition to set aside 90% of 1995 spending on the disabled to be used exclusively to serve the post-reform disabled population.

Concerns Raised by May 21 Republican Proposal

People with disabilities use proportionately more acute and long-term care services than people without disabilities. According to the 1990 Survey of Income and Program Participation (SIPP), people with disabilities were almost five times more likely to be in fair or poor health than the general population. **Medicaid coverage is a critical link for this population.** The May 21 Republican proposal to offer states more flexibility in defining disability for Medicaid eligibility purposes raises several concerns.

- **It is possible that states will use this new flexibility to cut back on the number of people with disabilities who receive Medicaid coverage.** Balancing the state budget on the backs of people with disabilities, essentially redefining them as the "undeserving poor" could be devastating.

- **Depending on state policies regarding the coverage of uncompensated care, it is possible that cutting the number of people with disabilities eligible for Medicaid could be costly to states.** States might have to absorb the full cost of long-term and acute/primary health care for people who are no longer eligible for Medicaid.

- **Decoupling Medicaid eligibility determination from SSI eligibility reduces access to and utilization of Medicaid services.** States would have the option to decouple SSI and Medicaid eligibility. Research shows that doing so reduces health and long-term care access for individuals with disabilities.

    - If the goal is to restrict SSI access, and thus Medicaid eligibility, it is more direct

to change the federal SSI definition. For example, in the recent case of drug addicts and alcoholics, the Administration and Congress supported restricting SSI access and a provision was included in H.R. 3136, which the President signed into law on March 29. If there are other problems in the federal disability definition, it makes infinitely more sense to fix the federal definition, rather than risk the problems engendered by authorizing 50 new definitions.

- **The incentives increase for states to shift personal care and home health expenditures to the Medicare program.** Under current policy, states have a strong incentive to bill Medicare for home health and personal care services provided to dual eligibles (people who are eligible for both Medicare and Medicaid). If Medicare pays, the costs are covered by the federal government; under Medicaid, states have to pay their share. Under the May 21 Republican proposal, with limited funds available for services for people with disabilities, the motivation for states to shift these costs to Medicare becomes even more compelling.

AMOUNT, DURATION, AND SCOPE LIMITS (ADS)
COMPARABILITY AND STATEWIDENESS

Summary: The 5/21 Republican bill language requires states to cover a minimum mandatory package of benefits. However, the bill repeals current law protections (comparability and statewideness requirements) by giving states flexibility to define amount, duration, and scope of benefits as narrowly as they choose, to offer different benefit packages to different State-defined groups, and to vary the benefit package among localities. The bill does not appear to allow the Secretary to disapprove state plans that impose unreasonable restrictions on the amount, duration, and scope of benefits offered.

Current Law:

States must cover a minimum package of services and may cover a range of optional services. They have the flexibility to establish reasonable limits on amount, duration, and scope of both mandatory and optional services so long as these statutory requirements are met:

- Services must be sufficient to reasonably achieve their purpose.
- States may not restrict amount, duration, or scope of mandatory services solely because of diagnosis, type of illness, or other conditions.
- Children get all services, regardless of general limits on amount, duration, and scope, for treatment of conditions detected by a childhood screening.
- Comparability: Services, with or without State-defined limits, must generally offer the same benefit package to all groups that States are required to cover, as well as certain optional groups with similar characteristics. Exceptions: certain mandatory groups (higher income pregnant women, certain Medicare beneficiaries) may get less.
- Statewideness: benefits and services are to be offered statewide.

This means that:

- States cannot provide a richer benefit package to more politically powerful groups, for example, more services to the elderly than to children.
- States cannot arbitrarily deny or reduce amount, duration, or scope of services in the mandatory minimum benefit package.
- States may impose durational limits on services, for example, across-the-board ceilings of, say, twelve physician visits or 14 hospital days per year.
    - Absolute numerical limits are approvable only if the state demonstrates that the needs of most beneficiaries will be met despite the limit. Where a state imposes an

across-the-board limit, services beyond the limit are not covered, even if medically necessary.

- States may use numerical limits as an administrative device to trigger medical review and limit payment for subsequent services to those determined to be medically necessary.

- States have the flexibility to limit payments for specific hospital stays or other kinds of services to:

  - those that are medically necessary and/or not experimental under utilization control/prior authorization programs,

  - those that are not experimental and are of proven effectiveness, and

  - a predetermined payment amount based on average length of stay or other presumption.

The May 21 Republican Bill:

The May 21 bill would allow complete state flexibility to determine limits on amount, duration, and scope of benefits. Benefits would no longer have to be sufficient nor comparable across eligibility groups or in all areas of the state. Federal review of the sufficiency of benefits to meet the needs of Medicaid beneficiaries would be eliminated.

This means that:

- Benefit packages for the elderly, or other favored or politically powerful groups could be more generous than children's benefits, for example, unlimited drug prescriptions for the elderly but an absolute limit of two per month for children, even for sick children whose health needs require more than two prescriptions per month.

- Benefits could vary for individuals within an eligibility group, for example, by diagnosis, based on political assessments that some diseases are more deserving of public funding than others.

- Benefit packages could be limited arbitrarily, unlike under current law, which prohibits arbitrary limits for mandatory services. States could adapt to budget pressures by across-the-board cuts below the level needed to meet the needs of the majority of Medicaid beneficiaries.

- Persons most affected would be those with the greatest need.

- In the extreme case, without the requirement for service levels to be sufficient, State-defined limits could render the proposed "guarantees" of mandatory services meaningless. In theory, for example, they could provide only one hospital day or one physician visit per year.

- A state could peg the relative generosity of the benefit package in a county or city to the level of financial support provided by that jurisdiction. Thus the poorest areas -- those with arguably the greatest need -- could have the most limited benefit packages and get the smallest share of Federal funds coming into the State.

EPSDT

(Early Periodic, Screening, Diagnosis, and Treatment Program)

Summary: The current Medicaid Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program provides universal, comprehensive medical services for early detection and treatment of illnesses and health conditions in children before they become serious and disabling.

The 5/21 Republican bill language drastically reduces the treatment requirement for illnesses and conditions discovered during an EPSDT visit. Under this proposal, treatment is required only for vision, hearing and dental health problems discovered during an EPSDT screen. While periodic health screens and exams are required, there is no requirement that illnesses and conditions discovered during the screen or exam be treated.

Current Law

Under current law, the EPSDT benefit package consists of all Medicaid services, mandatory and optional, ranging from preventive care services to inpatient hospital services.

States are required to cover all medically necessary treatment for Medicaid children -- regardless of whether the medical treatment is otherwise covered under the state Medicaid plan for adults.

States' Concerns are Unfounded

States have expressed concern that the requirement to provide all medically necessary treatment even when the treatment is not part of the state Medicaid plan is resulting in uncontrolled Medicaid expenditures and strained state budgets. However, an American Public Welfare Association (APWA) survey of states shows that State spending on services outside of the regular Medicaid benefit package for most States accounted for less than one half of one percent of total Medicaid spending.

States have also expressed concern that if challenged in court, they could be forced to provide EPSDT treatment services to adults due to benefit comparability requirements (i.e., Medicaid services should be the same for all beneficiaries.)

- Under current law, states are not mandated to provide services required by EPSDT to adults.

Administration Position

- The Administration believes that the Medicaid program should financially support the medical services necessary to correct health problems discovered among Medicaid children. Any modifications to the current treatment requirement under EPSDT would undermine this.

- The Administration, however, also recognizes that states are coping with budget problems. The Administration supports two potential actions which could assist states in confronting budget constraint.

    - The Administration's Medicaid and Welfare proposals would tighten the definition of disability by eliminating cash benefits, and therefore Medicaid eligibility, for individuals with certain behavioral disorders (e.g., drug addicts and alcoholics, children with maladaptive behaviors.)

    - Strengthening the law related to the present policy that if a State covers additional treatment services for children because of the EPSDT requirement, it is not mandated to provide those additional services for adults.

BENEFICIARY COST-SHARING
FAMILY PROTECTIONS

Summary: **The 5/21 Republican bill grants states broad discretion to impose cost-sharing requirements upon Medicaid beneficiaries. It imposes minimal cost-sharing limits only for certain services to children and pregnant women below poverty, leaving other women, children, and most disabled and elderly fully exposed to potentially serious financial consequences. While it also retains current law provisions aimed to protect spouses and other relatives of nursing home patients from excessive liability for the cost of care, loss of the more general cost sharing protections significantly minimizes these protections. For example, nursing home residents who have spent down their income to become eligible for Medicaid could be charged any level of cost-sharing. In addition, services could be reduced from the nursing home benefit resulting in the spouses or children on nursing home residents being forced to pay to ensure continuing coverage. Furthermore, states could charge elderly or disabled persons any level of premium, which could be set so high as to effectively exclude them from the program.**

Finally, states could for the first time require adult children of Medicaid beneficiaries to contribute to the cost of their care, except for long-term care.

Current Law

A state may not impose coinsurance, copayments or deductibles for any of the following services or individuals: all services for children, family planning, pregnancy related services, emergency services, hospice, in-patient services for spend-down eligibles, and services to the categorically needy who are enrolled in an HMO. A state may impose nominal charges upon other services. In addition, states may not impose premiums, enrollment fees, or similar charges upon categorically needy Medicaid beneficiaries (e.g., AFDC, SSI).

Current Law Copayment Schedule Where Copayments are Allowed	
State Payment for Service	**Maximum Copayment**
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00
Institutional Services	No more than 50% of the State's payment for the first day of care

Families are protected in several ways: The law protects income and assets of a couple to prevent the impoverishment of the spouse in the community when the other spouse is institutionalized. The law prohibits states from holding relatives financially responsible for a Medicaid beneficiary unless the beneficiary is the person's spouse or dependent child. Families are further protected by assurances of the adequacy of the Medicaid benefit and the prohibitions against balance billing by providers.

May 21 Republican Bill:

Cost-sharing: The only Federal restriction on states is a prohibition against cost-sharing in greater than nominal amounts on primary and preventive care services for pregnant women or children in families with income below 100% of the Federal Poverty Level. The elderly and disabled, as well as pregnant women, and children above poverty, would be subject entirely to state discretion on cost sharing, as would other kinds of services to women and children below poverty.

Family protections: Current law provisions on spousal impoverishment are retained. States would be prohibited from requiring adult children to contribute to the cost of long-term care, but not other kinds of services. However, the loss of other protections (e.g., that the scope of benefits be sufficient) exposes families and beneficiaries to the risk of having to pay for care that is no longer considered to be part of the nursing home benefit.

This means that:

- Under current law, pregnant women cannot be charged any copayment for a pregnancy-related service. But under the May 21 Republican bill, pregnant women could be charged nominal copayments for prenatal care visits and any level of cost sharing for emergency care or necessary surgery. Using the Standard Blue Cross Plan under the Federal Employees Health Benefits Plan (FEHBP) as a model, a pregnant woman could pay a $200 deductible and an extra $250 in deductibles for hospitalizations. Once the deductibles are paid, the Standard Blue Cross Plan imposes 25 percent coinsurance charges.

- Under current law, children cannot be charged any copayments for any service. But under the May 21 Republican bill, they could be charged nominal copayments for immunizations and EPSDT screenings, and they could be charged any level of copayment for emergency services or necessary surgery. Using the FEHBP Blue Cross Plan as a model, children could pay the same $200 in deductibles with an extra $250 deductible for hospitalizations. Once deductibles are met, the Standard Blue Cross Plan imposes 25 percent coinsurance charges.

- Under current law, nursing home residents who spend down their income to become Medicaid eligible cannot not be charged any copayment for any service. But under the May 21 Republican bill, they could be charged any level of copayments, deductibles, and premiums for any services. This would allow nursing homes to exclude Medicaid

recipients who could not afford the cost sharing out-of-pocket or who could not get the money from a spouse or other relative. Thus, cost-sharing policies could significantly reduce the spousal impoverishment and family member protections contained in the bill because the families would be forced to pay all of the nursing home resident's cost sharing or have their vulnerable family member not receive nursing home services.

- Under current law, disabled individuals may only be charged nominal copayments as shown in the schedule above. But under the May 21 Republican bill, disabled individuals could be charged any level of copayments and deductibles for any services, even those necessary to treat their disabilities. For example, under the Standard Blue Cross Plan of the FEHBP, these disabled people could face $200 deductibles, and then face 25 percent coinsurance charges.

- Under current law, most disabled individuals may not be charged any premium or enrollment fees. But under the May 21 Republican bill, all disabled individuals could be charged any level of premium or enrollment fees. These people could be effectively excluded from the Medicaid program if premium levels were overly burdensome. For example, the Standard Blue Cross FEHBP plan imposes premiums on enrollees of $560 per year.

- Under current law, adult children cannot be required by the States to pay for the cost of their parents care under Medicaid. While the 5/21 Republican bill retains this protection for long-term care, it does not retain it for acute care. That means that where an elderly Medicaid beneficiary is hospitalized for expensive treatment, the State Medicaid program could hold that individual's children liable for some of the cost of care.

This kind of cost sharing on the most vulnerable low income, disabled, and elderly populations could severely reduce access to the most basic and necessary health care services. Such cost sharing could nullify the "guarantee" of Medicaid coverage for these populations.

TRANSFER OF ASSETS/ESTATE RECOVERIES

Summary: **The 5/21 Republican bill repeals all current law protections and policies relating to the transfer of assets and estate recoveries. Depending on how states choose to draft their own provisions relating to these issues, a person's innocent actions could leave them with neither personal funds nor Medicaid coverage to cover the costs of care. Also, transfer penalties and estate recoveries could be applied to all Medicaid beneficiaries, not just limited groups as under current law.**

The 5/21 Republican bill retains current law limitations on liens on real property of Medicaid beneficiaries.

Current law:

- States must:
  - deny coverage for certain long-term care benefits for persons who transfer substantial assets for less than fair market value, and
  - recover from the estates of deceased beneficiaries who were age 55 or older when they received long-term care benefits.
- States may impose liens on the real property of certain permanently institutionalized beneficiaries of any age while they are alive.
- Beneficiary and family protections include:
  - No liens on real property nor recoveries from estates of deceased beneficiaries so long as there is a surviving spouse or minor or disabled child, or, in the case of liens, certain surviving siblings living in the home.
  - Look-back period for asset transfers is time-limited (36 months).
  - Individuals who gave away assets for some other purpose (e.g., yearly gifts to grandchildren or others) have the right to show that was the case and avoid the penalties applied to those who artificially impoverish themselves for Medicaid purposes.
  - States must not impose coverage penalties for asset transfers or recover from beneficiaries' estates if doing so would cause undue hardship.

5/21 Republican Proposal:

All current law requirements, limitations, and protections relating to the transfer of assets and estate recoveries would be repealed.

The May 21 Republican bill retains current law limitations on liens on real property of Medicaid beneficiaries.

Implications:

Implications depend on state decisions. States could be as generous or restrictive as they wish. States could apply more restrictive policies as a means to reduce Medicaid spending. Alternatively, they could, at the extreme, permit unlimited asset transfers and/or not recover from any estates.

- For individuals and families: Federal guarantees of beneficiary and family protections for asset transfers and estate recoveries (described above) are limited or eliminated. If States choose to be more restrictive than under current law, innocent actions could leave people with neither personal funds nor Medicaid to cover the costs of long-term care.
  - A state might deny all benefits to people who had given away an asset at any time in the past, for any purpose, even one not related to Medicaid eligibility, e.g., to help pay for a grandchild's college education, or to help a son or daughter purchase their first home.
  - A state could decide to recover from a person's estate even if the person's spouse was still alive. This could result in survivors having to sell their house to satisfy the state's claim against the estate.
- For states: Without specific federal authority, states would likely have to consider all of their policies in these areas de novo. Given the controversial and highly political content, States could face legislative gridlock. If state laws were passed, litigation would ensue, leading to uncertain outcomes as compared to current law.
- For spending: In states where authority to withhold benefits to artificially "poor" people or to recover from estates is either compromised or non-existent, Medicaid spending would increase for this asset-rich Medicaid subpopulation and their heirs. Since federal funds would be limited, increased spending for this group would be either at the expense of children and others who are genuinely impoverished, or, less likely, states could finance the increases with state-only money.

VACCINES FOR CHILDREN PROGRAM

Summary: The 5/21 Republican bill language repeals the Vaccines For Children Program. The Vaccines for Children Program was established in OBRA '90 to eliminate cost and delivery system barriers low income parents encounter when immunizing their children. It is widely supported by the Nation's Governors, the American Academy of Pediatrics, and State officials.

Background

The Vaccines for Children program (VFC) is an integral part of the Administration's comprehensive immunization initiative involving both public and private providers to increase vaccination levels for two-year-old children.

- The Administration's year 2000 immunization objective is to fully immunize at least 90 percent of two-year-old children with the recommended series of vaccine.

- Immunization rates are at the highest level ever recorded for the recommended series of vaccines including measles, mumps, rubella, diphtheria, pertussis, tetanus, and polio at 75% for two year olds.

The VFC program eliminates a cost barrier faced by Medicaid providers and low-income parents by supplying participating providers with vaccine purchased at a reduced federal price.

- Before VFC, Medicaid had to pay private sector vaccine prices (approximately $280 for the total series of vaccines) instead of the reduced federal contract price (approximately $130.)

- The high cost of vaccine coupled with the limited Medicaid reimbursement rates for immunization provided an economic disincentive for Medicaid providers to provide vaccines. As a result, the continuum of care for beneficiaries was disrupted as providers referred Medicaid beneficiaries to public health clinics for vaccines.

The shift from private prices to the reduced federal vaccine price saves millions of taxpayer dollars.

- California estimates that purchasing vaccines at the reduced federal price saves $40 million a year.

Impact of 5/21 Republican bill:

Repealing the Vaccines for Children program will remove an effective State tool for acquiring and distributing childhood vaccine.

- The VFC program operates in all states and has significant provider enrollment -- well over 39,000 provider sites.

- Through the VFC program all states are providing vaccine to public providers enrolled in the program, and all but a few states are distributing VFC vaccine to private providers.

- States have used the savings affiliated with the VFC program to extend the immunization program to uninsured groups.

The Republican bill would eliminate vaccine purchase contract authority for the Federal government and the States under Section 1928(d)

- The Centers for Disease Control and Prevention currently uses the VFC contract authority for all its vaccine purchases; elimination of this authority would stop the availability of vaccine in doctors' offices and public health clinics.

- States could no longer purchase additional vaccine with state funds for groups not otherwise VFC eligible; State costs would increase significantly or fewer children would be immunized.

Repeal of the VFC program would threaten our continued achievement of high immunization rates.

- The VFC program ensures that children have access to the newest disease preventing vaccines when they are approved and recommended.

- The VFC program was established to improve vaccine rates among two-year-olds: Almost 1.4 million children (25%) 19-35 months of age -- lack one or more of the recommended immunization doses.

RIGHT OF ACTION

Summary: **The May 21 Republican bill would eliminate the right of Medicaid beneficiaries to sue in federal court to enforce their federal entitlement. Beneficiaries could only sue in state courts, and could only appeal to the U.S. Supreme Court once all State appeals were exhausted, which could lead to inconsistent judicial interpretations of Medicaid law across the nation. In addition, Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation. Any federal guarantee to Medicaid coverage means that beneficiaries must have the ability to enforce their rights in federal court.**

Background

The purpose of the Medicaid program is to provide health care benefits to America's most needy citizens. Medicaid was created by the Congress as a federal-state program of basic minimum requirements and shared responsibility for funding. The federal share of Medicaid financing is over $100 billion per year. The ability of certain low income Americans to receive needed health care benefits through Medicaid is currently protected by the federal courts so that individuals in this program receive the same due process rights everywhere in the United States. Simply put, in order for American citizens to be able to receive health care services to which they are entitled, there must be a mechanism to enforce the provisions enacted by Congress. Anything less than a remedy in federal court would not guarantee uniform access to intended benefits.

The May 21 Republican bill

The May 21 Republican bill would require only that states provide a state right of action for individuals. There are a number of reasons why this approach is not acceptable.

- Medicaid would be the a federal program without a possibility of federal enforcement for those seeking remedy for non-provision of services. Other programs created under federal statutes -- ranging from Social Security to subsidies for beehive farmers -- would be enforceable in the federal courts, but Medicaid would not.

- Elements of Medicaid that are common to all states should be interpreted in ways that assure consistency--including situations where Medicaid interacts with other federal programs such as Social Security or Medicare. To achieve such consistency, a federal right of action must be available.

Administration Proposal

The President's plan for Medicaid reform retains clearly the right of individuals to seek relief in federal court. Further, the Administration's plan would repeal the Boren amendment, thereby eliminating the cause for suits brought by providers against states about payment rates. Since experience indicates that provider litigation is easily the largest cause of action in this area, additional revision that would restrict individual's rights would be unnecessary.

ASMB - NEW

Medicaid Financing Provisions in 5/21 Republican Bill Mirror Medigrant - - Not Governor's Agreement

Description

Under the May 21 Republican bill, the current Medicaid federal/state financial partnership will end, and will be replaced by a funding program similar to that seen under the Medigrant proposal. Federal Medicaid funding will be provided through block grants which are embellished by a very limited umbrella fund for enrollment growth. The bill also changes the concept and purpose of the FMAP while raising the minimum FMAP from 50 percent to 60 percent and allows states to generate Federal matching dollars through the use of provider taxes and donations.

Issues

* The funding formula described in the over 40 pages of legislative language in the Republican bill is still a Medigrant II style block grant.

* The formula is not based on program need and it is not linked to enrollment growth. About 97 percent of the funding is a fixed block grant to states. Amounts that states receive would be dictated by "floors" and "ceilings," and an adjustment factor designed to assure that Federal payments do not exceed the amounts actually written into the Republican legislation.

* The umbrella does not provide adequate protection from enrollment growth. The umbrella consists of only about 3 percent of total projected program spending, and covers increases in enrollment only for the year of the increase--NOT OVER TIME.

* Historically, the FMAP has been a formula for determining the amount that the Federal government would match actual state Medicaid expenditures. Under this bill, the FMAP is only used for calculating the State share necessary for drawing the capped Federal needs-based amount. States could reduce their own State spending by just enough to draw down the entire Federal needs-based amount.

* The lower State contributions required under the bill may result in lower State support for the Medicaid program. That means States could reduce spending by about $179 billion (about 29 percent) over the next seven years, solely as a result of the FMAP change.

* States could use taxes and donations to finance a significant percentage of the State share without contributing any real state dollars. This could also result in substantially lower overall support for the Medicaid program.

FUNDING FORMULA

Summary: **Under the May 21 Republican bill, the current Medicaid federal/state financial partnership will end, and will be replaced by a funding program similar to that seen under the Medigrant proposal. All but three percent of Federal Medicaid funding will be provided through block grants that are not directly tied to growth. Therefore, states that experience high enrollment growth could be forced to either increase spending without Federal assistance or cut enrollment and benefits.**

- **The funding formula described in the over 40 pages of legislative language in the Republican bill is still a Medigrant II style block grant.**

- **The formula is not based on program need and it is not linked to enrollment growth. About 97 percent of the funding is a fixed block grant to states. Amounts that states receive would be dictated by "floors" and "ceilings," and an adjustment factor designed to assure that Federal payments do not exceed the amounts actually written into the Republican legislation.**

- **The umbrella does not provide adequate protection from enrollment growth. The umbrella consists of only about 3 percent of total projected program spending, and covers increases in enrollment only for the year of the increase--NOT OVER TIME.**

Description of the Funding Formula

Funding for states will consist of four parts: a base pool amount, an umbrella fund for excess enrollment, a pool for Indians, and a pool for undocumented aliens. The base pool amounts and umbrella fund comprise the majority of the states' Federal funding.

Base Pool

Under the base pool amount, each state will get a certain amount of funding from a Federal "pool." Annual Federal pool amounts are written into the bill, and total $797 billion over the seven year (1996-2002) period. The 1996 allotments are written into the bill, but are used only to calculate allotments for 1997, when the policy begins. For 1997-2002, state allotments are based on a "needs-based amount" that are subject to floors (minimum amounts) and ceilings (maximum amounts) and an "adjustment factor" to assure that the sum of all states' allotments does not exceed the Federal pool amount. The amount by which the Federal pool increases from year to year is called the national growth percentage.

Needs-Based Amount

The needs-based amount is a state's program need multiplied by average spending per poor person, and adjusted by the state's hospital wage index and CPI. A state's program need is calculated by multiplying the number of people in poverty in the state times two weighting factors: the weighted national average spending per beneficiary group, and the case mix

proportions (Medicaid enrollment demographics) for the state in question. The Umbrella fund and the two pools are not factored into the state's needs based amounts.

Floors

There are three "floors" or minimum base allotment amounts that substitute for the needs-based amount if it is too low. If the needs-based amount is lower than the floor, then the allotment is not determined by the needs-based amount, but is simply the previous year's allotment updated by a specified growth rate subject to the following conditions:

- In 1997 the state's allotment growth between 1996 and 1997 will not be lower than 3.5 percent. This minimum growth rate falls every year until it reaches 2 percent in 2001. It stays at 2 percent thereafter.

x

- For states whose growth from 1996 to 1997 was above 95 percent of the national growth percentage, (as defined in the statute,) they will grow at 90 percent of that national growth percentage in 1998 and subsequent years.

x

- At no time will any state's allotment fall below .24 percent of the Federal pool.

x

Ceilings

The ceiling is based on the national growth percentage. If the needs-based amount is higher than the ceiling, then the allotment is not based on the needs-based amount, but is the previous year's allotment updated by a specified growth rate subject to the following conditions:

- No state's need-based amount can grow by more than 133 percent of the national growth percentage for a fiscal year.

x

- However, beginning in 1998, states that are one of the 10 states with the lowest Federal spending per person in poverty may grow by 150 percent of the national growth percentage.

Adjustment Factor

If total state allotments exceed the Federal pool amount in a given year, an adjustment factor is applied to reduce this total (and vice versa). Floor based allotments are not subject to the adjustment factor. The adjustment factor may need to be applied over several iterations to reduce total state allotments to the Federal pool amount.

Federal Medical Assistance Percentage

Since Federal spending is determined by the base allotment formula, the Federal Medical Assistance Percentage (FMAP) no longer determines total Federal payments. The FMAP is used purely to determine how much states must spend in order to draw down their full Federal allotment under the block grant.

As in previous Medigrant legislation, states get to choose the FMAP formula they want to use. They have three options:

1. The pre-1997 FMAP
2. The lesser of the new FMAP or the pre-1997 FMAP increased by 10 percentage points
3. 60 percent

Regardless of the option chosen, the FMAP is used purely to determine how much states must spend, rather than the current practice of the Federal government using this formula to match actual state expenditures.

Umbrella Fund

The umbrella would provide Federal payments beyond the base allotment if enrollment in certain groups unexpectedly increases. Umbrella payments are calculated for each year by subtracting CPI from the growth in the state's base allotment. The growth rate that is left over is multiplied by the number of beneficiaries by enrollment groups from the previous year to get the anticipated number of beneficiaries for the current year. This number is then subtracted from the actual number of beneficiaries in that group in the year. The resulting number of "excess people" is multiplied by 1995 spending per recipient, per group, indexed to CPI and multiplied by the pre-1997 FMAP. This is done for all groups and then summed, so that savings in one group will offset spending in the others.

Indian & Undocumented Aliens Pool

The Undocumented Aliens pool is $3.5 billion over the six year period, and is allocated proportionally amongst the fifteen states with the highest number of undocumented aliens. The pool for services to facilities serving Indians is $.5 billion over the seven year period, and is allocated proportionally amongst all states that have Indian-funded health facilities or programs.

Medicaid Financing Formula Is Not Based on Program Need

The May 21 Republican Bill contains a financing formula that claims to provide funding to states based on their Medicaid program need. However, under the Republican formula, 97 percent of Federal Medicaid spending is based on a block grant which is not directly tied to actual Medicaid enrollment growth. Instead, it uses a complicated formula to allocate the fixed Federal pool to states based on historical spending and the number of poor.

The formula does not reflect the states' true financial need for their Medicaid programs because the financing mechanism is not linked to states' Medicaid enrollment growth. Although the formula contains a component entitled "program need," this factor measures the number of poor people in a given state, not the number of people actually on Medicaid. As a result, if the number of Medicaid recipients in a state increases, but the state does not experience an increase in poverty rates, the base block grant component of a state's funding would not increase.

Furthermore, the formula is subject to floors, ceilings, and an adjustment factor to keep total Medicaid spending from exceeding the Federal pool allotment written into the legislation. These constraints are so predominant that real variations in a state's Medicaid case mix and poverty

rates will not change most states' allotments. It appears that less than five state allotments per year would be determined by the needs-based formula rather than floors and ceilings over the six year period (1997-2002). Therefore, actual allotments will differ from needs based allotments 90 percent of the time.

Umbrella Does Not Provide Adequate Protection From Enrollment Growth

The May 21 Republican Bill proposes to pay for unanticipated enrollment growth in a state's Medicaid program through an umbrella fund. However, this fund fails to protect states because it only accounts for three percent of Federal Medigrant spending and only seems to cover additional recipients for the year of the increase - not over time.

A State's umbrella fund allotment is calculated by multiplying the excess number of recipients in each recipient group by the average amount spent on a recipient in each group (in 1995, indexed by CPI) and the State's old FMAP; the products for each group are then added together. The number of excess recipients in each group is determined by subtracting the anticipated number of recipients from the actual number of recipients. Anticipated recipients are estimated by taking the State's growth in their base allotment, subtracting CPI, and multiplying the growth rate difference by the number of recipients in the previous year. If states are growing by less than CPI, the minimum growth is zero.

The umbrella fund does not cover long-term enrollment growth because state umbrella payments are based on the increment of change in enrollment - not the total enrollment. As a result, States only receive a supplementary payment to help cover additional recipients in the year that enrollment increases. In subsequent years, States will have to use their base allotments to continue to cover these additional beneficiaries and this allotment will have to be divided into increasingly smaller pieces over time. Eventually, States that experience sustained, high enrollment growth will be forced to either increase state-only spending or cut enrollment and benefits.

DISPROPORTIONATE SHARE PAYMENTS (DSH) REFORM

Summary: **While DSH payments are intended to assist States with the costs of caring for low income Medicaid and Medicare patients, in reality the distribution of DSH funds is unrelated to the distribution of these patients among States. Rather the DSH distribution largely reflects the extent to which States used creative financing schemes in the late 1980s and early 1990s to make themselves eligible for these funds. The May 21 Republican bill allows these inequities in the current distribution of funds to continue and does not allow "low DSH" States to catch up. This not only rewards those States which took advantage of financing loopholes in the past, but also it means that there is less Medicaid funding available for states with large disproportionate share caseloads.**

Background

- Disproportionate Share Hospitals (DSH) serve large numbers of uninsured and Medicaid beneficiaries for whom they are not fully compensated. DSH payments became a major source of Medicaid growth in the late 1980s and early 1990s as certain States "borrowed" money from DSH hospitals, used it to generate a Federal match, and returned the borrowed funds to the hospitals in the form of increased DSH payments. Medicaid spending grew approximately 30 percent a year by 1990 and 1991; half the growth was attributable to DSH payment growth. Statutory changes ended these creative financing schemes in 1991. Today Federal DSH spending is $10 billion or about 9 percent of Federal Medicaid. DSH growth is now more stable and projected by CBO to grow at 4.3 percent a year.

- The current distribution of DSH funding is unrelated to uncompensated care caseloads. In some high DSH States (those that spend more than 12 percent of their total Medicaid funds on DSH, such as Alabama, Connecticut, Louisiana, Maine, Missouri, New Hampshire, and South Carolina), Medicaid DSH payments exceeded regular Medicaid payments for inpatient hospital services. The maldistribution in DSH funds argues for targeting DSH expenditures to States with high uncompensated care caseloads. Almost half of DSH funds go to five States.

How Different Reform Proposals Treat DSH

The President's bill reduces and retargets DSH towards States with hospitals with a high volume of Medicaid and uninsured patients.

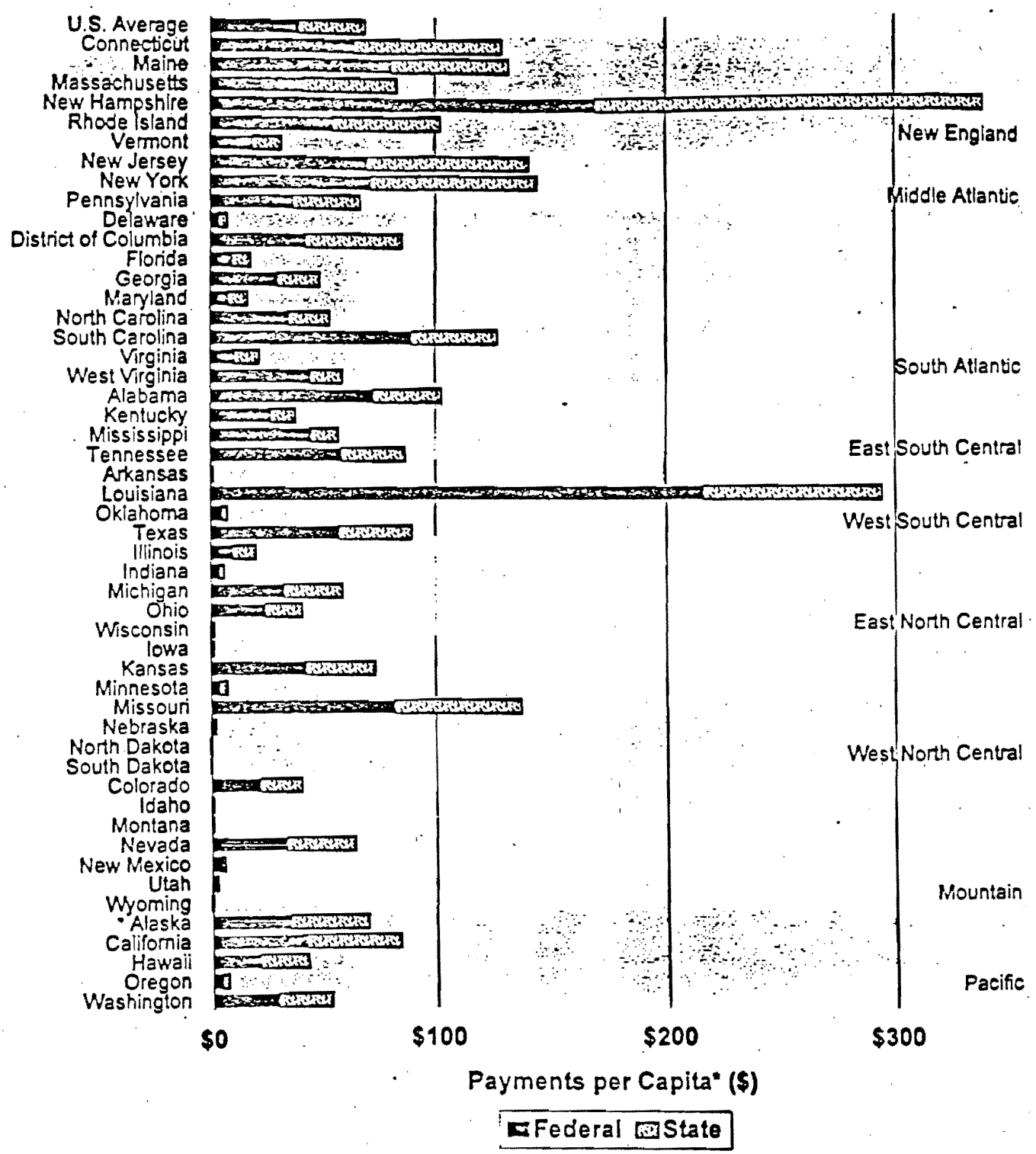
The May 21 Republican plan eliminates the DSH program but DSH payments are left in the base. In effect it allows the state DSH base to grow at the allowable growth percentage for the state's basic proghram under the forumla specified in the May 21'st draft. This perpetuates what many feel are current inequities in the system.

The Republican plan perpetuates current DSH inequities

The Republican plan maintains the current distribution of DSH funding by folding it into states base Medicaid allottments, even though that distribution does not reflect the distribution of uncompensated care across States. "Low DSH" States, such as Nebraska, Iowa, Arkansas, Wisconsin and North and South Dakota, are at a permanent disadvantage under this approach. Moreover, there is no retargeting of DSH payments, as under the Clinton plan, towards states with the highest disproprtionate share caseloads.

Figure 14

Medicaid Disproportionate Share Payments per Capita
By state and census region, federal & state expenditures, 1993



SOURCE: The Urban Institute, prepared for the Kaiser Commission on the Future of Medicaid. Based on HCFA 64 and the 1991-1993 March Current Population Surveys. 1993 population numbers are estimated. Expenditures do not include Arizona, U.S. Territories, accounting adjustments, or administrative costs.

PROVIDER TAXES AND DONATIONS

Summary: **The 5/21 Republican bill would allow States to generate Federal matching dollars through the use of provider taxes and donations. Therefore, States could use taxes and donations to finance a significant percentage of the State share without contributing any real State dollars. While Federal dollars are limited under the Republican proposal, allowing tax and donation schemes undermines the Federal-State partnership in financing the Medicaid program.**

The History of Taxes and Donations

During the late 1980s and early 1990s, when use of provider taxes and donations was unrestricted, some States used these arrangements to dramatically reduce their own real contributions to Medicaid while simultaneously increasing the amount of Federal funds available to them. States would tax providers and then return the taxes to the providers in the form of disproportionate share payments (DSH) and thereby draw down a Federal match, without having spent any real State dollars.

The result of such schemes was Federal Medicaid growth rates exceeding 25 percent a year in 1991 and 1992, over half of which was due to use of these financing mechanisms. Between FY 1989 and FY 1992, Federal spending for Medicaid DSH payments grew from $400 million to $10.1 billion; a 2,400 percent increase. By 1992, DSH payments accounted for 15 percent of all Federal Medicaid spending. In 1993, $17 billion in Federal and State dollars, one out of every seven Medicaid dollars, was recorded as DSH.

Many government officials have spoken out against past abuses of taxes and donations arrangements. For example:

- In May 1991 the Inspector General stated that "the growth of provider tax and donation programs is almost like an uncontrollable virus spreading from State to State."

- In July 1991, the Inspector General stated "The situation has become so egregious in the last several weeks that the proliferation of these programs threatens to bankrupt the Medicaid program."

- On February 29, 1996, Robert Reischauer, former director of the Congressional Budget stated that "...provider tax and donation practices [were used by] some States to transform Federal Medicaid dollars into general State fiscal relief." He continued, "...States will be able to use such schemes to reduce the amount of State resources needed to draw down their Federal grants."

As a result of these State funding abuses, limitations on taxes and donations arrangements were enacted in 1991 and 1993 with overwhelming bipartisan support.

The 5/21 Republican Proposal

The proposal removes provider tax and donation restrictions. Because this would allow States to finance significant portions of the State share without contributing any real State dollars, repealing these restrictions could result in substantially lower overall support for the Medicaid program.

CHANGES TO FMAP

Summary: **The 5/21 Republican bill allows States to choose between three Federal Medical Assistance Percentage (FMAP) formula alternatives. The bill raises the minimum FMAP from 50 to 60 percent. The change in the FMAP will have the effect of raising the national average FMAP from 57 percent to 65 percent. Because the bill establishes a block grant, the FMAP is used purely to determine how much States must spend in order to draw down their full Federal allotment, rather than using the FMAP to determine the Federal match for actual State expenditures as is done currently. The lower State contributions required under the bill may result in lower State support for the Medicaid program.**

The 5/21 Republican Proposal

The 5/21 Republican bill allows States to choose between three Federal Medical Assistance Percentage (FMAP) formula alternatives. As in previous Medigrant legislation, States may use either: 1) the current FMAP; 2) the lesser of an alternative FMAP based on the ratio of a State's share of total taxable resources (TTR) to the State's share of the pool and the current FMAP increased by 10 percentage points; or, 3) 60 percent. In any case, the bill changes the concept of the purpose of the FMAP. Under the old concept, the FMAP was a formula for determining the amount that the Federal government would match actual state Medicaid expenditures. Under the new concept, the FMAP is only used for calculating the State share necessary for drawing the capped Federal needs based amount.

The Impact of the Republican Plan on State Spending

The bill raises the minimum FMAP from 50 percent to 60 percent. Based on GAO's calculation of the FMAPs that would be applied under such legislation, the national average FMAP would increase from 57 percent to 65 percent, with as many as 27 States benefiting from a higher FMAP.[1] States could respond to the change in the following ways:

1. They could reduce their own State spending by just enough to draw down the entire Federal needs based amount. That means States could reduce spending by about $179 billion (about 29 percent) over the next seven years, solely as a result of the FMAP change. (In the absence of the FMAP change, just the reduction of the Federal baseline by $72 billion reduces required State spending by another $55 billion.)

2. They could maintain their current level of State spending, although they would not have the incentive of the Federal match.

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[1] Using the 1996 FMAPs, GAO estimated the applicable FMAP based on the Medigrant legislation in November 1995. The new average FMAP based on their calculations is 65%. Since this Republican bill uses the same FMAP alternatives, we assume the calculation would remain the same.

MEDICAID AS THE PAYER OF LAST RESORT

Summary: Making Medicaid the payer of last resort for other public health programs will cause possible administrative and fiscal problems for community health centers and other such providers.

Current Law:

Current law makes Medicaid the secondary payer for Medicare and other insurance programs that have a legal liability to pay for specific, enrolled individuals, but not for other public health care programs, which typically have a generally stated obligation to serve the poor or other needy groups.

The May 21 Republican Bill

The May 21 Republican bill contains a provision that would permit states to deny Medicare coverage for services that could be covered by Medicare or any other "public or private health care or insurance program."

This particular provision was not included in the NGA resolution as adopted on February 6, 1996, nor was it included in the Conference Agreement. It appears to have been added by the in drafting the May 21 bill.

Concerns about the May 21 Republican Bill

This provision will cause possible administrative and fiscal problems for community health centers (i.e., Ryan White clinics, migrant health centers, etc.) funded through the Public Health Service and other such providers that routinely treat Medicaid patients.

- These programs now bill Medicaid for services they provide to Medicaid eligibles, enabling them to use grant money and other revenues to serve other low-income persons or services not covered by Medicaid.
    - Without access to Medicaid payments, these clinics would have to operate on reduced budgets, reducing in turn their ability to serve their communities. In many cases, people in these communities have no other readily accessible sources of care.
- This provision would effectively defund the Ryan White grants, community and migrant health centers and all other federally qualified health centers, the maternal and child health block grant, and other important public health programs.
    - In addition to primary health care services, many of these program provide prevention, counseling, and wrap-around services (e.g., transportation) not

available elsewhere.

- These essential services remove barriers and allow disadvantaged people to gain access to the health care system.

- This provision would essentially restore the geographic and economic barriers and reduced health care delivery to the poor and elderly.

THE IMPORTANCE OF MAINTAINING TITLE XIX

Summary: **The current Medicaid program (Title XIX of the Social Security Act) and its implementation through federal and state policies has evolved through many years of federal and state debate and problem solving in order to balance the needs and interests of all those involved in the program--state and federal government and taxpayers, providers and beneficiaries. Significant changes, such as the new state flexibility in the President's plan, require that problems with the current statute be identified and revised in order to achieve an orderly and cost conscious transition. Such careful change is essential when dealing with a program serving 36 million individuals and spending nearly $200 billion federal and state dollars. Creation of a new statute and program -- as the 5/21 Republican bill does -- would foster unpredictable change and unintended consequences.**

Types of Issues Which Arise when a New Title is Created

Beyond specific policy concerns evident in the 5/21 Republican bill, additional issues arise in that bill as in any plan that creates a new title.

- **State and federal implementation issues.** Following enactment of Medicaid reform legislation, state and federal governments could begin revising their existing programs more easily if the familiar ground of the existing Medicaid statute were revised rather than replaced. Start up costs and delays in implementation would lead to very limited short term savings, and long term savings could be seriously compromised.

  -- Delays in developing new legislation could be a problem--particularly in states where the legislature meets only biennially.

  -- Development and issuance of new federal and state regulations and procedures would be time consuming, and mechanisms to provide federal funding might not be in place until a number of issues are resolved.

  -- All federal and state program forms, provider agreements, data systems, administrative systems, and survey and certification procedures would need re-examination.

- **Legal issues.** A vast number of issues--even those that have been long-settled--could be the subject of contentious and time consuming new litigation. This would be true even where the 5/21 Republican bill appears to continue certain parts of the program with little or no change.

- **Protections for federal and state governments, beneficiaries, and providers.** In addition to the many legal, administrative, and procedural issues that must be dealt with, there are important provisions in the current statute that provide protections to federal and state governments and taxpayers, beneficiaries, and providers.

Examples of Issues Which Arise When a New Title is Created

Some examples of types of title XIX protections that could be lost are as follows.

- **Beneficiaries are subject to rules within which they receive services under Medicaid.** Some of these will be changed consciously, others would likely change through lack of awareness, and would have potentially significantly serious unintended consequences. Some examples:

  --1920 Allows presumptive eligibility for pregnant women in certain situations, which allows immediate service by providers to pregnant women while the formal eligibility process is being completed.

  --1902(a)(17) Provides for standards for how income and resources are to be determined, and for taking into account only income and resources that are actually available to the individual. These assure that neighboring states use some comparable definitions for purposes of determining income under provisions such as required coverage of individuals under the federal poverty level.

  --1905(d)(1) Provides for federal quality standards for institutions caring for people with mental retardation and developmental disabilities. These standards assure basic rights such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.

  --1919(e)(7) Provides federal standards for pre-admission screenings and annual reviews for residents of nursing facilities.

  --1907 Generally may not compel a beneficiary to accept services contrary to individual religious beliefs; this is a protection of individual religious liberties within Medicaid, important to groups such as Christian Scientists.

  --1902(a)(7) Protection from disclosure of information. This creates the framework for privacy and release of information in the course of routine state Medicaid administration.

- **States and the federal government have procedural and due process guarantees, as well as links with other programs**. For example:

  --1902(a)(16) Individuals are the responsibility of their state of residence. Thus, states are not required to pay for services to residents of other states. If a resident of one state receives service in another state, the state of residence is not required to cover items not included in its state plan, nor is it required to pay for the services at rates higher than in its state plan.

--1914 Linking Medicaid withholding with Medicare withholding of overpayments to certain providers, with due notice requirements to the States. This assures coordination between Medicare and Medicaid in the case of overpayments.

- **Providers are assured that the Medicaid program will operate within certain expectations.** For example:

--1902 (a)(37) Payment of claims within 30 days. This is a standard business practice and protects providers from cash flow and other payment problems that could affect their willingness to participate in the Medicaid program.

--1902(a)(48) Method of demonstrating eligibility to provider when beneficiary has no fixed address. This gives providers some degree of confidence that individuals seeking Medicaid eligibility have a likelihood that they will not be determined ineligible because they have no fixed address.

--1902(a)(34) Retroactive eligibility of beneficiary for three months prior to filing the application, if found eligible for Medicaid.

MANAGED CARE QUALITY

Summary:The 5/21 Republican bill fails to assure mimimum quality assurance standards for Medicaid managed care plans. This is a serious shortcoming; almost one-third of Medicaid beneficiaries are enrolled in such plans and the number is projected to greatly increase under Medicaid reform.

The 5/21 Republican Proposal

The 5/21 Republican proposal does not mention quality assurance requirements or monitoring responsibilities for Medicaid managed care plans. It is unclear whether this proposal includes any provision to ensure that Medicaid enrollees receive high-quality managed care health care, or to protect them from low-quality health plans.

The Administration Plan

The President's plan replaces out-dated approaches to managed care quality assurance and ensures that states take an active role in ensuring quality by requiring States to develop their own quality improvement and monitoring programs. Our proposal also requires health plans to meet certain minimum requirements -- such as the provider capacity to meet the needs of their enrollees.

Quality assurance cannot be ignored. Nearly one-third of all Medicaid beneficiaries belong to managed care plans -- and most of these individuals are enrolled in managed care because their state requires them to do so. We believe that Medicaid beneficiaries and federal tax payers deserve complete assurance that these plans deliver the high-quality services they are paid to provide.

MEDICAID AND CHILDREN

Summary: Medicaid is a critical source of health insurance coverage for children. Approximately 18 million Americans under age 21, including between a third and a half of all babies under 1 year old, are covered under Medicaid. Medicaid is also the primary source of payment for medical services for children with disabilities.

The 5/21 Republican bill restricts the guarantee of coverage and benefits for millions of current and future Medicaid eligible children.

5/21 Republican Bill

Under the 5/21 Republican bill, millions of children will lose their federal guarantee of Medicaid eligibility. Under current law, Medicaid coverage of children ages 13-18 is being phased in -- by year 2002 all children ages 13 to 18 under 100% FPL will receive Medicaid.
The 5/21 Republican bill eliminates this guaranteed coverage. This change in Medicaid eligibility could affect up to 2.5 million children.

Those who do remain eligible will still lose the following guarantees which exists under current law:

- the guarantee that states will not discriminate in the amount, duration, and scope of services which they provide based on individuals' eligibility groups or diagnoses;
- the right to enforce in federal courts over state benefit and eligibility decisions;
- the guarantee that they will receive all medically necessary services to treat their diagnosed health problems.

Background

- Forty- nine percent of Medicaid beneficiaries (approx. 18 million) are low-income children under age 21.
  - Medicaid pays for about one-third of all births in the United States each year.
  - Between one-third to one-half of all babies under 1 year old and one-third of children ages 1 to 5 receive Medicaid.

Eligibility

- Under current Medicaid law, children under 19 born after 9/30/83 with income below 100 percent of poverty are being phased in for Medicaid coverage as a mandatory group.

- The 5/21 Republican bill language proposal would only provide mandatory eligibility to children up to age 13 (through age 12).

  - States would have the option to cover children over ages 13-18, but that coverage would no longer be mandatory.

  - HCFA estimates based on projected enrollment that 2.5 million children would lose their eligibility guarantee by 2002, but depending on State actions, not necessarily their coverage

Services

- Complete state flexibility with respect to the determination of amount, duration, and scope of services provides no protection against beneficiary discrimination within or across eligibility groups -- including children.

- No uniform, guaranteed adequate level of care would be required.

- Lack of comparability or statewideness requirements -- no guarantee of uniformity of benefits under a given State Plan.

- Redefining treatment under EPSDT -- there is no guarantee that states will provide any and all medically necessary services needed to treat detected health problems in Medicaid children.

- No federal right of action for individuals prohibits beneficiaries from challenging state decisions regarding ADS, comparability and statewideness.

- Repealing the Vaccine for Children program eliminates the cost-effective means for States to provide the childhood immunizations. This will result in reductions in the number of children vaccinated.

  - States and providers will have to purchase vaccine at private prices rather than at the government discount price.

State Definition of Disability

- State discretion to define disability will affect Medicaid children with disabilities - children with cerebral palsy, spina bifida, AIDS and other life-long debilitating diseases.

  - Medicaid is the primary source of payment for medical services for children with disabilities.

  - Medicaid covers 90 percent of all children with HIV and AIDS.

- As states are forced to provide medical care under a fixed block grant, coverage for the most expensive beneficiaries and services could be reduced.

- Families may be forced to give up one income in order for a parent to stay home and provide care to a disabled child.

- The required set-aside is insufficient to continue current level of services to all current disabled beneficiaries.

ACCOUNTABILITY

Summary: **There are a variety of provisions in the May 21 Republican bill that increase the proportion of federal spending on Medicaid while reducing the federal role as responsible fiscal manager. The Republican bill suggests a Medicaid program based on increased federal financial support and reduced federal involvement in assuring how congressionally appropriated Medicaid funds are spent.**

May 21 Republican bill

The bill provides states with almost total flexibility in program design including benefits, service delivery, and program administration. In addition, the bill would increase the FMAP from 50% to 60% and as a result states would be able to reduce their spending by about $200 billion over seven years, while the share of program expenses funded by the federal government would increase.

At the same time, the May 21 Republican bill would repeal title XIX and create a new title for the Medicaid program, thus changing the nature of the 30 year federal-state partnership that has largely been a successful one. This has the de facto effect of compromising seriously the existing framework for accountability that provides governance for the Medicaid program today.

Effect of May 21 Republican bill

These fiscal and structural changes would have the effect of reducing or eliminating some long-standing protections.

- Nearly a third of all Medicaid beneficiaries are currently enrolled in some form of managed care. The Republican bill makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care.

- Beneficiary and family financial protections such as spousal impoverishment and family responsibility have been central to the Medicaid program for years. Although the Republican bill appears to address these issues, the protection is hollow. The May 21 Republican bill eliminates critical federal oversight that assures changes to benefits do not jeopardize the sufficiency of coverage. In an environment where the states can determine how much of a given service is provided, or how much will be paid--without any protection against balance billing or cost sharing--beneficiaries and their families will be subject to serious fiscal barriers to service delivery, and may be required to exhaust their life savings to cover the cost of care.

Administration Proposal

The President's plan proposes unprecedented new flexibility for the states in how to operate their programs, pay providers, and use managed care and other delivery arrangements. At the same time, it retains core standards related to quality and beneficiary financial protections. It also

retains a structure and set of long-standing relationships between the states and the federal government that are the basis for fiscal and programmatic accountability.

There are ways, similar to the approach taken in the President's plan that would to provide states with considerably expanded flexibility in management and operation of their Medicaid programs, without reducing the framework of responsible accountability to meaninglessness.

There must be at least a modicum of reporting requirements and monitoring in a program that spends over $100 billion federal dollars per year. The May 21 Republican bill expands federal funding and reduces ongoing congressional and executive management of the program. There is a clear fiduciary responsibility that the federal government must fulfill. The framework to allow reasonable accountability is not present in the May 21 Republican bill.

MAY 21 REPUBLICAN PROPOSAL: IMPACT ON PEOPLE WITH DISABILITIES

Summary: **Medicaid is a critical source of health and long-term care coverage for people of all ages who have disabilities. The May 21 Republican bill seriously threatens this coverage: many disabled individuals currently covered by Medicaid (and their future counterparts) could lose Medicaid or experience significant cuts in service; nursing home eligibility and services could be scaled back; treatment services for disabled children would be streamlined; federal quality oversight and monitoring of key services would be eliminated; and the right to air grievances in federal court would be removed.**

Background

Medicaid is ***the critical link*** for health and long-term care services for people with disabilities. Although they need more health and long-term care services than the non-disabled population, people with disabilities are far less likely to have private insurance coverage for acute care; in addition to having less income and fewer resources, people with disabilities experience higher unemployment (and thus, less likelihood of having insurance through their workplace), and face significant barriers to private insurance (e.g., pre-existing condition limitations, lifetime and annual limits, prohibitively high premiums and copays).

Regarding long-term care, private insurance coverage is rarely purchased. The bulk of long-term care services are provided informally, by family and friends. The vast majority of formal, or paid, long-term care services are financed publicly, predominantly through Medicaid.

May 21 Republican Bill

Several provisions of the May 21 Republican proposal could have a devastating effect on low income people who have disabilities. Areas of particular concern include the following:

- **Disability Definition and Maintenance of Effort**: Under the May 21 Republican proposal, states would have great latitude to define who is disabled for the purposes of Medicaid eligibility. This would primarily effect the under-65 disabled population. States would no longer be required to cover individuals who meet the federal SSI disability standard; instead they would select whether to: (a) continue to cover the SSI eligible population; or (b) come up with their own definition of "disabled" for Medicaid eligibility. In the first year, the umbrella fund could only be tapped for individuals with disabilities if the state uses the SSI definition. States would also be required to devote at least 90% of 1995 spending on the newly defined disabled, if they opt to develop their own definition (and not use the SSI definition). The new definition and maintenance of effort provision raise some serious potential problems:

  - it is possible that states will use this new flexibility to cut back on the number of people with disabilities who receive Medicaid coverage.

  - depending on state policies regarding the coverage of uncompensated care, it is

possible that cutting the number of people with disabilities eligible for Medicaid could be costly to states. States might have to absorb the full cost of long-term and acute/primary health care for people who are no longer eligible for Medicaid.

- decoupling Medicaid eligibility determination from SSI eligibility reduces access to and utilization of Medicaid services. States would have the option to decouple SSI and Medicaid eligibility. Research shows that health and long-term care access for individuals with disabilities would be reduced.

- even if the maintenance of effort provision were more clearly defined, it would be difficult to enforce. Furthermore, there is no factor built in for increasing the maintenance of effort amount, and thus, there is no guarantee that spending will be maintained, much less grow if the size of the disabled population grows.

- there is no maintenance of effort requirement at all for states opting to use the current SSI definition; given limitations in funding under the program, states have incentives to reduce services to the eligible disabled population.

- the incentives increase for states to shift home health expenditures to the Medicare program. Under current policy, states have a strong incentive to bill Medicare for home health provided to dual eligibles (people who are both Medicare and Medicaid recipients). If Medicare pays, the costs are covered by the federal government; under Medicaid, states have to pay their share. Under the May 21 Republican proposal, with limited funds available for services for people with disabilities, the motivation for states to shift these costs to Medicare becomes even more compelling.

- **Nursing Home Eligibility:** Most elderly nursing home residents whose care is covered by Medicaid become Medicaid-eligible because they fit under one of two state-optional eligibility groups: either the "medically needy," who have "spent down" their income to cover medical care, or those whose income is below 300% of the SSI level. The May 21 Republican bill lets states define what constitutes income and resources. If income and resource tests are more restrictive than current law, a large number of current beneficiaries could lose their eligibility for Medicaid. For example, states could restrict eligibility based on home ownership; currently, a home of any value does not affect a person's eligibility. Under the May 21 Republican bill, home owners could be found ineligible. This could have a major impact on eligibility for nursing home care. Regardless, the May 21 Republican proposal limits eligibility for new recipients to people with incomes below 275% of poverty. In addition, the proposal eliminates the personal needs allowance for nursing home residents who are single, leaving them with no spending money.

- **Spousal Impoverishment and Family Financial Responsibility**: Although the May 21 Republican proposal: (a) prohibits states from billing families for services provided under Medicaid; and (b) retains the spousal impoverishment protections currently in Medicaid,

these protections will not be as effective as current policy because other protections in the Medicaid program are not provided. This is an especially serious concern for families of individuals in nursing homes and other long-term care settings. First, because of limitations on eligibility, fewer people will be eligible for nursing home care, and therefore ineligible to benefit from the family and spousal protections. Clearly, the families of individuals who are ineligible for Medicaid under new, restricted state eligibility standards, would be liable for the cost of their relative's care. Second, the May 21 Republican bill would allow states to determine the policy on statewideness and comparability of benefits, as well as eliminate the requirement that all mandatory services be provided to all mandatory eligibles. Thus, states would have significant flexibility to limit benefits, including nursing home services. Finally, the May 21 Republican bill would eliminate current law protections for community spouses of nursing home residents if the community spouse is not at risk of impoverishment because he or she has substantial income in their own right.

- **ICF/MR Quality**: The May 21 Republican proposal does not include critical federal quality standards for institutions for people with mental retardation (intermediate care facilities for the mentally retarded -- ICFs/MR). There would be no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist people in achieving the highest level of independence, and the right to adequate health care.

- **EPSDT**: Treatment under EPSDT is severely curtailed and includes only dental, hearing, and vision services. Under the EPSDT program, states are currently required to provide all medically necessary treatment for Medicaid eligible children. The program provides a host of services that not only help in the early and efficient diagnosis of disabilities, but also help prevent more significant complications and secondary problems. In addition, EPSDT provides resources to cover the therapeutic and other specialized medical services needed by children with disabilities. Coupled with a potential change in the disability definition, significantly scaling back the currently defined EPSDT treatment requirement could have the effect of closing the last available door for preventive and treatment services on children with disabilities and their families.

- **Managed Care**: The May 21 Republican proposal offers states extensive flexibility to move Medicaid recipients into managed care for their health care services, with much less federal involvement. The state of the art in meeting the extensive needs of a highly diverse population of people with disabilities through managed care approaches is in its infancy. Current knowledge is highly limited regarding key issues such as benefit package design, rate setting, coordination of services, and quality assurance. As a result of this limited knowledge base, many states have opted, to date, to carve out one or more of the disabled populations from their managed care plans, and the federal government has supported these decisions. The May 21 Republican proposal would allow states to move the disabled into managed care with a lot less "red tape." It is possible that efforts to capitate payments and save money, without extensive planning, research, and quality safeguards could have terrible consequences for individuals with disabilities in terms of

the quality of services they receive.

- **Federal Right of Action for Individuals and Providers**: The May 21 Republican proposal would eliminate the guarantee that consumers and providers could have their grievances against the Medicaid program heard in federal court. The maintenance of effort requirement is significantly weakened when viewed in light of the elimination of the federal right of action. With potentially devastating cuts in eligibility and benefits, the elimination of the federal right of action is another strike against one of the most vulnerable Medicaid populations. The disabled could be left, literally, with no where to turn for appropriate health and long-term care.

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IMPACT OF REPUBLICAN MEDICAID PROPOSAL NURSING HOME RESIDENTS AND THEIR FAMILIES

The Republican proposal could affect families of Medicaid beneficiaries in nursing homes in a number of ways. Although the Republican bill appears to maintain current law provisions, certain essential protections are eliminated, severely undermining these provisions.

- Spousal (and children's) impoverishment:

  Proposal: While the Republican bill maintains current law provisions protecting income and assets for spouses and dependent children, and prohibiting states from requiring adult children from being required to pay for their parents' care, these provisions are severely compromised by the loss of other protections, included in current Medicaid law but not in the Republican bill, necessary to truly protect spouses and families of Medicaid beneficiaries.

  Impact: The necessary provisions that would be eliminated from current law are:

  Current law protects individuals from being required to use their own income to pay for their spouse's nursing home care. The Republican bill eliminates these provisions and would take this protection away and leave policy in this area up to states. Community spouses who are not at risk of impoverishment because they have substantial income in their own right would no longer be protected.

  Under current law, a home of any value usually does not affect its owner's eligibility if the owner or spouse or certain other dependents are still living in the home. Under the Republican proposal, it appears that states could deny eligibility to persons owning a home of modest value or to persons whose spouse or child is still living in the home.

Coverage of and payments for nursing home benefits:

Proposal: While states would be required to cover nursing home care and home health for mandatory eligibles, and prohibiting states from requiring adult children from being required to pay for their parents' care, the Republican bill would allow states to determine the policy on amount, duration, and scope of these benefits without federal review of the "sufficiency" of the remaining benefit, as well as the amount providers are paid.

Impact: Most current nursing home beneficiaries (87 percent of the roughly 1.6

million now covered) are covered at state option. Therefore, the coverage mandate would not apply to the majority of people now served.

Although states are prohibited from requiring adult children from being required to pay for their parents' care in nursing homes, if states use the proposed flexibility to narrowly define the "scope" of benefits it covers, what is covered in the nursing home benefit could be reduced. For example, physical and speech therapies could be "unbundled" from the nursing home service and family members could be required to make payments because the services were no longer part of the nursing home benefit. Beneficiaries would then only be able to access some services, even those beneficiaries defined as "mandatory," if their families paid for these "additional" services. Those unable to pay might have to do without.

Likewise, states could limit the "duration" of the nursing home benefits, thus leaving days "uncovered" every month.

- Family financial contributions; other personal cost-sharing:

  Proposal: While states would be prohibited from requiring families to pay for the cost of certain long-term care services, the Republican bill would repeal the current restrictions on state-imposed copayments. It would also permit states to require families to pay for services other than long-term care.

  Impact: Beneficiaries could face financial burdens to pay excessive state-imposed copayments or other cost-sharing on long-term care services. If these copayments are not paid the beneficiaries could be denied the services in its entirety. In addition, states could require families to pay for other kinds of non-nursing home services.

  In addition, despite the nominal prohibition against making families financially responsible, families could still be faced with the dilemma of whether to pay or not to pay for services needed by an elder parent that the state no longer covers.

- Impact of home ownership on eligibility:

  Proposal: The Republican bill would allow states to define what kinds of assets (and income) count against eligibility thresholds. Thus the value of a person's home could be counted as an asset. Under current law, home ownership is not obstacle to eligibility, because it is excluded by the methodology of determining a persons assets.

  Impact: People could be made ineligible because of "excess assets" represented by the value of their homes. The only way they could obtain coverage would

dispose of their home, possibly selling it and spending the proceeds down to the state-defined resource threshold. The impact is most likely to occur in the case of persons in institutions who are not living in their homes at the time but who hope to return to them.

- Transfers of assets, estate recoveries:

  Proposal: The Republican bill repeals these current law provisions.

  Impact: States could choose to be more punitive (or less) than under current law.

  For example, states could broaden the scope of the transfer of asset penalty, which is now limited to denial of certain long-term care benefits, to any or all benefits. Changing the benefits to which the penalty applies has the effect of also extending the population that is potentially affected from persons needing long-term care, as under current law, to anyone needing medical assistance.

  States could lengthen the duration of the transfer of asset penalty without limit from the current three year period. This change could lead to beneficiaries being penalized even if they transferred assets for a legitimate reason or did so years before applying for benefits. Their families could face substantial hardship paying for their elders' nursing home care if the state denies assistance.

  States could use the flexibility regarding recoveries from estates of deceased beneficiaries to claim assets needed by survivors, including the home.

  Further, states would no longer be barred from seizing the deceased beneficiary's home under their estate recovery programs even if a spouse or child continues to lives in it.

UNDOCUMENTED IMMIGRANTS

Summary: The Republican 5/21 bill differs from the Administration plan in several significant ways. First, it would repeal the requirement that states provide emergency medical services to undocumented immigrants. Second, it would allow states the option to not only provide emergency services but prenatal care as well. And finally, by matching both optional services at 100%, but within the block grant base allocation, it provides a strong disincentive for states that do not receive or exceed a supplemental allotment to take advantage of either option.

Current Law:

- For undocumented immigrants otherwise eligible for Medicaid, states may receive federal matching funds under Medicaid (at their usual rate) only for emergency medical services (including emergency labor and delivery, but not prenatal care). States must provide such emergency services.

- Some states have voluntarily provided other services, such as prenatal care, to undocumented immigrants, using state-only funds.

  - The State of California, under Proposition 187, is proposing to cease state funding for prenatal care for undocumented immigrants.

  - The State of New York has a federal court order requiring federal matching funds for prenatal care for undocumented immigrants.

Republican 5/21 Bill:

- The Republican bill would repeal the requirement to provide even emergency services to undocumented immigrants.

- If states choose to provide Medicaid covered services to undocumented immigrants, the bill would allow them only two options: (1) provide emergency medical services, defined as under current law, plus (2) the additional option to provide prenatal care.

  - States would be reimbursed for both services at a rate of 100% federal funds from their block grant base amount. However, states which do not receive or exceed a supplemental allotment would use up their base allotment faster on these services for undocumented immigrants (matched at 100%) than on other services (matched at their usual state rate).

  - This would provide a strong disincentive for states to exercise the bill's options and reimburse providers from Medicaid base allotment funds for services to undocumented immigrants.

- In states that choose not to cover these services under Medicaid, there would be a strong incentive for other health care providers to dump undocumented immigrants on the already over-burdened public hospitals.

  - This would exacerbate public hospitals' problems of charity and uncompensated care.

  - It would also lead to increased loss of life as well as increased incidence of serious chronic health conditions and life-long disabilities for undocumented immigrants. The chronically ill and disabled would be even more likely to try to remain in the U.S. so that they could return to these same public hospitals.

- The Republican 5/21 bill would provide $3.5 B over 5 years in supplemental federal funds.

  - The funding would increase from $500 M to $900 M.

  - The supplemental funds would be divided among the 15 states with largest number of undocumented immigrants. However, beginning in FY 1998, the Secretary of HHS must consult with INS, states, and others to update the immigration population estimates and allocations among states may change.

  - The supplemental funds would operate outside the block grant. Funds not spent in any year could not be carried over to future years.

Administration Proposal:

- The Administration would retain current law provisions requiring all states to provide emergency medical services (including emergency labor and delivery, but not prenatal care) to undocumented immigrants. These costs would be counted in both the base year and per capita calculations, would be matched at the usual state rates (thus avoiding the disincentive of the Republican bill's 100% rate), and must come from capped funds in future years.

- The Administration would also provide $700 M per year (level funding) for 5 years for a total of $3.5 B in 100% federal supplemental funding.

  - It would be divided among the 15 states with the largest number of undocumented immigrants (using INS estimates of 10/92, without updates which might change states and their allocations unpredictably) to help pay the state share of emergency medical costs.

  - These supplemental funds would not be counted in either base year or per capita calculations, and this funding would operate outside of the cap.

AMERICAN INDIANS/ALASKA NATIVES

Summary: The 5/21 Republican bill would reduce state responsibilities to assure appropriate availability of and to share in payments for services to their Medicaid-eligible American Indian and Alaska Native (AI/AN) citizens. The bill would extend 100% federal matching to services provided by all types of Indian health providers and would add a new supplemental fund to give states separate resources for these providers. However, the net result for Indian health providers could be significantly less funding available and for Indian Medicaid eligibles significantly less health care access than under either current law or the Administration proposal.

Current Law:

- Members of federally-recognized Indian tribes as dual citizens of both their tribe and of the U.S. and their state of residence. As such, Indian people are, and must continue to be, dually eligible for services by the Indian Health Service (IHS), provided under the federal trust and treaty responsibilities, and for Medicaid and any other services for which they qualify on the same basis as any other U.S./state citizen.

- Consistent with these principles of dual citizenship and dual eligibility, states are currently reimbursed at 100% for Medicaid services provided to Indian eligibles by facilities of the IHS and at their usual state matching rate for Medicaid services provided to Indian eligibles by tribal, urban Indian, and non-Indian health providers.

Republican 5/21 Bill:

Tribes have long sought to be treated on an equal basis with both states and IHS. The Republican bill contains elements which appear to move in that direction. However, the details of operation could have the effect of leaving Indian Medicaid eligibles and the Indian health providers that serve them with even fewer resources available to meet their needs than under either current law or under the Administration proposal.

- The Republican 5/21 bill would retain the 100% reimbursement states currently receive for Medicaid services by IHS facilities and extend it to tribal and urban Indian facilities as well. The bill language is unclear as to whether any or all of the three categories of Indian health providers would have access to state reimbursements from Medicaid block grant base funds, or would be limited to reimbursement from the special grant (below) and perhaps from a portion of the umbrella fund.

- The bill language is not explicit, but appears to raise additional concerns. It appears to permit states to continue to count Indian Medicaid eligibles for purposes of their base and supplemental allocations, and to then allow them to redirect these funds to serve other populations. The bill is unclear as to whether Indian eligibles would retain their dual eligibility to use non-Indian as well as Indian health providers.

- As NGA requested, the Republican bill contains a new special grant for Indians using 100% federal funds. However, it is unclear on whether grant funds would be used only to reimburse IHS, or all three types of Indian health providers (IHS, tribes, and urban Indian organizations).

  - If the intent of the fund is to reimburse all three types of providers, then the bill language may not achieve that purpose. The bill refers only IHS facilities and limits allocations from the fund only to states with IHS facilities.

  - The special grant would be funded at a level which increases from $72 M in FY 1997 to $95 M in FY 2002 (when authorization ends).

  - IHS alone is currently being reimbursed for Medicaid services at over $120 million per year, and those levels are projected to increase substantially in future years. The funding level in the bill would leave IHS, even if it alone received the new funds, with a significant unreimbursed amount. As a domestic discretionary program, IHS is unlikely to receive other funds to compensate for this shortfall.

  - The funding level would be even more inadequate if the supplemental grant amount is intended to also cover tribal and urban Indian provider reimbursements.

- The Republican bill would allow funds transferred from other public agencies, including Indian tribes, to count toward the state match. This language would appear to permit a state to require tribes (which are governmental entities and frequently Medicaid providers as well) to pay part, or even all, of the state's share of funds to draw the federal match.

- The Republican 5/21 bill would allow states unfettered discretion in deciding which health providers could participate in Medicaid managed care programs.

  - Otherwise qualified Indian health providers could be excluded from participation.

  - Indian eligibles enrolled in managed care could have no Indian provider to choose or to serve as their default assignment. Many, out of long habit, would continue to go to Indian providers (who, under other federal laws, cannot turn them away), even if they are not a participating managed care provider. The providers could then be left at full risk for the cost of services to managed care enrollees.

- The Republican 5/21 bill would end the special cost-based reimbursement for all FQHCs and RHCs (including those operated by Indian health providers). This ignores the special role such providers often play for Indian people and their lack of alternative resources. It could endanger their continued viability and leaving Indian people even more under-served.

- The Republican bill continues restrictions from the 1995 reconciliation bill. Only in states with at least one IHS facility, must the Medicaid plan describe what provision, *if any*, the state has made to pay such facilities; and how Medicaid services to eligible Indians will be provided, as determined by the State in consultation with Tribes and Tribal organizations.

  - Many states have federally-recognized Indian populations, and may have tribal and/or urban Indian health providers, but lack IHS facilities (e.g., California). No consultation would be required in such states, nor would state plans be required to describe how services would be provided to eligible Indians.

  - Even in a state with IHS facilities, the "if any" language would allow a state to reimburse IHS facilities at unsustainably low rates, or not at all.

Administration Proposal:

The Administration's proposal more effectively recognizes the special needs and federal responsibilities for AI/AN people and Indian health providers serving them.

- It would retain the current 100% reimbursement to state Medicaid programs for covered services provided to Medicaid eligible AI/ANs by IHS facilities.

- Reimbursements to states for all Indian health providers (IHS, Tribal, and urban Indian facilities) would be provided outside the per capita cap. This would accommodate faster Indian population growth and remedies to Indian under-enrollment in Medicaid and lack of Medicaid billing capacity by Indian providers.

- Indian Medicaid eligibles would retain their dual rights to seek services from other Medicaid providers on the same basis as other Medicaid eligibles. States would be reimbursed for these services at the usual Federal matching rate, subject to the cap, for these services, thus maintaining a fair share of responsibility for their Indian citizens.

- The Administration plan would provide important new protections by guaranteeing IHS, tribal, and urban Indian providers that otherwise qualify the option to participate in state Medicaid managed care programs. It also would make participating Indian providers the default assignment for Indian Medicaid eligibles who did not choose another provider.

- The Administration plan would retain 100% cost-based reimbursement for Indian FQHCs and RHCs indefinitely, even after this type of reimbursement is phased out for other FQHCs and RHCs. This would recognize the high costs to these providers of meeting the complex needs of their service populations, and the frequent lack of alternative providers and alternative populations across which to spread risk and cost.

- The process for state plan amendments would require all states to include tribes, tribal organizations, IHS facilities, and urban Indian health organizations.