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MEDICAID REFORM: SAVING AN AMERICAN SUCCESS STORY

THE HONORABLE BOB GRAHAM*

I. MEDICAID: AN AMERICAN SUCCESS STORY

Medicaid was established in 1965 as a jointly funded federal-state program to provide medical assistance to low-income Americans.[1] Each state is responsible for designing and administering its own Medicaid program, subject to certain federal requirements involving issues such as eligibility, level of service provided, and health care provider payments.[2] The federal government pays a portion of whatever qualifying expenditures a state Medicaid program incurs, and the states have the option of providing any additional services.[3]

For the past thirty years, the Medicaid program has been the lifeblood of the United States' health and long-term care delivery system for millions of Americans. Indeed, over thirty-six million Americans received Medicaid benefits in 1995.[4] Medicaid is the only source of medical coverage for many Americans with diverse health care needs. It provides a medical safety net for pregnant women and children, the elderly, and disabled Americans. The program provides preventive care for low-income and moderate-income pregnant women and children, and it provides long-term care for the elderly and persons with disabilities.[5]

Through a federal-state government partnership, Medicaid provides acute-care and preventive care coverage that is similar to the employer-

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* Senior U.S. Senator from Florida. B.A., 1959, University of Florida; J.D., 1962, Harvard University. This Article was adapted by Charles R. Fletcher, Articles Editor, from a series of speeches given by Senator Graham.

1. U.S. CONGRESSIONAL RESEARCH SERVICE, MEDICAID SOURCE BOOK 1 (1993) [hereinafter MEDICAID SOURCE BOOK].

2. *Id.* The only state without a formal Medicaid program is Arizona, but since 1982, Arizona has been receiving federal funds through a Medicaid waiver program. *Id.*

3. *Id.*

4. Bruce C. Vladeck, Administrator, Health Care Financing Administration, Statement Before the U.S. House of Representatives Subcommittee on Human Resources and Intergovernmental Relations, Jan. 18, 1996, *available in* Federal Document Clearing House.

5. *Id.* at 2.

based coverage available to other Americans.[6] Additionally, Medicaid provides to senior citizens and disabled Americans long-term care rarely available through any other source.[7] This long-term care has also been a lifeline for America's fragile elderly. Over sixty percent of the nursing home residents in this country qualify for Medicaid,[8] many qualifying only after their life savings have been depleted by chronic medical conditions.[9] Great strides have been made in improving the quality of care for our elderly who depend upon Medicaid for their survival. For the senior citizens of our nation, Medicaid has been a tremendous success.

Medicaid also successfully provides for the needs of other segments of America. For example, the Qualified Medicaid Beneficiary program, covers Medicaid premiums, deductibles, and co-payments for beneficiaries who have incomes below the federal poverty level.[10] Nearly seventeen million low-income Americans participate in this program.[11] This program has made the difference between preventive care in a doctor's office and intensive care in a hospital emergency room. The many families whose lives have been bettered through the Medicaid program all have their own stories to tell.[12] These families could have been your family, my family, or any other American family.

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6. *Id.*

7. *Id.*

8. MEDICAID SOURCE BOOK, *supra* note 1, at 811.

9. *Id.* at 841.

10. *See generally* U.S. GOVERNMENT ACCOUNTING OFFICE, MEDICARE: EFFORTS TO ENHANCE PATIENT QUALITY OF CARE (1994).

11. MEDICAID SOURCE BOOK, *supra* note 1, at 11, 13-15.

12. Many of these stories are profiles in courage—the courage of families trying to deal with health setbacks and scarce resources. For instance, Yvette Elkins, of Columbus, Ohio,

> [a]fter giving birth to her first child[,] stopped working to stay home with her baby. Shortly after she resigned, she learned that she was pregnant again. Soon after, her husband left her and the baby. For the first time in her life, Yvette began receiving welfare. Two weeks after her second child was born, Yvette began interviewing for full-time jobs. She depended on Medicaid to bridge the gap between homelessness and gainful employment. Medicaid paid for prescription drugs, doctor visits, and emergency visits; all critical services since Yvette's younger child suffered from chronic ear infections. Transitional Medicaid allowed Yvette to catch up on back bills and advance far enough to obtain a job that offers benefits.

141 CONG. REC. S16,645 (daily ed. Nov. 3, 1995). Another example is the story of Donna Guyton of Nashville, Tennessee:

> A mosquito bite is irritating, but hardly ever life-threatening. After a fateful family vacation to Michigan in 1990, Donna's son, Patrick, contracted viral encephalitis, possibly from a mosquito bite. He was hospitalized for three and a half months and suffered from severe seizures. He eventually had to be placed in a drug-induced coma. Until September of 1991, he was covered under his father's medical insurance. Then his father's company was bought out, and when they re-enlisted in the plan, Patrick was not covered. Patrick was covered by COBRA for 29 months and in November 1992, he was enrolled in the Medicaid Model Waiver Program at Vanderbilt HMO so that he could receive care from the specialists he needed. But Vanderbilt's Medical director consistently denied the care that the specialists re-

We cannot turn our backs on older Americans who have given so much to our country. We cannot eliminate preventive care for low-income women and their children. Nor can we retreat from the gains we have made in providing a decent quality of life for developmentally disabled Americans.

Not long ago, when the consensus emerged from across the country to stop warehousing the handicapped in shamefully large institutions, the goal was to get as many people as possible out of institutions and into community-based home settings.[13] The federal-state Medicaid partnership became the framework for change. The Medicaid framework was flexible and able to act as quickly as the states desired. That flexibility is the beauty of the Medicaid federal-state partnership. Some states moved quickly, but unfortunately some did not. However, the results speak for themselves: in 1967 there were over 194,000 mentally retarded or developmentally disabled Americans living in state institutions; in 1990, there were only 86,219.[14]

Furthermore, this incredible effort to deinstitutionalize the handicapped and enable them to lead more independent lives has actually reduced the cost of care. While an institutional bed can cost as much as $92,000,[15] the cost, on average, is $22,000 for a "home waiver" bed where a disabled American can receive needed care in his or her own home.[16] Although these numbers provide some sense of the savings Medicaid has achieved through deinstitutionalization, more impressive is the number of people whose families stayed together—at home—because of Medicaid. Today, some six million disabled Americans are covered under Medicaid.[17] There is a compelling national interest in assuring a humane quality of life for the disabled and infirm.

To tout Medicaid's successes is not to ignore its faults. There is work to be done to improve accountability, combat fraud and waste, and check growth in spending. However, the current proposals to give block grants to the states and dismantle this American success story by eliminating the federal-state partnership would destroy the flexible institutional frame-

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quested. As a result of the poor attention and insufficient medication, Patrick . . . has had other health and emotional problems.

141 CONG. REC. S16,646-47 (daily ed. Nov. 3, 1995).

13. MEDICAID SOURCE BOOK, *supra* note 1, at 862, 869.

14. *Id.* at 870.

15. *New Medicaid Caps Set off Alarm for Disabled Care*, COLO. SPRINGS GAZETTE TELE., Aug. 21, 1995, at D1 ("In the costliest of cases, institutionalizing a severely mentally retarded person . . . can cost $92,000 a year; $72,000 in a group home or private apartment; or $25,000 a year at home with a family.").

16. MEDICAID SOURCE BOOK, *supra* note 1, at 909, 902.

17. Diane Rowland, Executive Director of the Kaiser Commission on the Future of Medicaid, Statement Before the U.S. House of Representatives Committee on Commerce, Mar. 6, 1996, *available in* Federal Document Clearing House.

work that has been so successful.[18] Furthermore, the proposed block grant funding formula actually rewards states that have taken advantage of flaws in the existing Medicaid program. Part II of this Article discusses the failures of the block grant proposal. Part III describes how we can achieve these goals without discarding the federal-state partnership that has served the people of our nation so well during the past thirty years and how we can continue to provide a medical safety net for poor, elderly, and disabled Americans.

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18. The Republican Congressional leadership proposed as part of the 1996 budget reconciliation bill a Medicaid reform package that would have replaced the existing federal-state Medicaid partnership with a new block-grant program that did not provide meaningful federal guarantees of eligibility or benefits. Donna Shalala, Secretary of the Department of Health and Human Services, Statement Before the U.S. Senate Finance Committee, June 13, 1996, *available in* Federal Document Clearing House.

The block grant program was designed to allocate to each state Medicaid program one lump sum per year. Each state could then do with the money what it wished, with few limitations. This achieved two goals of the Republican Congressional Majority: 1) it vested decision-making authority in the state agencies, and 2) it set a fixed limit on federal Medicaid expenditures by changing Medicaid from a per person benefit to an annual grant. *See id*.

One of the Clinton Administration's fundamental problems with the block-grant proposal was that it ended the Federal government's commitment to the states to bear part of the burden of changes in demand on state Medicaid programs and left states with the full financial responsibility for providing health care to individuals who would qualify for services in the future due to unanticipated enrollment increases or economic downturns. *Id*. The Congress passed the block grant proposal as part of a 1996 budget package, but President Clinton vetoed the budget, due in part to his opposition to the Medicaid block-grant program.

In February 1996, the National Governors' Association (NGA) approved the outlines of a bipartisan Medicaid reform plan. This bipartisan effort rejected block grants and adopted elements of the per capita cap approach to Medicaid that I proposed last year and that is discussed in part III of this Article. The NGA proposal held some promise to be a real basis for Medicaid reform. However, the Republican majority in both houses of Congress introduced a revised version of their Medicaid bill, a version that is much more similar to the legislation which President Clinton vetoed last year than is the bipartisan reform envisioned by the governors. *Id*. at 3.

> [The Republicans'] Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year and rejected by the Governors at our winter meeting …. [A]ccording to our early calculations, 96 percent of the funding under this new formula is distributed precisely in the same manner as your earlier bills proposed. You have created a block grant for this program with essentially the same language and parameters of the vetoed bill—a block grant that denies a safety net for our most vulnerable citizens.

Id. (quoting a May 29, 1996 letter from four Governors to Senator William Roth, Chairman of the Senate Finance Committee).

As of the writing of this Article, Congressional Republicans and the Clinton Administration have not reached an agreement on Medicaid reform. *See id*. While the level of the budget cuts and other details of the Republican proposal may change, it remains substantially the same proposal Congress passed last fall—the proposal that President Clinton vetoed. *See id*. Consequently, if Congress passes the current Republican proposal, it could very well be vetoed again.

II. MEDICAID BLOCK GRANTS: MISGUIDED MEDICAID REFORM

Now Medicaid is under attack. It is hard to understand the justification for the $72 billion that the Republicans wanted to cut from the projected needs of the program.[19] There are those who point to the increase in the Medicaid program and then blindly conclude that the program is bloated and inefficient, with money spent haphazardly at best. However, a thorough examination of the Medicaid program—why it has grown, how it has grown, why it is expected to grow—will lead to the inescapable conclusion that the U.S. Congress cannot cut $72 billion in funds in Medicaid without having infants dying, the elderly neglected, and the disabled unnecessarily institutionalized.[20]

Take the projected needs of the Medicaid program through the year 2002—$899 billion[21]—and then subtract the amount of the proposed cuts—$72 billion. The amount of money is that is left—$827 billion—is now going to pay for $899 billion in projected needs. That simple math illustrates that the proposed block grants will come up short.

A. Abuse of the Disproportionate Share Hospital Program

An amendment to the first Budget Reconciliation Act of 1996 gave $10.2 billion[22] largely to those states that were the primary abusers of Medicaid disproportionate share hospital funds in the past.[23] In effect, Congress rewarded the very states that manipulated the Medicaid system and abused the Medicaid disproportionate share hospital program (DSH). The intent of

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19. The Congressional Budget Office projects that a 10% annual increase in Medicaid spending over the next seven years is necessary to maintain existing services levels. CONGRESSIONAL BUDGET OFFICE, THE ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 1997-2006 74 (May 1996) [hereinafter BUDGET OUTLOOK: 1997-2006]. The Republican leadership during the first session of the 104th Congress proposed funding Medicaid at a level $182 million below the projected needs over seven years. Christina Kent, *Threatened by Reform?*, AM. MED. NEWS, Oct. 23, 1995, at 1. This proposed cut would have reduced annual growth from the current rate of 10% per annum to about 2%. Christina Kent, *Radical Medicaid Plans Shift Power to States*, AM. MED. NEWS, Oct. 9, 1995, at 1. After negotiations, the Congress passed a budget that cut Medicaid by $176 billion, approximately 17% less that the projected need. Christina Kent, *AMA Promotes State Feasibility on Medicaid-With Safety Net*, AM. MED. NEWS, Dec. 18, 1995, at 3 [hereinafter Kent, *State Feasibility*]. President Clinton vetoed this budget. *Id.* In the second session of the 104th Congress, Republicans proposed $72 billion in cuts over 6 years and, as of the writing of this Article, this proposal is still under debate.

20. Expressing his concerns about pending Medicaid reforms to a group of public health officials, former Surgeon General C. Everett Koop, M.D., said he had "never seen such discouragement among health care professionals." Surgeon General Koop later concluded that "most of the reform plans have more to do with political posturing and very little to do with what is best for the health of the American people." Deborah L. Shelton, *Public Health Fears Threat from Declining Funds*, AM. MED. NEWS, Nov. 20, 1995, at 6.

21. CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF THE PRESIDENT'S BUDGET PROPOSAL FOR FISCAL YEAR 1996 45 (Apr. 1995); Telephone Interview with Nani Coloretti, Office of Management and Budget (July 10, 1996) [Coloretti Interview].

22. *See* S. 1357, 104th Cong., 1st Sess. §§ 2121, 2122, 7014 (1995).

23. *See infra* notes 33-50.

DSH payments, instituted by legislation, was to assist hospitals that treat great numbers of Medicaid and low-income, uninsured patients with special needs.[24] Recognizing that these hospitals would have a small privately insured patient base, Congress intended these "disproportionate share" hospitals to have their Medicaid payments supplemented.[25]

In fiscal year 1989, federal funding for Medicaid DSH payments was just $569 million.[26] However, in coming up with their shares of those funds, some states began to see the potential in the use of donations and provider tax revenue as the state shares of Medicaid expenditures.[27] Provider taxes and donations allowed states to increase federal Medicaid funds while backing out of providing their states' matching shares and sometimes effectively pocketing the federal share of money meant for disproportionate share hospitals.[28] What was created with good intentions was creatively abused by states across the nation.[29]

The abuse was so great that between fiscal year 1989 and fiscal year 1992, federal spending for Medicaid disproportionate share hospital payments grew from $400 million to $16.5 billion, more than a 4000 percent increase.[30] In states such as Michigan, Texas, and Tennessee, Medicaid DSH payments actually exceeded regular Medicaid payments for inpatient hospital services.[31] This rapid growth—a 4000 percent increase in just four years—was a tremendous reason for Medicaid's overall spending growth during the period from 1989 to 1993. The Kaiser Commission on the Future of Medicaid estimated that over one-half the annual increase in Medicaid between 1991 and 1992 was due to increases in DSH payments concentrated in about fifteen states.[32] By 1994, DSH payments accounted for twelve percent of total Medicaid spending.[33]

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24. MEDICAID SOURCE BOOK, *supra* note 1, at 319.

25. *Id.* at 319-320.

26. *Id.* at 321.

27. U.S. GENERAL ACCOUNTING OFFICE, MEDICAID: STATES USE ILLUSORY APPROACHES TO SHIFT PROGRAM COSTS TO THE FEDERAL GOVERNMENT 2 (1994) [hereinafter ILLUSORY APPROACHES].

28. *Id.* at 1.

29. According to the General Accounting Office, Michigan, Tennessee, and Texas are among the worst abusers of the DSH program. *Id.*

30. MEDICAID SOURCE BOOK, *supra* note 1, at 322.

31. THE KAISER COMMISSION ON THE FUTURE OF MEDICAID, MEDICAID SPECIAL FINANCING ARRANGEMENTS: DISPROPORTIONATE SHARE HOSPITALS (DSH) PAYMENTS, PROVIDER TAXES, AND INTERGOVERNMENTAL TRANSFERS 3 (1995) [hereinafter KAISER COMMISSION]; ILLUSORY APPROACHES, *supra* note 27, at 5, 10.

32. Rowland, *supra* note 17, at 4.

33. Telephone Interview with the Health Cost Estimates Unit, Congressional Budget Office (July 10, 1996).

B. The DSH and Provider Donations "Scam": How It Happened

Until 1985, Medicaid rules did not specifically allow the use of donated funds for any purpose other than training.[34] At that time, the Health Care Financing Administration[35] viewed the uses of donated funds for other purposes as a potential opportunity for misuse as a "kickback" by organizations such as long-term-care facilities or data-processing companies that receive Medicaid business.[36] However, by 1985, the Health Care Financing Administration had concluded that the potential for abuse was minimal, and a new regulation was promulgated allowing the use of donated funds for virtually any purpose, provided certain conditions were met.[37]

Soon states developed programs to use donated funds to finance the states' shares of Medicaid spending.[38] States found very creative ways to increase their state contributions and, thereby, the federal matches. In the case of Pennsylvania,

> 1170 hospitals got together, formed a foundation [and] borrowed some $365 million from a lending institution. They donated the money to the State treasury. The Federal match for Pennsylvania is such that the State got $380 million to match the $365 million they put up. The $365 million that was put up by this group of 170 hospitals went to the 170 hospitals as increased disproportional share payments, so they were made completely whole including the cost of borrowing the money. . . . The $380 million that the Feds put in, the only new money in the system, went to some 260 hospitals in the state . . . to increase rates to hospitals . . . .[39]

The General Accounting Office (GAO) noted that states often churned or even laundered federal Medicaid dollars through state hospitals. The GAO found that

> financing mechanisms used [by high-DSH states]. . . effectively increased the federal percentage share of Medicaid medical assistance payments . . . . Although Medicaid payments were made in accordance with the federal medical assistance percentage rates, as established by law, our analysis shows that the federal dollars account for a greater share of Medicaid expenditures than ultimately benefitted providers in these states. The financial arrangements we have highlighted resulted in

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34. 42 C.F.R. § 432.69 (1985); MEDICAID SOURCE BOOK, *supra* note 1, at 500.

35. The Health Care Financing Administration is the agency within the Department of Heath and Human Services that administers federal Medicaid spending and oversees state Medicaid programs. *See* Vladeck, *supra* note 4, at 2.

36. *Id.*

37. MEDICAID SOURCE BOOK, *supra* note 1, at 500 (42 C.F.R. § 433.45(b) (1986) listed two conditions regulating the use of donated funds: 1) the funds had to be transferred to the Medicaid agency and be under its administrative control, and 2) the funds could not revert to the donor unless the donor was a nonprofit organization.).

38. *Id.* at 501.

39. *Id.* at 502.

> providers only receiving a net benefit from Medicaid payments because they either returned the payments to the state treasury or directed the payments for use in non-Medicaid programs. . . .[40]

Based on evaluations of the DSH program, the Health Care Financing Administration warns that

> state donation and tax programs . . . have the potential to undermine the basic premise of the Medicaid program—that funding be shared through a Federal Match of state monies. In a matching program, those responsible for expenditure decisions and the direct fiscal management of the program must have a reasonable stake in the costs. This shared responsibility works to shape their decisionmaking to contain costs.[41]

As a result of these scams, Congress enacted legislation to create state-specific ceiling limits on each state's spending for DSH-payment adjustments to twelve percent of the state's total Medicaid spending for the year.[42] This limit, combined with other changes in the amount of money a single hospital can receive and the definition of what constitutes a provider tax, has been effective at controlling these costs. In fact, at least eighteen states that have twelve percent of their overall Medicaid spending in DSH payments are capped at the absolute dollars they received in 1993.[43]

C. Republican Budget Plan

Congress is prepared to abandon the successful aspects of the Medicaid program and reward those who abused the Medicaid program in the past. Last fall, this was done in an amendment that decreased the federal reduction in Medicaid payments to states from $187 billion to $176 billion.[44]

Some of the winners and losers are well known by now. In the Senate proposal, approximately $11.2 billion in additional Medicaid dollars would have been distributed over the next seven years to states with two Republican Senators, while states with two Democratic Senators would have lost an additional $3.6 billion.[45] Less well known is the fact that states that have had excessive Medicaid disproportionate share programs

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40. ILLUSORY APPROACHES, *supra* note 27, at 12.

41. MEDICAID SOURCE BOOK, *supra* note 1, at 501.

42. Medicaid Voluntary Contribution and Provider-Specific Tax Amendment of 1991, Pub. L. No. 102-234, 102 Stat. 234 (1991); *see* MEDICAID SOURCE BOOK, *supra* note 1, at 500, 511.

43. KAISER COMMISSION, *supra* note 31, at 2; MEDICAID SOURCE BOOK, *supra* note 1, at 503-113.

44. *See* S. 1357, 104th Cong., 1st Sess. § 2121 (1995) (amended by S. Amd. 3028).

45. *Studies in Brief: States Like New Hampshire and Louisiana*, INSIDE HEALTH CARE REFORM 1 (June 1, 1995). The Center on Budget and Policy Priorities found that the Senate bill would "lock in the historical spending patterns among states." *Id.*; *see* S. 1357, 104th Cong., 1st Sess. § 2121 (1995) (amended by S. Amd. 3028).

in the past would have also been big winners. New Hampshire and Louisiana, the most notorious examples of excess, had special fixes in the Senate bill to excuse those two states from fully matching the federal funding they would have received during the next few years.[46]

Meanwhile, nine other states,[47] all of which have disproportionate share programs that far exceed the national average and some of which have schemed against the federal treasury in the past, would have received $14.8 billion in increased Medicaid funding during the next seven years as a result of the Republican leadership Medicaid plan.[48] Current law caps these "high-DSH" states' programs.[49] However, the Republican deal would have allowed these states to keep and make permanent all of those dollars by including these funds in the states' base allotments and would have allowed them to increase that money annually from this year forward. Thus, it provided a $14.8 billion windfall for nine "high-DSH" states.[50] The rest of the nation's states—mostly "low-DSH" states—would have lost another $3.6 billion from an amendment that added an additional $10.2 billion back to the Medicaid program.[51]

D. Social Security Trust Fund Raid

The Senate planned to pay for these supplemental Medicaid allocations by mandating a 2.6% Cost-of-Living Adjustment (COLA) for 1996. Under the Roth amendment, this money was "found" when the Senate declared that the cost-of-living adjustment for 1996 would be 2.6%, which was lower than the 3.1% projected when the budget bills began moving through Congress last spring.[52] The result of the lower COLA, said proponents, would be lower outlays for programs tied to the Consumer Price Index (CPI), such as Social Security.[53] At first glance, this sounds great—let's recognize the economic reality that COLAs will be lower next year than anticipated. Upon closer inspection, however, the logic fails and it becomes clear that the funding was either phony or, more likely, a raid on the Social Security Trust Fund.

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46. *Studies in Brief*, *supra* note 45. While this budget package was vetoed by President Clinton, *see supra* note 18, similar fixes were part of the Omnibus Consolidated Recision and Appropriations Act of 1996, Pub. L. No. 96-10, § 519 (1996), which was subsequently enacted as a compromise budget.

47. Alabama, Connecticut, Kansas, Michigan, Missouri, New Jersey, South Carolina, Tennessee and Texas. KAISER COMMISSION, *supra* note 31, at 11.

48. 141 CONG. REC. S16,808 (daily ed. Nov. 8, 1995).

49. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendment of 1991, Pub. L. No. 102-234, 102 Stat. 234 (1991); *see* MEDICAID SOURCE BOOK, *supra* note 1, at 321-22.

50. 141 CONG. REC. S16,808 (daily ed. Nov. 8, 1995).

51. *Id.*

52. *See* S. 1357, 104th Cong., 1st Sess. § 7481 (1995) (amended by S. Amd. 3028).

53. *Id.*

In order to understand this, a brief explanation of how the budget is scored is in order. In April, 1995, the Congress established an economic baseline.[54] This baseline forecasts the level of federal revenues and expenditures for the next seven years and is grounded on current law and current and projected economic data.[55] In making these economic projections, the Congressional Budget Office makes assumptions regarding a number of factors.[56] Some of the factors include inflation, interest rates, gross domestic product (GDP), and revenues.[57] From that baseline, the Congressional Budget Office can estimate the impact that changes in law will have on federal revenues or expenditures.[58]

Since the economic baseline was established, some of the assumptions have turned out to be high and others low. For example, at the end of 1995, inflation was lower than expected, gross domestic product was slightly higher than expected and interest rates were higher than projected.[59] While it is true that the fact that the 1996 COLA will be 2.6% rather than 3.1% will result in $13 billion in lower outlays, this will be more than offset by other factors (*e.g.*, higher interest rates) that increase outlays or decrease revenues.[60] Thus, the Senate's financing of the additional Medicaid funds is phony.

So where does this money come from? Let's look at the language of the Roth amendment:

> Notwithstanding any other provision of law, in the case of any program within the jurisdiction of the Committee on Finance of the United States Senate which is adjusted for any increase in the consumer price index for all urban wage earners and clerical workers (CPI-W) for the United States city average for all items, any such adjustment which takes effect during fiscal year 1996 shall be equal to 2.6 percent.[61]

This clearly specifies that the money would come from programs, or outlays—not Department of Defense outlays, or funding for roads and bridges, or foreign aid, which are not in the jurisdiction of the Finance Committee. The overwhelming majority of the outlays within the jurisdiction of the Finance Committee—an amount totaling $12 of the $13 billion—is for Social Security.[62] So the only conclusion is that the Senate

54. CONGRESSIONAL BUDGET OFFICE, ECONOMIC AND BUDGET OUTLOOK: AN UPDATE 45 (1995) [hereinafter BUDGET OUTLOOK: AN UPDATE].
55. *Id.*
56. *Id* at 13.
57. *Id.* at 14, 58-59.
58. *Id.*
59. *Id.* at 15.
60. *Id.*
61. *See* S. 1357, 104th Cong., 1st Sess. § 7481 (1995) (amended by S. Amd. 3028).
62. 141 CONG. REC. S16,808 (daily ed. Nov. 8, 1995).

took $12 billion from the Social Security Trust Fund to pay for more Medicaid allocations.[63]

How can a 0.5% reduction in the CPI constitute a raid on the Social Security Trust Fund? The Roth amendment took into account only outlays impacted by the lower 2.6% COLA. But there are other ramifications of a lower COLA. For example, many workers' salaries are tied to the CPI. And if those salaries rise by only 2.6% rather than 3.1%, then payroll taxes will be lower and, consequently, less money will flow into the Social Security Trust Fund than would have occurred if the COLA had been 3.1%.

The correct question is not how a lower COLA will impact Social Security outlays. The proper question is what the net effect of all of the economic changes this year would have been to the Social Security Trust Fund. The answer has two components: outlays and revenues. The Social Security outlays would have been reduced by a total of $18 billion—$12 billion from the COLA reduction to 2.6% and $6 billion from other changes.[64] However, the economic data accumulated since March, 1995 also will affect revenues and, according to the Congressional Budget Office, updating the economic baseline will result in a $62 billion dollar decrease in Social Security Trust Fund revenues during the next seven years.[65] Accordingly, the net effect of revising Congressional economic estimates to the Social Security Trust Fund is a decrease of $44 billion.[66] So, if we want to face economic reality, the Social Security Trust Fund would have $44 billion less in it than our budget assumed. And, while the Social Security Trust Fund is losing $44 billion as a result of economic changes since March, 1995, the Senate approved diverting an additional $12 billion from the Trust Fund.

The Republicans cannot have it both ways. If the proposed reduction in the COLA was not a real cut in spending but merely reflected reality, then it did not represent savings and should not qualify to offset real, new Medicaid spending. If, however, the proposed reduction in the COLA

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63. *See* Thomas Daschle, *Democrats Offer Amendments To Get Budget Negotiations Moving, Correct Worst Problems in Reconciliation Bill*, Nov. 2, 1995, *available in* WESTLAW, File No. 11630810. Senator Daschle called the Roth amendment a "illegal use of nearly $12 billion in COLA funds as offsets to buy Republican votes for reconciliation." *Id* at 2. This shifting of funds can legitimately be characterized as illegal because the Congressional Budget Act prohibits the use of funds not included in the budget (Social Security) to pay for budget expenses (Medicaid). *Id; see* 2 U.S.C. § 641(d), (g) (1995). Medicaid is included in the general budget, while Social Security is funded separately through the Social Security Trust Fund. *See* Daschle, *supra*, at 2.

64. Daschle, *supra* note 63, at 2.

65. BUDGET OUTLOOK: AN UPDATE, *supra* note 54, at 22.

66. *Id.*

was real, then it constituted a diversion of funds from the Social Security Trust Fund.[67]

Currently, Congress is considering a Republican Medicaid reform proposal that is substantially the same as that passed and vetoed in the first session of Congress. Congress should not enact this block grant proposal, but rather should look for an alternative allocation solution.

III. MEDICAID REFORM TO SAVE AMERICA'S MEDICAL SAFETY NET

The only way to reform Medicaid is to restrain growing costs without jeopardizing the successful aspects of Medicaid. The Senate is not irrevocably wedded to block grants; there is a better way. The foundation of the block grant proposal—enhanced flexibility for the states—is built on shaky ground, eroding every day. Shaky, that is, unless you define "flexibility" as the freedom to raise state taxes or local property taxes, or the flexibility to pit the elderly against child beneficiaries. Otherwise, there is scant flexibility the states can receive that they cannot already get under the waiver program.[68] The Department of Health and Human Services has pioneered with willing states extraordinary demonstration projects, where statutory and regulatory requirements can be waived to permit new approaches to health care.

In November 1995, I met with Mr. Bruce Vladeck, Administrator of the Health Care Financing Administration. My question to him was a simple one: what flexibility to allow innovation would the block grants give states that they cannot get today through the waiver program. His answer: precious little.[69] And what do the states give up in exchange for this marginal new flexibility? The answers include: 1) the federal partnership to assist them if they experience caseload growth; 2) the federal partnership during times of economic hardship or recession; and 3) the federal partnership when there is a natural disaster.[70]

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67. As discussed earlier, using saving from an off-budget program, such as Social Security, to fund an on-budget program, such as Medicaid, is a violation of Congressional budget rules. Daschle, *supra* note 63, at 2; *see* 2 U.S.C. § 641(d), (g) (1995).

68. As states have felt the pressures of rising Medicaid costs, they have looked for alternative strategies for providing adequate health care while limiting costs. In order to facilitate more effective methods of providing Medicaid services, states have had to deviate from the traditional Medicaid structure. David Parrelle, Statement Before the U.S. House Subcommittee on Human Resources and Intergovernmental Relations, Jan. 18, 1996, *available in* Federal Document Clearing House. One way that the federal government satisfied this need for flexibility is through waiver programs such as the section 1115 research and demonstration waiver. *Id.* This waiver allows a state to set up an experimental health care delivery program and determine whether it will meet the needs of the state. *Id.* at 4. Even though waiver programs are designed to provide flexibility, the Health Care Finance Administration reviews the waiver to ensure it meets certain criteria. *Id.* at 5.

69. 141 CONG. REC. S16,847 (daily ed. Nov. 9, 1995).

70. *Id.*

When Hurricane Andrew hit Miami, Florida's Medicaid caseload shot up by 12,000 people.[71] Under block grants, a state that is knocked to its knees by a flood, a riot, an earthquake, or a hurricane, would not find a helping hand from the federal government at a time it needed help getting back onto its feet.

So if block grants are this bad, is the only alternative "business as usual" in Medicaid? No; there is a way to have the best of both worlds—to contain costs while maintaining the federal-state partnership. The best of both worlds is the "per capita cap" proposal that is gaining momentum as the "win-win" answer to the block grant's "lose-lose" proposition. The per capita cap approach provides that health care and coverage can be protected and costs controlled by disciplining the program with an annual limit in federal spending per beneficiary.

This approach maintains the individual guarantee to Medicaid coverage and creates incentives for states to maintain health care coverage. Funding would follow the patient, not some bureaucratic entity. The per capita cap approach that I presented to the Senate in November 1995 saves $62 billion over the next seven years.[72] It enhances state flexibility and reduces the rate of growth in federal Medicaid spending to a level that is sustainable for the states, the beneficiaries, and the federal government. It assures that states with innovative demonstrations already underway can continue to operate their programs and that other states wishing to innovate have the resources and ability to do so.

Let me briefly outline how the per capita cap approach would work. Federal funding would be allocated to states on a per person-in-need basis. If, hypothetically, it costs $1000 to provide Medicaid benefits to a person in California, the federal government would allocate its share of money, or $500 in this case, for each person who qualifies for Medicaid in the state. If needs increase because of population shifts, recession, natural disaster, or public health calamity and more people become eligible for coverage, the federal partnership and contribution of $500 per person would be guaranteed—not as under a block grant where a fixed sum is allocated regardless of circumstance. The incentive is to reduce costs and not cut people off coverage because if states arbitrarily cut people off, they lose the federal match. Costs are what must be controlled. If, for example, California were to spend more than $1000 per person cap, Cali-

71. Robert Reischauer, Statement Before the U.S. Senate Committee on Finance, Feb. 29, 1996, *available in* Federal Document Clearing House.

72. This per capita cap proposal, which I proposed in November 1995, 141 CONG. REC. S16,845-48 (Nov. 9 1995), is quite similar to the proposal President Clinton announced in December 1995. *Medicaid Per-Capita Cap Locks in State Disparities*, WASH. HEALTH WK., Dec. 18, 1995, at 1; *see* BUDGET OUTLOOK: 1997-2007, *supra* note 19, at 61. The President's per capita cap proposal is estimated to save $54 billion over six years. Rowland, *supra* note 17, at 4. The National Association of Governors adopted a Medicaid budget proposal that includes a variation on the per capita cap approach. Coloretti Interview, *supra* note 21.

fornia would make up that difference. Again, under a per capita cap, the money follows the need and person. As a result, during economic booms, or when health needs decline, the federal government would share in the savings—also not as under the block grant system that obligates money regardless of the needs of the residents of the state or the payments made by the state.

The cap would be stated in inflation terms on an annual basis in order to protect states from potential inflation increases. The cap would be cumulative and thus allow states enough flexibility to apply savings under the cap from one year to the next. Caps would be applied separately to the elderly, the disabled, children, and their mothers. This separation into four distinct groups avoids the sinister "zero sum game" that is endemic to block grants—a game in which one group's interests are pitted against the others'.

This formula may appear complicated, but it really is a clone of the way states allocate and distribute school dollars to the districts.[73] In fact, with only four categories to consider, it is far simpler than most "per pupil" school district formulas.[74] The per capita cap idea is also one that should be familiar to many of my Republican colleagues. It is a concept that was supported in health proposals introduced by Senators Dole, Gramm, and Chafee in 1994.[75]

The Medicaid per capita cap approach permits the states to move toward managed care and other types of arrangements that save money without needing federal waivers.[76] Another advantage to the per capita cap approach is that many other detailed rules and process-oriented requirements would be phased out. States would be held accountable for performance outcomes with respect to certain quality and access measures.[77] The federal government would be interested in the outcomes of state health and long-term care delivery systems but would not be mandating how to achieve those outcomes.

Finally, the per capita cap approach would cap and retarget future growth in the DSH program. The per capita cap approach would assure that children, low-income women, and disabled and elderly Americans would have continued coverage for hospital, physicians, and nursing home care services. This approach would cut costs, not people.

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73. *See, e.g.*, FLA. STAT. § 361.081 (1995).

74. *Id.*

75. *See Chafee Drops Medicaid Bill; HMOs Weary of Block Grants*, INSIDE HEALTH CARE REFORM, June 1, 1995, at 1; *Chafee Medicaid Reform Alternative to Block Grants Evolving in Senate*, INSIDE HEALTH CARE REFORM, June 15, 1995, at 1.

76. GOVERNMENT ACCOUNTING OFFICE, MEDICAID: RESTRUCTURING APPROACHES LEAVE MANY QUESTIONS 6 (Apr. 1995). This provides great flexibility for states to alter state Medicaid programs to adapt to the changing needs of beneficiaries without having to go through the arduous Medicaid waiver process for each program modification.

77. Per capita caps "put states at full risk for the management of the program." *Id.*

IV. CONCLUSION

The $62 billion reduction in spending achieved through the per capita cap approach amounts to a surgical cut, not the meat-ax approach of the $72 billion cut under the block grant legislation that passed the Senate in 1995.[78] Further, the per capita cap approach would continue the federal-state partnership in detecting fraud and punishing defrauders. Medicaid fraud, DSH abuse, and unconstrained spending amount to a cancer on our nation's health and long-term care delivery system. However, it is a treatable, not terminal, condition. In our zeal to cure this affliction, let's not kill the patient in the process. Let's not kill the very federal-state partnership that has served this nation so well for thirty years. After all, behind the $72 billion in cuts are human beings who will pay the price for our haste.

In addressing the Medicaid and welfare block grant debates, David Broder of the *Washington Post* wrote eloquently of the fear that under block grants, "the states will engage in a 'race to the bottom' that shreds the social safety net."[79] He predicted the likeliest scenario under block grants as follows: "What would happen when federal funding is reduced and federal standards are eliminated is that the 50 legislatures would become the arena, each year, in which the welfare population would have to compete against other claimants for scarce dollars."[80]

I share his bleak view of the future in America under block grants. You cannot have a race to the bottom without casualties along the way. Along the way in the block grant "race to the bottom" will be eyeglasses for the elderly and unfilled prescriptions formerly covered under Medicaid. Such benefits will not survive the race to the bottom, and the individual losses will be great and even overwhelming. Along the way in the block grant "race to the bottom" will be families torn apart by unnecessary nursing home placements and institutionalization. Home health care and other Medicaid waiver services will not survive the race to the bottom. Along the way in the block grant "race to the bottom" will be ugly legislative sessions in fifty state legislatures, where, among the conflicts, the elderly will be pitted against children and the mentally retarded against AIDS sufferers in a battle royal for the block-grant dollar.

Is that what we want for America? The race to the bottom has yet to begin, and it need never begin. There is another way. Per capita cap legislation is our way out of the "race to the bottom" and is our ticket to a twenty-first century that maintains an American federal-state stake in the health and welfare of its citizens.

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78. 141 CONG. REC. S16,847-48 (daily ed. Nov. 9, 1995) (quoting David Broder).

79. 141 CONG. REC. S16,848 (daily ed. Nov. 9, 1995).

80. Kent, *State Feasibility*, *supra* note 19, at 1; *see* H.R. 2491, 104th Cong., 1st Sess. (1995).