MEMORANDUM

TO: Gene

cc. Chris

FROM: Jeanne Jeanne

RE: **CHILDREN'S HEALTH & GOVERNORS**

DATE: July 16, 1997

Per our conversation, here is a quick update of the Governors' meeting. Attending were: Frank, Jack, Josh, Emily and Chris; Governors Chiles, Miller, Romer, Carper and Dean (by phone). It lasted an hour.

Frank and Chris presented respectively. Frank emphasized accountability. Given (1) the amount of funding, (2) states' history of trying to maximize Federal funding, and (3) the bipartisan goal of covering as many uninsured children possible, provisions that safeguard Federal funding are critical. The usual types of provisions include: (1) eligibility rules to prevent substitution of coverage; (2) financing rules that prevent states from replacing their current funding with new Federal funding; and (3) state contribution rules to ensure that this funding is real. We are working on others.

Afterward, Chris pushed back on the issue of flexibility. He reminded the Governors that this new children's program is very different than Medicaid. It lacks Medicaid's requirements for payment rates; managed care standards and quality; and Federal review through state plan amendments. In particular, states have wide latitude in determining who is eligible and do not have to offer children EPSDT — major changes from Medicaid. Thus, charges that the grant is not "flexible" are not true.

He then went on to defend our support for two provisions. First, they oppose the requirement that a child receive at least the FEHBP Blue Cross Blue Shield benefits (with hearing, vision, and mental health parity). Chris remarked that the House benefits — inpatient, outpatient, physician, surgical, lab and x-ray, and well-child visits — account for about 80 percent of the costs of the Blue Cross plan. The remaining 20 percent is accounted for primarily by prescription drugs, and also hearing and vision and other services that are important for healthy kids. He also made the point that our Democrats in Congress feel very strongly that this is a compromise from Medicaid and that the range of services needs to be specified to qualify as meaningful. The second issue is the requirement that states phase in Medicaid coverage of poor children by 2000 instead of 2002. As we discussed, 20 states have already accelerated this phase-in. CBO assumes that even if we fully funded this acceleration and it would only cost $700 million over 5 years. These 13 to 18 year olds are between 50 and 100 percent of poverty should benefit from some of the $16 (or $24) billion.

To my surprise, the Governors responded well. They praised us for how much we had given in the way of flexibility, and said that Chris made a compelling case on benefits. They also raised some Medicaid issues such as DSH, the Senate provision on Medicaid cost sharing for Medicare beneficiaries, and the unfunded mandate from the Medicare home health copayment. Chris raised the issue of the tobacco tax, which the Governors said that they would consider. We offered to keep the dialogue open, and the meeting ended.

I also want to briefly follow up on our conversation about the extra $8 billion and our basic recommendations. We have three principals for the children's health initiative: (1) meaningful coverage, meaning a defined, comprehensive benefits package with limited cost sharing for the poorest; (2) accountability, to ensure that states are not using the new funds to replace existing state or private spending; and (3) efficiency, to provide financial incentives to assure that the coverage is targeted to uninsured children.

Probably, the most effective way to meet these criteria is a Medicaid mandate. We could easily afford mandating coverage of children up to 150 percent of poverty with the funds we have — and probably have enough money left over to offer a higher matching rate. However, mandates have not been a viable option in this environment, so we worked on the same concept on a voluntary basis. The Chafee-Rockefeller proposal basically said that states expanding coverage had to use Medicaid to cover children up to 133 percent of poverty before accessing the grant funds. This failed due to Democrats changing their position on this (Breaux, Graham, Bryan). Now, we are trying at least to level the explicit financial incentives between Medicaid and the grant approach (e.g., making equal matching rates; having no differential preconditions for Medicaid options). However, I agree with CBO analysts that few states will opt for Medicaid given its richer benefits and greater regulation. Consequently, we are working on financial incentives to encourage states to do outreach for Medicaid (e.g., higher matching rate for any new child enrolled, regardless of whether they are currently or newly eligible and requirements for school-based enrollment).

Given this situation, I am personally skeptical about the marginal value of adding another $8 billion to the grant without any new conditions on its use. If we are literally increasing the funding by 50 percent, we can probably ask more of states. Some of the funds could buy out some of the state spending associated with the more rapid phase-in of poor children's coverage. We could possibly add to the current requirement, that they cover poor children first, that they cover lower income children through Medicaid. And, as stated above, incentives to fund any new enrollee (currently or newly eligible) are a good use of money. This directs funds to the poor and near poor, who are more likely to be uninsured.

Finally, I want to reiterate a point that Chris often makes. This is an historic opportunity. The $16 or $24 billion is the largest expansion since Medicaid began and, if we succeed in incorporating our principals — meaningful coverage, accountability, and efficiency — we will have done well. The prospects for meeting these criteria look good. However, we can always do better and if the $8 billion gives us some leverage, we should use it.