Teaching Medicaid: A Tool for Health Law Teachers (2004 Update)

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Topics

• Medicaid’s role as a health insurer: major themes
• Eligibility and services
• Where do Medicaid expenditures go and how important are they to the health care system?
• Medicaid as health care payer and its role in supporting the health care safety net
• Medicaid’s role in state financing
• Medicaid’s role as a legal entitlement
• Does Medicaid need reform and if so, what should reform accomplish?
Medicaid’s Role as a Health Insurer: Major Themes
Figure 3

Medicaid’s Major Themes

- Markets versus social contract through direct government benefits
- Federalism
- Legal rights versus largesse
Medicaid Versus Private Health Insurance: A Conceptualization of The Social Contract Theme

<table>
<thead>
<tr>
<th>Private Health Insurance</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designed to avoid risk and engage in “fair discrimination” to avoid “moral hazard” of higher than actuarially projected use</td>
<td>Designed to insure the uninsurable (populations and services). The “non-actuarial” insurer</td>
</tr>
<tr>
<td>• Limitations on eligibility (pre-existing condition exclusions and waiting periods)</td>
<td>• Eligibility based on poverty, disability, age, pregnancy, illness, and other high risk factors considered uninsurable</td>
</tr>
<tr>
<td>• Aggressive marketing to best risks</td>
<td>• Affirmative, prompt enrollment obligations, even at the point of service; entitlement often linked to illness or medical condition</td>
</tr>
<tr>
<td>• Limitations on coverage (diagnostic-specific coverage limits, coverage exclusions, high cost sharing, stringent definitions of medical necessity)</td>
<td>• Broad defined-benefit coverage rules, limited or no cost sharing, prohibitions against diagnostic discrimination, a broad concept of medical necessity, particularly for children</td>
</tr>
</tbody>
</table>
Figure 5

The Themes of Federalism, Social Contract, and Largesse

• Federalism
  – Federal requirements versus state flexibility over coverage design, coverage decisions, provider payment, and administration

• Private enforceability
  – Can individuals be said to have “rights” under Medicaid?

  – Are these rights enforceable against state and federal defendants and if so, under what circumstances?

  – Unlike Medicare and employee benefits, no clear legislative provision within the “four corners” of the Medicaid statute authorizing private enforcement of federal rights
Eligibility and Services
Basic Elements of Eligibility

- Connection to one or more federally enumerated, recognized eligibility categories (e.g., age, disability, pregnancy, child <18, parent of child < 18)
- Financial eligibility (income and assets, with complex valuation tests)
- Satisfaction of applicable citizenship or legal residency status
- Satisfaction of federally defined state residency standards
## Medicaid Beneficiary Groups

<table>
<thead>
<tr>
<th>Mandatory Populations</th>
<th>Optional Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children below federal minimum income levels</td>
<td>• Children above federal minimum income levels</td>
</tr>
<tr>
<td>• Adults in families with children (Section 1931 and TMA)</td>
<td>• Adults in families with children (above Section 1931 minimums)</td>
</tr>
<tr>
<td>• Pregnant women ≤133% FPL</td>
<td>• Pregnant women &gt;133% FPL</td>
</tr>
<tr>
<td>• Disabled SSI beneficiaries</td>
<td>• Disabled (above SSI levels)</td>
</tr>
<tr>
<td>• Certain working disabled</td>
<td>• Disabled (under HCBS waiver)</td>
</tr>
<tr>
<td>• Elderly SSI beneficiaries</td>
<td>• Certain working disabled (&gt;SSI levels)</td>
</tr>
<tr>
<td>• Medicare Buy-In groups (QMB, SLMB)</td>
<td>• Elderly (&gt;SSI; SSP-only recipients)</td>
</tr>
<tr>
<td></td>
<td>• Elderly nursing home residents (&gt;SSI levels)</td>
</tr>
<tr>
<td></td>
<td>• Medically needy</td>
</tr>
</tbody>
</table>
Sample Medicaid Eligibility Pathways for Women

- Pregnant, Income < 133% FPL
- Uninsured Woman < Age 65 with Breast or Cervical Cancer
- Adult Receiving SSI, Income < $531/month (Elderly or Disabled)
- Parent Leaving Welfare, <185% FPL
- Parent with Income < ’96 AFDC level
- Non-disabled Adult without Children, $0 Annual Income
Sample Medicaid Eligibility Pathways for Men

- Non-disabled Adult without Children, $0 Annual Income
- Parent Leaving Welfare, <185% FPL
- Adult Receiving SSI, Income < $531/month (Elderly or Disabled)
- Parent with Income < ’96 AFDC level

Figure 10

K A I S E R C O M M I S S I O N O N
Medicaid and the Uninsured
Figure 11

Health Insurance Coverage of Nonelderly Persons by Poverty Level, 2002

Notes: The federal poverty level was $14,348 for a family of three in 2002. Percentages may not total 100% due to rounding.

251 million 42 million 44 million 41 million 125 million
NOTE: Based on a family of three. The federal poverty level was $8,980 for a single person and $15,260 for a family of three in 2003.
Figure 13
Percent of Residents Covered by Medicaid, by State, 2001-2002

# Figure 14

## Required and Optional Benefits

<table>
<thead>
<tr>
<th><strong>Required Items &amp; Services</strong></th>
<th><strong>“Optional” Items and Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians services</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Laboratory and x-ray services</td>
<td>Medical care or remedial care furnished by licensed practitioners</td>
</tr>
<tr>
<td>Inpatient hospital services</td>
<td>Diagnostic, screening, preventive, and rehab services</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Clinic services</td>
</tr>
<tr>
<td>Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21</td>
<td>Dental services, dentures</td>
</tr>
<tr>
<td>Family planning and supplies</td>
<td>Physical therapy</td>
</tr>
<tr>
<td>Federally-qualified health center (FQHC) services</td>
<td>Prosthetic devices, eyeglasses</td>
</tr>
<tr>
<td>Rural health clinic services</td>
<td>TB-related services</td>
</tr>
<tr>
<td>Nurse midwife services</td>
<td>Primary care case management</td>
</tr>
<tr>
<td>Certified nurse practitioner services</td>
<td>ICF/MR services</td>
</tr>
<tr>
<td>Nursing facility (NF) services for individuals 21 or over</td>
<td>Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)</td>
</tr>
<tr>
<td></td>
<td>Inpatient psychiatric hospital services for individuals under age 21</td>
</tr>
<tr>
<td></td>
<td>Home health care services</td>
</tr>
<tr>
<td></td>
<td>Respiratory care services for ventilator-dependent individuals</td>
</tr>
<tr>
<td></td>
<td>Personal care services</td>
</tr>
<tr>
<td></td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
</tr>
</tbody>
</table>
Figure 15
Health Status and Functional Limitations of Non-elderly Low Income Adults
Medicaid vs. Privately Insured, 1996-1998

Self-Reported Health Status

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medicaid</th>
<th>Privately Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair or Poor</td>
<td>11%</td>
<td>3%</td>
</tr>
<tr>
<td>Excellent</td>
<td>14%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Limitations

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medicaid</th>
<th>Privately Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair or Poor Mental Health</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Social or Cognitive Limitations</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Difficulty Lifting, Walking, or with Steps</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Unable to Perform Activity of Daily Living</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Any Limitations</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Note: All differences are statistically significant at the 5% level. Low income defined as those with incomes less than 200% of the Federal Poverty Level. Adults defined as age 19-64.


K A I S E R C O M M I S S I O N O N
Medicaid and the Uninsured
Note: “Poor” is defined as living below the federal poverty level, which was $14,348 for a family of three in 2002.
Figure 17

Medicaid’s Role for Selected Populations

Percent with Medicaid coverage:

- Nonelderly Americans: 10%
- Poor: 37%
- Near Poor: 17%
- Poor Children: 52%
- Poor Pregnant Women: 53%
- Poor Parents: 34%
- Poor Disabled Adults: 41%
- Poor Medicare Beneficiaries: 56%
- People Living with HIV/AIDS: 44%
- Nursing Home Residents: 60%

Note: “Poor” defined as living below the federal poverty level.
Figure 18
Trends in the Uninsured Rate of Children, by Income Level

Uninsured Rate

23%

Children with incomes below 200% of poverty

6%

Children with incomes above 200% of poverty

5%

SOURCE: Center on Budget and Policy Priorities analysis of NHIS data.
Figure 19

Medicaid’s Impact on Access to Health Care

Percent Reporting

- Did Not Receive Needed Care
  - Adults: 30%
  - Children: 16%

- No Pap Test
  - Women: 28%
  - Children: 13%

- Did Not See a Doctor
  - Adults: 53%
  - Women: 33%
  - Children: 20%

Medicaid’s Relationship to Medicare
Figure 21

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FY2002

Total Spending on Benefits = $232.8 Billion

- Spending on Dual Eligibles: 42% ($13.4 Billion)
- Prescription Drugs: 6% ($13.4 Billion)
- Non-Prescription: 36% ($82.7 Billion)
- Spending on Other Groups: 59% ($136.7 Billion)

NOTE: Due to rounding, percentages do not total 100%.
Figure 22
National Spending on Nursing Home and Home Health Care, 2002

**Nursing Home Care**

- Other Private: 3%
- Other Public: 2%
- Private Insurance: 7%
- Out-of-Pocket: 26%
- Medicaid: 50%
- Medicare: 12%

Total = $103.2 billion

**Home Health Care**

- Other Public: 5%
- Private Insurance: 22%
- Out-of-Pocket: 18%
- Other Private: 3%
- Medicaid: 23%
- Medicare: 32%

Total = $36.1 billion

Figure 23

Implications of Provisions in the New Medicare Bill for States

- Medicare will provide prescription drug coverage to Medicaid beneficiaries who are also enrolled in Medicare (the "dual eligibles")
  - However, states may not supplement the Medicare prescription drug benefit for dual eligibles through Medicaid. They must instead use state general revenue funds
- States will be required to make payments to the federal government totaling $115 billion over the next 10 years
  - Payments are designed to offset the fiscal relief states will receive as a result of no longer providing prescription drugs to dual eligibles under Medicaid
  - Between 2004 and 2006, this provision will cost states $1.2 billion more than they would have otherwise spent. Over 10 years, states will save a total of about $17 billion.
- States will assume new responsibilities for administering the Medicare prescription drug card in 2004 and the low-income subsidy in 2006
Where Do Medicaid Expenditures Go, and How Important are They to the Health Care System?
Figure 25

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:

<table>
<thead>
<tr>
<th>Period</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-95</td>
<td>10.0%</td>
</tr>
<tr>
<td>1995-98</td>
<td>3.6%</td>
</tr>
<tr>
<td>1998-2000</td>
<td>7.8%</td>
</tr>
<tr>
<td>2000-2002</td>
<td>11.9%</td>
</tr>
<tr>
<td>2004 (Projected)</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

Figure 26

Medicaid’s Role in the U.S. Health System

Health Insurance Coverage, 2002

- Employer: 56%
- Other: 6%
- Uninsured: 15%
- Medicaid: 12%
- Medicare: 12%

Total Population = 285 Million

Note: Excludes active military members

Personal Health Spending, 2002

- Out-of-Pocket Payments: 16%
- Other Public: 7%
- Other Private: 4%
- Private Insurance: 36%
- Medicaid: 17%
- Medicare: 19%

Total = $1,340 Billion


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Medicaid and the Uninsured
Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.

Medicaid Expenditures by Service, 2002

Total = $248.7 billion

SOURCE: Urban Institute estimates based on data from CMS (Form 64).
Figure 29

Distribution of Medicaid Spending by Eligibility Group and Type of Service, 1998

Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

Figure 30

Medicaid’s Role in the Health System, 2002

Medicaid as a share of national personal health care spending:

- Total Personal Health Care: 17%
- Hospital Care: 17%
- Professional Services: 12%
- Nursing Home Care: 49%
- Prescription Drugs: 18%

Total National Spending (billions):
- $1,340
- $486.5
- $501.5
- $103
- $162

Figure 31

Average Annual Rate of Expenditure Growth for Medicaid Services, 2000-2002

<table>
<thead>
<tr>
<th>Service</th>
<th>Average Annual Rate of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicaid Services</td>
<td>12.9%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>11.2%</td>
</tr>
<tr>
<td>Physician, Lab, X-Ray</td>
<td>12.6%</td>
</tr>
<tr>
<td>Outpatient Hospital, Clinic</td>
<td>13.7%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>18.8%</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>9.5%</td>
</tr>
<tr>
<td>Home Care</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.
SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.
Figure 32

Sources of Medicaid Expenditure Growth

- **Keeping pace with health care inflation**
  - Pressure to increase provider payments
  - Escalating costs for prescription drugs

- **Changing patterns of health care utilization**
  - Expanding home- and community-based services
  - Increase in prescription drug utilization

- **Expanding enrollment**
  - Economic downturn
  - Growth of the disabled population in Medicaid

- **Use of “Medicaid maximization” arrangements** which increase federal contributions to state programs above legal levels permitted under “federal medical assistance percentage (FMAP)” law
Figure 33

Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002

Total = $48.2 billion


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Medicaid and the Uninsured
Medicaid as a Health Care Payer and Supporter of the Health Care “Safety Net”
Medicaid Provider Participation

- **47%** Accept **ALL** New Medicaid Patients
- **25%** Accept **SOME** New Medicaid Patients
- **28%** Accept **NO** New Medicaid Patients

**SOURCE:** Medicare Payment Advisory Commission, 1998-1999 survey of physicians.
Hospital Payment-to-Cost Ratios, 2000

Figure 37

Growth in Medicaid Long-Term Care Expenditures, 1991-2001

- Institutional care
- Non-Institutional Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Institutional Care</th>
<th>Non-Institutional Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>$34 (86%)</td>
<td>$14 (14%)</td>
</tr>
<tr>
<td>1996</td>
<td>$52 (79%)</td>
<td>$21 (21%)</td>
</tr>
<tr>
<td>2001</td>
<td>$75 (71%)</td>
<td>$29 (29%)</td>
</tr>
</tbody>
</table>

Source: Burwell et al. 2002, HCFA-64 data.
Figure 38

Comparison of Health Center and Physician Office Patients by Payor Source

Source: 2000 National Ambulatory Medical Care Survey (visits); Center for Health Services Research and Policy Analysis of 2001 UDS (patients).
Medicaid’s Role in State Financing
Figure 40
State Medicaid Spending as a Percent of General Fund Expenditures, 2002

Total State General Fund Spending = $496 billion


KAISER COMMISSION ON Medicaid and the Uninsured
Figure 41

Medicaid As a Percent of Federal Grant Funding to States, 2001

- Medicaid: 44%
- All Other: 27%
- Higher Education: 5%
- Transportation: 10%
- Public Assistance: 4%
- Elementary & Secondary Education: 10%
- Corrections: 0.3%

Figure 42
Federal Medical Assistance Percentages (FMAP), FY 2004, Including Temporary Fiscal Relief

NOTE: The percentages listed reflect the temporary increase in federal Medicaid matching rates enacted in the Jobs and Growth Tax Relief Reconciliation Act of 2003, which is effective for the first 3 calendar quarters of FY 2004.
Federal Share of Medicaid Financing (FMAP) v. Percentage of Poor Covered by Program

Medicaid as a Legal Entitlement
The States’ Legal Entitlement: Unemployment, Medicaid, and SCHIP Trends 2000-2003

NOTE: Trend lines are in tens of billions of dollars for Medicaid spending, billions of dollars for SCHIP spending, and unemployment rate for unemployment data.

State Variation in Medicaid Spending Growth Rates, 1991 - 2001

Average Annual Rate of Medicaid Spending Growth, 1991-2001

- Lowest State: 6.9%
- Median State: 11.5%
- Highest State: 15.7%

SOURCE: Data provided by the Urban Institute based on Form 64. Data include expenditures on DSH, but excluded administrative costs and accounting adjustments.
Figure 47
The Individual Legal Entitlement: Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2003

Long-Term Care
Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, and home health services.

Acute Care
Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to MCOs, and payments to Medicare.

Children | Adults | Disabled | Elderly
--- | --- | --- | ---
$1,700 | $1,900 | $12,300 | $12,800

Note: Expenditures do not include DSH, adjustments, or administrative costs.
SOURCE: CBO Baseline; KCMU and Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports.
States’ Medicaid Response to the Current Fiscal Crisis
Figure 49

Underlying Growth in State Tax Revenue
Adjusted for Inflation and Legislative Changes, 1997-2004

Figure 50

Sources of Growth in Federal Medicaid Expenditures, 2002-2003

Total Increase in Expenditures for Beneficiaries = $11 billion

Factors Behind Expenditure Growth

- Services-related: $8.4 billion (47%)
- Enrollment-related: $2.0 billion (53%)

Children 18%
Adults 5%
Elderly and Disabled 77%

Figure 51

Total Reduction in Medicaid Spending Resulting from State Budget Cuts

Medicaid spending reduction if states cut Medicaid budgets:

- **FMAP = 50%**
  - State Funds Saved: $100
  - Federal Dollars Lost: $100
  - Total Reduction: $200

- **FMAP = 65%**
  - State Funds Saved: $100
  - Federal Dollars Lost: $186
  - Total Reduction: $286

- **FMAP = 70%**
  - State Funds Saved: $100
  - Federal Dollars Lost: $233
  - Total Reduction: $333

SOURCE: Kaiser Commission on Medicaid and the Uninsured.
Figure 52

Number of States Implementing Medicaid Cost Containment Strategies Over the Past Three Years (FY 2002 – FY 2004)

- Controlled Drug Costs: 50
- Reduced or Froze Provider Payments: 50
- Reduced or Restricted Eligibility: 34
- Reduced Benefits: 35
- Increased Co-Payments: 32

Does Medicaid Need Federal Reform?
What Should Federal Reform Accomplish?
*Revised method estimates for 1999 are comparable to later years, except they are based on a smaller sample. SOURCE: KCMU and Urban Institute analysis of March Current Population Survey data.
Figure 55

Health Insurance Coverage of Low-Income Adults and Children, 2002

<table>
<thead>
<tr>
<th></th>
<th>Uninsured</th>
<th>Medicaid</th>
<th>Employer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (&lt;100 Poverty)</td>
<td>25%</td>
<td>56%</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td>Near-Poor (100-199% Poverty)</td>
<td>17%</td>
<td>36%</td>
<td>41%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Parents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (&lt;100 Poverty)</td>
<td>43%</td>
<td>34%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Near-Poor (100-199% Poverty)</td>
<td>31%</td>
<td>13%</td>
<td>49%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Adults without children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (&lt;100 Poverty)</td>
<td>46%</td>
<td>22%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Near-Poor (100-199% Poverty)</td>
<td>37%</td>
<td>9%</td>
<td>37%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Notes: Adults age 19-64. Data may not total 100% due to rounding.
Figure 56
Projected Annual Rate of Federal Medicaid Spending Growth v. Other Federal Spending, 2003-2013

<table>
<thead>
<tr>
<th>Program</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>8.5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>6.6%</td>
</tr>
<tr>
<td>Social Security</td>
<td>5.5%</td>
</tr>
<tr>
<td>Defense</td>
<td>2.7%</td>
</tr>
<tr>
<td>Nondefense</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

What Ought to Drive Reform?

It depends on one’s point of view:

- The cost of the program and state manipulation of FMAP rates, OR
- The rising number of uninsured people, the need to finance uninsurable and higher cost health services for persons with chronic and serious health conditions, and the need to relieve state fiscal burdens, OR
- Both
Reforming Medicaid

• How one approaches reform depends on how one defines the problem to be addressed.

  – An essential program which, in its current form, is inadequate to deal properly with various problems: a voluntary employer-based insurance system; insurers and employer sponsored health plans that operate on market (versus social contract) principles and seek to limit financial exposure to chronic illness and higher costs; the heavy burden of health spending that falls on state governments; and inadequate funding for broader population health programs

  OR

  – A program that is unaffordable, a tremendous drain on state and federal budgets, susceptible to state “scams,” and economically inefficient and antiquated in its continued provision of comprehensive and essentially free services to eligible persons while leaving out millions of others.
Two Visions of Federal Medicaid Reform

- Retain basic program structure while making certain reforms
  - Alter the federal/state financial partnership by increasing the FMAP and retaining the state entitlement
  - Close the categorical coverage gaps (e.g., low income adults without children)
  - Increase financial eligibility standards
  - Eliminate the “institutional bias” by augmenting coverage of community services
  - Improve provider payment levels and support for the safety net

- Shield the federal government from excessive and inefficient spending
  - Place an aggregate cap on federal contributions to state budgets
  - Eliminate the legal entitlement in states to open-ended financing
  - Eliminate the legal entitlement in individuals and providers
  - Eliminate some, most, or all eligibility and benefit rules to allow reductions in coverage and slimmer services
  - Eliminate provider payment rules