Medicaid Per Capita Caps: When Democrats Supported and Republicans Opposed Them, 1995–1997

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ABSTRACT

Congressional Republicans have called for restructuring Medicaid, reviving a debate that has largely remained dormant for two decades. During the mid-1990s, Congress and President Clinton advanced competing Medicaid reform proposals. Republicans urged that the federal government issue Medicaid block grants to states. The White House and congressional Democrats proposed instead to place per capita limits on federal Medicaid payments to states. The most salient difference between these approaches is that per capita allotments retain the individual entitlement to Medicaid while block grants generally do not. Today, Republicans who once resisted Medicaid per capita allotments support them, and Democrats who backed such allotments oppose them. Given this legislative history, policymakers seeking common ground might look to Medicaid per capita allotments as a point of departure.

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Congressional Republicans who have vowed to repeal and replace the Affordable Care Act (ACA) have called for restructuring Medicaid, reviving a debate that has largely remained dormant for two decades. GOP congressional leaders propose to transform Medicaid into a program of federal per capita allotments to states, a proposal their party spurned when President Clinton advanced it during the 1990s.[1] Today the parties' positions are reversed: Republicans who once resisted Medicaid per capita allotments have lately emerged as their champions; Democrats who backed such allotments 20 years ago now oppose them.[2]

The partisan role reversal belies the fact that both parties have, at one point or another, seen merit in the proposal, suggesting that it might reasonably serve as the basis for bipartisan negotiation and compromise.

The 1990s debate over per capita allotments and block grants took place in a political context in which prominent members of both parties agreed that the rate of federal Medicaid spending growth should be curbed and that states should have more latitude in program administration. They parted sharply, however, over how best to restructure the Medicaid program. Aside from

1. In March 2017, the House Budget Committee favorably reported H.R. 1628, the American Health Care Act. Section 121 established a Medicaid per capita allotment program, effective January 1, 2020. Subsequently, the House Rules Committee favorably reported a rule (H. Res. 228) that included an amendment that would allow states to choose between Medicaid per capita allotments and a block grant. The House adopted the rule on March 24, but H.R. 1628 was withdrawn from House consideration later that same day.

2. Former US representative Henry Waxman (D-CA), for example, recently wrote an op-ed that called Medicaid per capita allotments a "radical plan" that he found "alarming." Henry Waxman, "Republicans' Alarming Proposal Would End Medicaid As We Know It," *Washington Post*, February 27, 2017. At a January 1996 committee hearing, then-representative Waxman's statement for the record said that Medicaid per capita caps would respond "to the pleas of those who want more cost discipline in Medicaid without terminating the guarantee of basic health and long-term care to 36 million Americans." *Unfunded Mandates in Medicaid, Hearing before the Subcomm. on Human Resources and Intergovernmental Relations of the H. Comm. on Government Reform and Oversight*, 104th Cong. 111 (1996) (statement of Henry A. Waxman, D-CA).

disagreements over the size of federal Medicaid cuts, the most contentious issue was whether the federal government should "block grant" the program or place per capita limits on federal Medicaid payments to states. The most salient difference between these approaches, discussed at greater length below, is that per capita allotments retain the individual entitlement to Medicaid, while block grants generally do not.

That distinction is often lost in the current debate. House Speaker Paul Ryan (R-WI), for example, released a document in June 2016 that summarized the views of congressional Republicans on repealing and replacing the ACA. The document had this to say about Medicaid:

> Our plan maximizes state flexibility by providing states a choice of either a per capita allotment, or a block grant. Depending on their unique set of circumstances, states could choose the block grant option, or otherwise default into a per capita allotment approach.[3]

"In the end, Congress and the president compromised on a bill that balanced the federal budget without fundamentally changing the Medicaid program."

The notion that block grants and per capita caps are interchangeable or that states should be free to choose between them would have been alien to those engaged in the Medicaid reform debates of the mid-1990s.

This paper traces the legislative history of that debate, which pitted supporters of block grants against those who advocated per capita allotments. Congressional Republicans and, for a time at least, the National Governors Association supported block grants. President Clinton, with the backing of congressional Democrats, strongly advocated per capita caps. Neither proposal won enactment.

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3. Office of the Speaker of the House, *A Better Way: Our Vision for a Confident America*, June 22, 2016, 25. The version of Medicaid reform introduced by House leaders, however, provided for the establishment of per capita caps, without offering states the choice to receive a block grant. That choice also was included in a House bill to "repeal and replace" the ACA (see footnote 1).

The debate, which continued for more than two and a half years and was punctuated by vetoes and government shutdowns, ended with a whimper. In the end, Congress and the president compromised on a bill that balanced the federal budget without fundamentally changing the Medicaid program. A legislative history of those events offers important lessons to those engaged in the current debate over the future of Medicaid.

BACKGROUND

Medicaid is an entitlement program of medical assistance that is jointly financed by the states and the federal government. Created in 1965, the program, combined with the related Children's Health Insurance Program (CHIP), enrolled nearly 75 million people in December 2016—roughly 23 percent of the US population.[4] The Congressional Budget Office (CBO) estimates that the program will cost the federal government $393 billion in fiscal year 2017.[5]

States are required to cover the medical expenses of certain categories of individuals, including low-income families with dependent children; pregnant women with incomes up to 133 percent of the federal poverty level (FPL); children in households with incomes up to 133 percent of the FPL; and aged, blind, and disabled individuals who qualify for Supplemental Security Income (SSI). The program provides states with great flexibility in setting income-eligibility requirements for parents and caretakers of dependent children. Alabama, for example, only covers people in this category up to 13 percent of the FPL (annual income of $1,568), while the District of Columbia covers them up to 216 percent of the FPL (annual income of $26,050).[6]

Beginning in January 2014, states also were required to cover nonpregnant, nondisabled adults with incomes up to 138 percent of the FPL. The Supreme Court ruling in *National Federation of Independent Business v. Sebelius* relieved states of this obligation, effectively making it a state option.[7] As of March 2017, 31

4. The Henry J. Kaiser Family Foundation, "Total Monthly Medicaid and CHIP Enrollment" (for timeframe December 2016), accessed April 18, 2017, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0.
5. Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2016–2026*, August 2016, 76, table 1-2.
6. Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (Washington, DC: Medicaid and CHIP Payment and Access Commission, December 2016), 94–95, exhibit 35.
7. National Federation of Independent Business v. Sebelius, 567 U.S. __ (2012).

states and the District of Columbia had elected to cover this population. States also may, at their option, cover additional categories of individuals.[8]

Medicaid enrollment and spending have accelerated since full implementation of the ACA in 2014. Average monthly enrollment had increased by 18.15 million people (30 percent) as of December 2016 compared with pre-ACA enrollment, according to the Kaiser Family Foundation.[9]

Although most people associate the Affordable Care Act with subsidies for the purchase of individual health insurance, Medicaid has produced the bulk of coverage gains under the program.[10] As a result, pledges by the Trump administration and congressional leaders to "repeal and replace Obamacare" generally involve rolling back the law's Medicaid expansions.[11]

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8. These include the following: parents with incomes above the levels established by the former AFDC cash assistance program; pregnant women with incomes between 133 and 185 percent of the FPL; aged, blind, and disabled persons whose income exceeds SSI thresholds; and nonelderly, nonpregnant, nondisabled individuals with incomes above 138 percent of the FPL. See Elicia J. Herz, *Medicaid: A Primer*, Congressional Research Service, July 18, 2012, 4.

9. Kaiser Family Foundation, "Total Monthly Medicaid and CHIP Enrollment." Because there is considerable "churn" in the program, with people constantly moving on and off the rolls as their incomes and life circumstances change, enrollment is often presented in terms of monthly averages. This number is smaller than the total number of people who were on Medicaid *at some point* during the year. For example, the Medicaid and CHIP Payment and Access Commission, using enrollment data from the Centers for Medicare and Medicaid Services (CMS), estimates that a total of 81 million people received Medicaid benefits at some point during fiscal year 2015. But the average monthly enrollment (also referred to as the "full year equivalent") was 68.9 million. See Medicaid and CHIP Payment and Access Commission, *MACStats*, 3, exhibit 1, and 28, exhibit 10.

10. Edmund F. Haislmaier and Drew Gonshorowski, "2015 Health Insurance Enrollment: Net Increase of 4.8 Million, Trends Slowing" (Issue Brief No. 4620, Heritage Foundation, Washington, DC, October 31, 2016). The study finds a net increase of 14 million in the number of people with public and private coverage between December 2013 and December 2015. Of this total, 11.8 million were added to Medicaid and CHIP. This figure differs from others in the literature because it relies on Medicaid and CHIP enrollment figures rather than on survey data. For December 2013, the study uses figures compiled by the Kaiser Family Foundation. For subsequent months, it uses data reported to the CMS by the states. Government surveys consistently undercount the number of people with Medicaid coverage. The National Health Interview Survey (NHIS), for example, estimates that 17.8 percent of the population was enrolled in Medicaid or CHIP in 2015. The American Community Survey (ACS) estimates the population enrolled in Medicaid or CHIP in 2015 at 15.3 percent. According to the Medicaid and CHIP Payment and Access Commission, which collected enrollment data from the CMS, the correct figure is 22.8 percent. See Medicaid and CHIP Payment and Access Commission, *MACStats*, 3, exhibit 1. That exhibit also contains the NHIS estimate. The 2015 ACS estimate of Medicaid enrollment can be found at US Census Bureau, "Public Health Insurance Coverage by Type: 2015 American Community Survey 1-Year Estimates," American FactFinder, accessed February 24, 2017, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S2704&prodType=table.

11. For example, H.R. 3762, a "partial repeal" bill that was vetoed by former president Obama, would have ended the Medicaid expansion, effective January 1, 2017.

TABLE 1. MEDICAID BLOCK GRANTS VERSUS PER CAPITA CAPS

	GOP's block grant proposal	President Clinton's per capita cap proposal
Reduce rate of growth of federal Medicaid spending?	YES	YES
Institute an overall cap on federal spending?	YES	NO
Adjust federal spending for inflation?	YES	YES
Retain Medicaid entitlement for all beneficiaries?	NO*	YES
Establish different caps for different eligibility groups?	NO	YES
Adjust federal spending for increase in eligible population?	NO	YES

* Although the block grant in its original form removed the individual Medicaid entitlement, subsequent versions protected the entitlement for certain categories of beneficiaries.

These discussions also have given rise to suggestions that congressional Republicans might seek more sweeping Medicaid changes, including proposals to "block grant" the program or impose per capita caps on federal Medicaid spending.

BLOCK GRANTS VERSUS PER CAPITA CAPS

The discussion of Medicaid block grants and per capita caps harks back to a debate between the Clinton White House and congressional Republican insurgents that occurred during the mid-1990s. The administration backed per capita caps while congressional leaders sought to "block grant" the program. Table 1 highlights some of the most salient differences between the two approaches.

Both President Clinton's per capita cap proposal and the Republican block grant proposal would have reduced the projected rate of growth in federal Medicaid spending. Although cost estimates for both plans differed over time, Republicans sought greater federal savings.[12] The GOP plan achieved those savings by imposing an inflation-adjusted cap on federal Medicaid payments to each state. The Clinton per capita cap proposal, by contrast, limited federal spending on a per capita basis. Clinton would have applied different caps to different populations. Those caps recognized, for instance, that the costs of providing nursing home care to an elderly person were higher than those of providing medical care to relatively healthy children. It also allowed federal spending to rise with Medicaid enrollment increases.

12. This difference in fiscal effects was not inherent. Because both approaches placed a ceiling on federal Medicaid spending, the savings would have depended largely on where the cap was initially set and how it was adjusted for inflation.

The most important structural difference between block grants and per capita caps has to do with whether individuals retain an entitlement to Medicaid. The per capita cap proposal retained the entitlement; the block grant proposal, at least in its initial form, did not.[13] This single difference produced an ideological divide that the Republican Congress and Clinton White House were unable to bridge.

BALANCED BUDGET ACT OF 1995

The 1994 election resulted in a Republican House majority for the first time since 1955.[14] The party also regained a Senate majority it had lost in 1986. This change has been in part attributed to the unpopularity of President Clinton's healthcare reform proposal.[15] That proposal set out to achieve universal health insurance coverage, but in the face of mounting public opposition it was never brought to a Senate or House vote.[16]

The new congressional majority pledged to produce a budget that CBO would project as balancing the federal budget within seven years (by 2002), largely through cuts in federal entitlement and discretionary spending.[17] The Clinton White House and congressional Democrats largely opposed these efforts.

Given the partisan divide over this fiscal goal, Republicans sought to use the budget reconciliation process to achieve their ends.[18] That process provides a means of avoiding a Senate filibuster and enabling the majority party to enact legislation without the support of the minority party. The process begins with a budget resolution that sets spending and revenue targets for congressional committees. The resolution requires a majority vote of both bodies and is subject to limitations on Senate floor debate and amendments. It cannot be

13. Later versions of the proposal did retain entitlements for certain populations, such as low-income pregnant women and children. The overall cap on federal spending, however, did not adjust for increases in these entitled populations.
14. US House of Representatives, "Party Divisions of the House of Representatives, 1789–Present," accessed March 16, 2017, http://history.house.gov/Institution/Party-Divisions/Party-Divisions.
15. Miller Center, University of Virginia, "Bill Clinton: Campaigns and Elections," accessed March 16, 2017, http://millercenter.org/president/biography/clinton-campaigns-and-elections.
16. Paul Starr, "What Happened to Health Care Reform?," *American Prospect*, no. 20 (Winter 1995): 20–31.
17. David E. Rosenbaum, "Congress Passes GOP's Budget-Balancing Plan," *New York Times*, June 30, 1995.
18. This is also the process congressional Republicans used in January 2017 to enact an ACA partial "repeal and replace" proposal.

filibustered. A budget resolution is not sent to the president for signature, since it is not law and is only binding on Congress.

Budget resolutions often contain reconciliation instructions—directives to committees to write legislation within their respective jurisdictions to achieve the spending and revenue targets contained in the budget resolution. Each committee's bill is then sent to the body's Budget Committee, which combines them into a single "reconciliation" bill for floor consideration.

The reconciliation bill, like the budget resolution, is considered under special rules in the Senate. Debate is limited to 20 hours, the bill cannot be filibustered, and there are strict limitations on amendments that are in order during floor consideration.[19] Because it is a law, a reconciliation bill, unlike a budget resolution, requires the president's signature.

The proposal to convert Medicaid into a program of block grants to states was a major provision of the reconciliation bill that Congress considered in 1995. The fiscal year 1995 budget resolution that the House considered assumed this fundamental Medicaid change.[20] The accompanying committee report stated that the intent was for the Energy and Commerce Committee to write a reconciliation bill to "convert the current Medicaid program into a system of block grants to states" and "[restrain] the growth of federal outlays for Medicaid."[21]

The conference agreement that the Senate and House adopted in June 1995 instructed their respective committees of jurisdiction to achieve substantial Medicaid savings, leaving it to those committees to decide whether to achieve

"The proposal to convert Medicaid into a program of block grants to states was a major provision of the reconciliation bill that Congress considered in 1995."

19. These limitations, contained in the so-called Byrd rule (2 U.S.C. § 644 [2012]), also apply to provisions of any reconciliation bill or reconciliation conference report. If a provision or amendment contains material that the Byrd rule defines as "extraneous," it is subject to a point of order that can only be waived by the affirmative vote of three-fifths of senators duly chosen and sworn.
20. H. Con. Res. 67 (1995).
21. H. Rept. 104-120 at 87 (1995).

those savings through block grants and whether to eliminate the Medicaid entitlement.[22]

The Clinton administration strongly opposed Congress's balanced budget proposal generally and its Medicaid proposal in particular. The White House issued a document contrasting its approach to deficit reduction with that assumed in the budget resolution.[23] The document included a defense of its Medicaid per capita cap proposal, which it characterized as "preserving coverage" for Medicaid recipients. Per capita caps, the document argued, would retain the individual entitlement to Medicaid in a cost-effective way:

> To limit the growth of federal Medicaid spending, the plan establishes a per capita limit to constrain the rate of increase in federal matching payments per beneficiary. The limits maintain the federal financial commitment to states in the event of an economic downturn that requires states to add beneficiaries.

The House Committee on Commerce conducted several hearings on Medicaid reform during the summer of 1995. Bruce Vladeck, then administrator of the Health Care Financing Administration (HCFA), the agency that oversaw Medicaid, elaborated on the administration's support for per capita caps in testimony before the committee in June.[24] Vladeck's testimony was sharply critical of the Medicaid block grant proposal. He objected both to the magnitude of the proposed cuts and to the proposal's design:

> There is no way to finance $187 billion over seven years from efficiencies alone. Neither wholesale use of managed care nor any other programmatic change will provide sufficient savings to maintain the current coverage levels.[25]

In addition to faulting the funding levels in the House budget, Vladeck voiced the administration's objection to block grants. He contrasted block grants with per capita caps on federal Medicaid spending, which the president favored.

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22. H. Rept. 104-159 at 75 (1995). The committees of jurisdiction—House Commerce and Senate Finance—were instructed to send legislation to the Budget Committee that would limit Medicaid spending to $773.1 billion over seven years by reducing the rate of federal spending increases over that period.
23. White House, "The President's 7 Year Balanced Budget Proposal, 1995" (Office of Management and Budget), accessed March 16, 2017, https://clinton5.nara.gov/WH/New/html/7year.html.
24. *Transformation of the Medicaid Program—Part 2, Hearing before the Subcomm. on Health and Environment of the H. Comm. on Commerce*, 104th Cong. (1995) (statement of Bruce Vladeck, administrator, Health Care Financing Administration).
25. Ibid., 19.

> The President has proposed per capita limits on federal Medicaid spending, which will provide an additional incentive for states to control program spending but will not force them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, states will be able to manage within these limits, while Medicaid beneficiaries—including senior citizens, disabled people and children—will retain their health care coverage.[26]

He described the difference between the per capita cap and block grant approaches to Medicaid reform as "fundamental":

> There are fundamental differences between the President's plan and the House budget resolution. We rely on per capita limits to allow for changes in enrollment, while the House proposal is based on an aggregate cap and therefore does not provide room for enrollment growth.[27]

This ideological chasm between block grants and per capita caps was not bridged during more than two years of debate between the president and congressional leaders. While both sides agreed that the federal government should reduce Medicaid spending and provide states more flexibility in administering the program, they could never agree on how the program should be restructured. Throughout the debate—which would involve government shutdowns and other episodes of high drama—Congress insisted on block grants, while the administration consistently advocated in favor of per capita caps.

The House Committee on Commerce approved Medicaid legislative language in September 1995.[28] It repealed Title XIX of the Social Security Act (Medicaid) and replaced it with a program of grants to states, which it dubbed the MediGrant program. That program would end the individual entitlement to Medicaid, replacing it with a state entitlement to a set amount of funds. In order to draw down those funds, each state would be required to spend at least 85 percent of its historical average Medicaid spending on each of three groups: low-income families, low-income elderly, and low-income blind and disabled.

26. Ibid., 22.
27. Ibid., 23.
28. The language is available in Title XVI of the Balanced Budget Act of 1995, H.R. 2491, 104th Cong. (1995).

Thus, while the program did not entitle any *individual* to Medicaid, it did require states to continue devoting a specified amount of resources to *categories* of individuals. These provisions were incorporated into the broader reconciliation bill, which the House passed on October 26, 1995.[29]

The Senate Budget Committee chair, Pete Domenici (R-NM), introduced the Senate version of the reconciliation bill that same month.[30] The measure included the Medicaid Transformation Act of 1995. Like the House bill, the measure achieved substantial federal Medicaid savings through the creation of a block grant.

During floor consideration, Senator Bob Graham (D-FL) unsuccessfully moved to commit the bill to the Finance Committee with instructions to

> achieve the Medicaid savings through implementation of a Medicaid per capita cap with continued coverage protections and quality assurance provisions for low-income children, pregnant women, disabled and elderly Americans instead of through implementation of a Medicaid block grant.[31]

Graham described his proposal as providing "a rational reduction in Medicaid [spending] that would afford states additional flexibility in administering the program, while retaining an entitlement to services for poor children, their mothers, the disabled and the frail elderly."[32] A number of Democratic senators spoke in support of the Graham motion.[33]

The motion was tabled by a vote of 51 to 48.[34] Republican senators William S. Cohen (R-ME) and Arlen Specter (R-PA) joined 46 Democrats in supporting Graham's per capita cap proposal. No Democratic senator voted against the Graham motion.

The Senate did, however, make other changes to the Medicaid bill. The measure they adopted retained an entitlement to services for eligible children

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29. The measure passed by a vote of 227 to 203, including four Democrats. During the House floor debate on that measure, Rep. Bill Orton (D-UT) offered an amendment that sought to substitute a Medicaid per capita cap for the block grant. The amendment failed, with 68 Democrats and 4 Republicans supporting the measure.
30. S. 1357, 114th Cong. (2015).
31. 141 Cong. Rec. S15714 (October 26, 1995).
32. Ibid., S15727–28.
33. Those speaking in support of the motion included Paul Wellstone (D-MN), Barbara Mikulski (D-MD), Edward M. Kennedy (D-MA), Jay Rockefeller (D-WV), Barbara Boxer (D-CA), Paul Sarbanes (D-MD), Dianne Feinstein (D-CA), Patty Murray (D-WA), Russ Feingold (D-WI), James Exon (D-NE), and Chris Dodd (D-CT). See 141 Cong. Rec. S15714–28 (October 26, 1995).
34. 141 Cong. Rec. S15779 (October 26, 1995).

under 13, for pregnant women, and for aged, blind, and disabled SSI recipients. The Senate passed its bill on October 27, 1995.[35]

The conference report "block granted" the Medicaid program but hewed more closely to the Senate version in retaining the entitlement for certain groups. The House and Senate both voted to adopt the conference report on November 17.[36]

The president signed his veto message with the same pen President Johnson had used to sign Medicare and Medicaid into law in 1965.[37] In that message, transmitted to Congress on December 6, President Clinton wrote that the bill

> would cut Federal Medicaid payments to States by $163 billion over 7 years and convert the program into a block grant, eliminating guaranteed coverage to millions of Americans and putting States at risk during economic downturns. States would face untenable choices: cutting benefits, dropping coverage for millions of beneficiaries, or reducing provider payments to a level that would undermine quality service to children, people with disabilities, the elderly, pregnant women, and others who depend on Medicaid.[38]

A day after vetoing the Republican bill, President Clinton submitted his own deficit reduction proposal, the third he had proffered over the course of the year.[39] In addition to other provisions relating to taxes and entitlement spending, the president renewed his call for Medicaid capitated allotments. As with earlier iterations of his budget, he proposed to set separate caps on federal payments to states for each of the four major eligibility groups: pregnant women, children, people with disabilities, and older individuals. Each of these four caps would be adjusted for inflation. Individuals in those groups would remain entitled to

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35. S. 1357, 114th Cong. (2015), roll call 556; see https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=104&session=1&vote=00556 (accessed March 16, 2017).
36. The House vote was 237 to 189. The Senate approved it by 52 to 47. No Democratic senator and only five Democratic representatives voted in favor of the bill.
37. Todd S. Purdum, "As Long Promised, President Vetoes GOP Budget," *New York Times*, December 7, 1995.
38. Veto of H.R. 2491.
39. Jim Cornelius, "Medicaid Reform: Per Capita Caps," Congressional Research Service, March 29, 1996, 5. House Republicans introduced a budget resolution containing the president's proposals (H. Con. Res. 122). On December 19, the House unanimously voted to reject it, 412 to 0. Bill Heniff Jr., "Congressional Budget Resolutions: Historical Information," Congressional Research Service, November 16, 2015, 8.

Medicaid services, requiring the federal government to increase its aggregate payments to states based on growth in the Medicaid rolls.[40]

MEDICAID REFORM DEBATE IN 1996

The budget impasse between the president and Congress resulted in a government shutdown that began on December 15, 1995, and ended on January 6, a period of 21 days.[41] As part of the agreement to reopen shuttered federal agencies, President Clinton transmitted a new budget proposal to Congress on January 9, 1996. Unlike his three previous budgets, this one would "achieve a balanced budget not later than the fiscal year 2002 as certified by the Congressional Budget Office," removing a major bone of contention between Congress and the White House.[42] CBO had not scored any of the president's prior budget proposals as achieving balance within a seven-year window, something congressional Republicans repeatedly demanded.

"A day after vetoing the Republican bill, President Clinton submitted his own deficit reduction proposal, the third he had proffered over the course of the year."

The new budget once again proposed to transform Medicaid into a program of per capita caps:

> A per capita cap would limit the amount of federal spending per eligible person while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, disabled, and pregnant women and children meeting certain criteria will continue to be eligible for health benefits, while reducing the rate of increase in

40. Specifically, they would be indexed by the five-year average growth in nominal GDP, adjusted to meet the seven-year spending reduction targets required to reach balance. See Cornelius, "Medicaid Reform," 5.
41. Jessica Tollestrup, "Federal Funding Gaps: A Brief Overview," Congressional Research Service, October 11, 2013, 3.
42. Message from the President of the United States, January 9, 1996. The president's previous budgets had not achieved balance. Moreover, congressional Republicans had repeatedly criticized the White House for relying on estimates prepared by its own Office of Management and Budget rather than on those prepared by CBO.

> Medicaid spending to a level that is sustainable for states and the federal government.[43]

In testimony later that month before the House Government Reform and Oversight subcommittee, HCFA Administrator Bruce Vladeck once again underscored the administration's objection to the House's Medicaid block grant proposal:

> Most simply, we just do not believe that the MediGrant program, as contained in the balanced budget bill, provides nearly enough funding to continue to provide existing levels of coverage to existing beneficiaries, even with greater program efficiencies, and certainly not to accommodate the growth that might come about as a result of economic recession or just continued increase in the number of low-income people in this society.[44]

That shortcoming could be remedied, Vladeck argued, by replacing the block grant with the president's per capita cap proposal.

> We believe at the same time that we can protect access to high-quality health care while providing states with additional flexibility, as is outlined in the President's proposal. We would continue the basic federal partnership with the single change of limiting the growth in per-person spending by the major categories of persons covered. If states had to expand enrollment as a result of population change or economic circumstances, more than otherwise would have been expected, they would receive additional federal funds in order to cover these folks.

Former congressman Henry Waxman (D-CA), who was not present at the hearing, submitted a prepared statement endorsing the per capita cap proposal.

> The President's per capita cap proposal responds to the pleas of those who want more cost discipline in Medicaid without terminating the guarantee of basic health and long-term care to 36 million Americans. Under the President's approach, states would have both the incentives and the tools to manage Medicaid more

43. Ibid., 8.
44. *Unfunded Mandates in Medicaid, Hearing before the Subcomm. on Human Resources and Intergovernmental Relations of the H. Comm. on Government Reform and Oversight*, 104th Cong. 70 (1996) (statement of Bruce Vladeck, administrator, Health Care Financing Administration).

> efficiently, and the federal government would maintain its commitment to sharing in the costs of providing [care]. . . . The policy differences between the President's approach and the Republican Medicaid repeal could not be more fundamental. They are the difference between guaranteed basic coverage and rationing of basic care to 36 million Americans.[45]

On February 5, the president renewed his commitment to per capita caps in his fiscal year 1997 budget. The document called for seven-year Medicaid savings of $59 billion through that reform:

> Under the budget, a per capita cap limits Federal spending growth per person while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, people with disabilities, and pregnant women and children who depend on Medicaid will remain eligible for health benefits while it cuts the rate of increase in spending to a level that States and the Federal Government can support. In contrast to a block grant, the Administration's plan protects States facing population growth or economic downturns.[46]

As with his earlier proposals, separate per capita caps would be established for each of the four major Medicaid eligibility groups, based on a state's prior-year spending. Those caps would be indexed for inflation. Mandatory eligibility groups and benefits would be maintained.

The House budget resolution was structurally similar to the one that had provoked a confrontation with the White House the year before.[47] It continued to call for a budget that CBO said would reach balance by 2002, a goal President Clinton reluctantly embraced in January 1996. It included reductions in taxes and entitlement spending. It also renewed the GOP commitment to reforming

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45. *Unfunded Mandates in Medicaid, Hearing before the Subcomm. on Human Resources and Intergovernmental Relations of the H. Comm. on Government Reform and Oversight*, 104th Cong. 111 (1996) (statement of Henry A. Waxman, D-CA).

46. *Budget: Budget of the United States Government, Fiscal Year 1997* (Washington, DC: US Government Printing Office, 1996). The president reiterated his support for per capita caps in a March 1 budget supplement. See "Strengthening Health Care," chapter 6 of *Budget Supplement: Budget of the United States Government, Fiscal Year 1997* (Washington, DC: US Government Printing Office, 1996).

47. H. Con. Res. 178, 104th Cong. (1995–1996), reported by the House Budget Committee on May 14, 1995 (H. Rept. 104-575).

welfare and Medicaid, eliminating entitlements to both and giving states wide latitude in administering federal cash and medical benefits for the poor.

As in the prior year's measure, the budget resolution looked to "block grant" Medicaid. This time, though, its position was strengthened by the February 6 announcement that the National Governors Association (NGA) had embraced a modified version of the MediGrant proposal.[48] Those modifications called for maintaining the Medicaid entitlement for the following populations: cash welfare recipients (that is, recipients of benefits from Aid to Families with Dependent Children, or AFDC); elderly people on SSI; children under seven; pregnant women with incomes below 133 percent of the FPL; children ages 7–12 in households with incomes below 100 percent of the FPL; and persons with disabilities.[49] The House resolution included a sense of the Congress resolution embracing the NGA recommendations.[50]

The resolution also instructed relevant committees to write reconciliation legislation specific to Medicaid and welfare reform.[51] In contrast to 1995, when Congress had bundled its Medicaid reform proposals with reductions in taxes and in Medicare spending, the House resolution called for considering Medicaid strictly in the context of reform to other public assistance programs, including AFDC and Food Stamps. The conference agreement retained these reconciliation instructions for the House, as well as a sense of the Congress provision endorsing the NGA Medicaid recommendations.

On July 18, the House approved the Welfare and Medicaid Reform Act (H.R. 3734).[52] The bill made considerable changes to various cash welfare programs, "block granting" and renaming the AFDC program, imposing work requirements and time limits on benefits, and strengthening child support enforcement provisions.[53] On Medicaid, it hewed closely to the NGA recommendations on populations who would continue to be eligible for services, but it also reduced spending and, most significantly, rejected the president's per capita proposal in favor of block grants.

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48. R. Kent Weaver, "Deficits and Devolution in the 104th Congress," *Publius* 26, no. 3 (Summer 1996): 59n23.

49. Arleen Leibowitz and Helen DuPlessis, "Restructuring the Medicaid Program," RAND Corporation, accessed March 16, 2017.

50. H. Con. Res. 178, § 10, expressed the sense of the Congress that legislation should "guarantee coverage for low-income children, pregnant women, the elderly, and the disabled as described in the National Governors' Association February 6, 1996, policy on reforming Medicaid."

51. H. Con. Res. 178, § 4(a)(1).

52. Roll call 331; see http://clerk.house.gov/evs/1996/roll331.xml (accessed March 16, 2017).

53. The AFDC entitlement program was replaced by a block grant known as Temporary Assistance to Needy Families (TANF).

Despite this softening of its original MediGrant proposal, the White House stood its ground. The president continued his veto threat against the House bill. But some administration aides quietly told Republicans that the president might sign a welfare reform bill if it were shorn of the MediGrant provisions.[54]

Adding to the intrigue was the looming presidential election. Former Senate majority leader Bob Dole (R-KS) had by that point secured the support of enough delegates to assure his nomination as the GOP presidential candidate. He had resigned his Senate seat in June, staking his political future on defeating President Clinton in the November election.[55] By July, Dole's prospects already had grown dim.[56] Congressional Republicans knew that sending the president a welfare reform bill he would sign would strengthen Clinton's appeal to moderates, whose support Dole would need to make his candidacy competitive.

Congress took the deal. On July 23, the Senate passed a version of the reconciliation bill that "block granted" nonmedical assistance to low-income populations but preserved the Medicaid entitlement. The vote in the Senate was 74 to 24.[57] Little more than a week later, the House adopted a conference report that retained the Medicaid entitlement, 328 to 101.[58] The Senate followed suit on August 1.[59] President Clinton signed the bill into law on August 22, a week after the GOP convention concluded and four days before the Democratic convention began.

BALANCED BUDGET ACT OF 1997

President Clinton's reelection did not weaken the administration's support for Medicaid reform. And although entitlement spending growth had begun to slow, GOP control over both houses of Congress assured that curbing federal spending would continue to be a major congressional priority. Medicaid restructuring remained at the heart of the discussion over entitlement reform. In its fiscal year 1998 budget, the White House once again proposed to establish per capita caps on federal Medicaid spending:

54. Peter Edelman, "The Worst Thing Bill Clinton Has Done," *Atlantic*, March 1997.
55. Adam Nagourney and Elizabeth Kolbert, "How Bob Dole's Dream Was Dashed," *New York Times*, November 8, 1996.
56. The Gallup poll showed Dole lagging Clinton by 17 points in July 1996. See "Poll Trends: The 1996 Presidential Election," Gallup News Service, accessed March 16, 2017.
57. Roll call 232. Democrats split evenly on the vote, with 23 supporting the measure and 23 opposing it. Lauch Faircloth (R-NC) was the lone Republican to vote against the bill.
58. As in the Senate, Democrats split, with 98 voting in the affirmative and 98 in the negative. Two Republicans voted against the measure.
59. This time the vote was 78 to 21. Roll call 262.

> Even though the growth in Medicaid spending has fallen in recent years, aggregate Medicaid spending still will grow at an average annual rate of 7.2 percent from 1997 to 2002. To ensure that Medicaid's explosive growth of the 1980s and early 1990s does not resume, the budget would set a per capita cap on Medicaid spending, based on spending per beneficiary in a base year, increased by an annual growth limit. The cap protects States facing population growth or economic downturns because it ensures that dollars follow people, allowing Medicaid spending to respond to changes in caseload and the economy.[60]

In her February 6, 1997, press conference on her agency's budget, Donna Shalala, secretary of Health and Human Services, contrasted the per capita cap proposal with the block grant approach:

> Medicaid, too, needs a new look—but not a new soul. . . . We are creating a per-person limit on the growth rate of federal Medicaid payments. Let me be clear: This per capita cap is neither a block grant nor a cost-shift. It's a sensible way to make sure that our progress in holding down costs continues and that the people who need Medicaid get it.[61]

The administration thus continued to promote the virtues of its Medicaid per capita cap proposal and to distinguish it from the block grant approach that congressional Republicans had championed.

The year 1997, unlike the two previous years, did not produce high budget drama. Talks between congressional leaders and the administration extended into the spring, culminating in a May 2 bipartisan agreement.[62] The agreement bound all parties to support a budget resolution that would set agreed-upon limits on defense and nondefense discretionary spending, reduce entitlement spending, and take other actions to achieve fiscal balance by 2002.

The agreement included specific budgetary targets for several programs, including Medicaid. The parties agreed that reconciliation legislation should achieve five-year Medicaid savings of $13.6 billion to be derived largely by reducing disproportionate share payments to states and by giving them more flexibility

60. *Budget: Budget of the United States Government, 1998* (Washington, DC: US Government Printing Office, 1997), 52.
61. "Press Conference Remarks by HHS Secretary Donna Shalala," February 6, 1997, HHS.gov archive.
62. The text of the agreement can be found in H. Rept. 105-100 (1997) at appendix A.

in managing their programs.[63] Significantly, the agreement excluded both block grants and per capita caps.

The 1997 budget agreement laid to rest the debate over Medicaid reform. The Balanced Budget Act of 1997 (BBA 97) was enacted on August 5.[64] The bill gave states added flexibility in how they administered the Medicaid program. That included authorizing them to require recipients, with the exception of children with special needs and seniors, to enroll in managed care organizations.[65] It also allowed them to use primary care case-management services without first obtaining a waiver from the federal government.[66] And it replaced a provision that limited the authority of states to establish payment rates for medical providers with one that authorized states to set such rates, so long as they provided for public notice and comment.[67]

CBO estimated that it would achieve just $7 billion in Medicaid savings.[68] The act nevertheless met its overall deficit reduction goals. When Republicans took control of Congress, they set out to balance the federal budget by 2002. According to CBO, the federal government ran a surplus in fiscal year 1998, which began less than two months after BBA 97 was signed into law. With the federal budget balanced, interest in restraining entitlement spending waned on both ends of Pennsylvania Avenue.

CONCLUSION AND POLICY IMPLICATIONS

Interest in restructuring Medicaid, largely dormant for two decades, has recently been rekindled. The current debate takes place in a very different environment from the one that prevailed during the 1990s. Republicans have proffered Medicaid restructuring proposals in the context of repealing and replacing the ACA, rather than as a means to bring the federal ledgers into balance. Democrats have pledged to protect the ACA, whose Medicaid expansion has been the biggest reason why the percentage of the population who

63. H. Rept. 105-100 at appendix A, 144. The agreement also called for new spending of $16 billion over five years "to provide up to five million additional children with health insurance by 2002" (145). That language ultimately led to the creation of the State Children's Health Insurance Program in the reconciliation bill that came to be known as BBA 97 (Pub. L. No. 105-33, 111 Stat. 251 [1997]).
64. Pub. L. 105-33, 111 Stat. 251 (1997).
65. Pub. L. 105-33, § 4701.
66. Pub. L. 105-33, § 4702.
67. Pub. L. 105-33, § 4711.
68. Congressional Budget Office, "Budgetary Implications of the Balanced Budget Act of 1997," 1, https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/costestimate/summary.pdf.

lack health insurance is at its lowest level on record.[69] Coverage gains have been most pronounced in states that expanded their Medicaid programs to cover nonpregnant, nondisabled adults with incomes of up to 138 percent of the FPL.[70] Supporters of the ACA are strenuously opposing Medicaid per capita caps.

Democrats and Republicans have switched sides on this proposal. During the 1990s, Republicans disparaged per capita allotments in their unsuccessful pursuit of block grants. The per capita allotment proposal had the strong and consistent backing of the Clinton White House. The virtues the Clinton administration saw in per capita caps—limiting federal Medicaid costs and incentivizing states to moderate spending, while preserving the entitlement to medical services—are now touted by congressional Republicans.[71]

In view of this history, attempts to characterize a per-beneficiary cap on federal Medicaid spending as dismantling the program lack credibility. President Clinton, Henry Waxman, Bob Graham, and their contemporaries were stalwarts of the Medicaid program. They did not set out to destroy Medicaid but to save it.

The contemporary divide over the proposal thus appears to be less ideological than partisan. Democrats oppose it, not because it would "end Medicaid as we know it," but because it is part of a broader GOP effort to "repeal and replace" the ACA.[72] There are substantial differences between the two parties over how a per capita allotment should be designed. What level of funding should the government set for each of the Medicaid eligibility groups? Should growth in these per capita funding levels be pegged

"The virtues the Clinton administration saw in per capita caps—limiting federal Medicaid costs and incentivizing states to moderate spending, while preserving the entitlement to medical services—are now touted by congressional Republicans."

69. Haislmaier and Gonshorowski, "2015 Health Insurance Enrollment."
70. Rachel Garfield and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid" (Issue Brief, Kaiser Commission on Medicaid and the Uninsured, October 2016).
71. For a discussion of the pros and cons of Medicaid per capita caps, see John Holahan, Joshua Wiener, and David Liska, "The Medicaid Reform Debate in 1997" (Occasional Paper No. 1, Urban Institute, July 1997).
72. Henry Waxman made this allegation in a February 2017 op-ed. Waxman, "Republicans' Alarming Proposal Would End Medicaid As We Know It."

to increases in medical prices, general inflation, or some other measure? How much freedom should states be given to impose cost-sharing or work requirements?

Reaching accord on such issues will be challenging. But we can reasonably infer from the legislative history of the debate that occurred during the 1990s that neither party should object in principle to per capita allotments. Policymakers involved in the ACA debate who seek common ground would do well to look to Medicaid per capita allotments as a potential starting point for constructive dialogue.

ABOUT THE AUTHOR

Doug Badger served as a senior health policy adviser to President George W. Bush. In that role he developed administration policy and represented the White House in negotiations over the Medicare Modernization Act, which established a Medicare drug benefit, revitalized the Medicare Advantage program, and created health savings accounts. Badger has also served as a senior policy adviser to Senate GOP leadership for a variety of healthcare-related legislation, including the Balanced Budget Act of 1997, the Patient's Bill of Rights, the Children's Health Insurance Program (CHIP), and President Clinton's proposed healthcare overhaul. He has coauthored two Mercatus studies on the Affordable Care Act.

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