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THE IMPACT OF REAGAN-ERA POLITICS ON THE FEDERAL MEDICAID PROGRAM

*Kenneth R. Wing**

People who rely on Medicaid for their health care may have a bleak future. The agenda of the Reagan Administration, if fully implemented, threatens to dismantle Medicaid as currently constituted, and to leave millions of people without financial access to physicians, hospitals, nursing homes, and the array of other medical services provided for the poor through Medicaid since its creation in 1965. Even if the eventual result is only a drastic limitation on federal funding, and not an explicit or implied mandate to repeal the program, the result is likely to be much the same. If the reductions in federal efforts now being implemented are followed by further reductions in the years ahead, the financial burden of Medicaid, as with many other domestic spending programs, will be shifted primarily to the shoulders of state and local governments. Given current economic and political realities, few—if any—states will be able or willing to maintain the program at anything comparable to current levels. Following a pattern that has been set for nearly two decades, states will struggle to find program reforms, but in the final analysis most states will have little choice but to drastically reduce program coverage or limit eligibility, leaving many poor people with little or no access to adequate medical care.

No one supporting the Administration, of course, would fully agree with such a pessimistic view of Medicaid's future. The original Reagan scheme, particularly the proposal for Medicaid funding reductions, was billed in much more positive terms. Reagan's proposed Medicaid program cuts were described as limitations in program growth, with the implication that these and other domestic spending reductions were in large part temporary measures, the necessary belt-tightening required of the nation in order to return to a more prosperous and more conservative national course. Indeed, the original blueprint held out the possibility of a conservatively designed alternative to Medicaid, in tandem with the restructuring of

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health care financing in general. The Administration has also considered a federal-state "swap," a federal takeover of the responsibility for financing and administering the program, in return for which the states would accept full responsibility for a list of other domestic spending programs currently federally supported.

Medicaid recipients should find scant consolation in the Administration's promises. A conservative alternative to health care financing or to the Medicaid program, whatever the merits of such proposals, has yet to demonstrate even the slightest political viability. If major reformation of Medicaid has a future at all, it is a distant one. Even the proposal for a federal takeover appears to be more of a political gambit than a realistic policy alternative. If adopted, the Medicaid "swap" would only shift the focus of responsibility for implementing budget reductions from the states to the federal government. In no way, however, would it secure the future of the program. Indeed, once federalized, Medicaid would become even more vulnerable to the prevailing budget-cutting sentiments in Congress and within the Reagan Administration.

As for the characterization of the budget reductions as limitations on program growth rather than as a dismantling of the program, the Administration-inspired changes forged by the 97th Congress must be viewed against the realities of the existing program. These reductions have cut deeply into a program already pared to a minimum in many states. Yet the Administration and Congress, by their own political design or by the demands of a less than prosperous economy, seem determined to press for further program reductions and to dig deeper into federal Medicaid expenditures in years to come. Reductions in Medicaid funding will be neither as temporary nor as superficial as the "belt-tightening" metaphor suggests, nor are they likely to be accompanied by anything that can be accurately described as program reform. The political future may be difficult to predict with specificity, but surely the level of publicly-sponsored medical care for the poor will be severely reduced in the coming years, leaving millions of poor Americans to rely on the charitable capacity of the nation's health care providers—or simply to go without. What follows is an attempt to support this characterization of Medicaid and its political future.

Section I of this article is a description of Medicaid, its structure prior to 1981, and the legal and political history of its development and implementation. In addition to providing the basis for understanding the potential impact of the proposed Medicaid changes, this section will emphasize the impact on the program of its larger political context and its relation to

broader social and economic issues—forces that have sustained the program through two decades of controversy, but that have also imposed rather rigid restraints on its development.

In Section II of this article, the original Reagan agenda for reordering federal spending priorities is summarized, with particular focus on Medicaid and other health-related programs. This discussion is followed by an analysis of the fate of the Reagan proposals through the political turmoil of the 97th Congress, and the eventual statutory and administrative changes in Medicaid brought about through the first half of the Reagan Administration.

Section III assesses the initial impact of these changes and the probable effects on Medicaid for the next several years, as states react to the program changes and funding limitations imposed by the new federal order.

I. LEGAL AND POLITICAL HISTORY OF MEDICAID

A. *Origins and Structure of Medicaid*

The original Medicaid program was a creature of peculiar origins.¹ It evolved somewhat unexpectedly from the political debates over the enactment of the Medicare program,² and was predesigned in large part by the

1. For background on the legislative history and prevailing politics surrounding the enactment of the Medicaid and Medicare legislation in 1965, see R. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA* 19-43, 76 (1974). For a critique of Stevens & Stevens and a slightly different political analysis, see Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643 (1975).

2. Commentators have noted that the principal focus of political attention in 1965 was on the heavily publicized Medicare legislation, not on the Medicaid program amended into the Medicare bill during congressional deliberations; thus Medicaid has been frequently labeled as a "sleeper," hastily considered and not fully understood at the time it was passed. See R. STEVENS & R. STEVENS, *supra* note 1, at 51, 68, 76-78, 108.

Such observations are understandable. Medicare has a long and intriguing political and legislative history. See, e.g., R. HARRIS, *A SACRED TRUST* (rev. ed. 1969) and R. STEVENS & R. STEVENS, *supra* note 1, at 19-36. Medicaid was virtually a new provision added to the pending Medicare proposal during the congressional deliberations in 1965, apparently as part of the political compromise necessary to secure passage of Medicare. See Butler, *Legal Problems in Medicaid*, in R. ROEMER & G. MCKRAY, *LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS* 217 (1980). There was a little debate and no committee hearings held on the specific legislative provisions later to become title XIX of the Social Security Act, the Medicaid legislation. *Id.*

It is not even clear from the committee reports, hearings, or floor debate who were the principal sponsors of the Medicaid provision or, for that matter, who authored it. See, e.g., S. REP. NO. 404, 89th Cong., 1st Sess. 289 (1965).

Under these circumstances it is hardly surprising that commentators characterized Medicaid as a "sleeper" or found that Congress did not fully understand the ambitious program it had spawned. Indeed, the original cost estimates later proved that Congress had grossly underestimated at least the financial dimensions of the program. See note 54 *infra*. Subse-

patchwork of state and federal social welfare programs spawned by the New Deal and its Great Society progeny.³ As originally conceived, it was principally a state-administered, federally funded medical care reimbursement program,⁴ financing benefits to the four categories of federal welfare recipients,⁵ and, at the option of each state, other indigent people.⁶ Nonetheless, it offered the potential for a nationwide catastrophic health insur-

quent congressional amendments indicated that many legislators, once the real dimensions of the program were realized, were immediately willing to retreat significantly from the program they had supported in 1965. See discussion of federal program cutbacks in 1967 and 1969, *infra* notes 53-55.

These observations notwithstanding, the thesis that Congress did not understand Medicaid as it was enacted should not be taken too literally. There is no doubt that Congress did intend, in the broadest sense of the term and in the strict legal sense, to enact a Medicaid program. Understandably, most legislators, and most of the public, were probably focusing their attention on the highly publicized Medicare program. Except for those legislators privy to the behind-the-scenes machinations, the Medicaid program was likely regarded, if at all, as an expansion or extension of the pre-existing Kerr-Mills program or the welfare vendor payment system. See description in R. STEVENS & R. STEVENS, *supra* note 1, at 26-36. But the Medicaid statutory language in its original form set out a reasonably clear set of objectives and a clear overall purpose: to establish a medical benefits program for the poor. Pub. L. No. 89-97, § 121(a), 79 Stat. 343 (1965).

Critics have pointed out that the terms of the statutory scheme are poorly designed to carry out these objectives, and that Medicaid as designed has many gaps in its coverage. See R. STEVENS & R. STEVENS, *supra* note 1, at 349-50. Moreover, some of the more ambitious of the statutory objectives have been subsequently amended or excepted, and Congress has in the ensuing years demonstrated that it is at least ambivalent about its commitment to the poor in the face of growing costs and continual pressure from the provider community and other interest groups. Nonetheless, there have been no serious attempts to repeal the program or to retreat from the general thrust of Medicaid, only to control its growth and to limit its scope—even under the initial Reagan budget cutbacks.

This analysis has been uniformly supported by the courts. Even while allowing great discretion to the states in administering their programs, the Supreme Court has held that the federal statute requires that state discretion at least be consistent with the program objectives and with the declared purpose “to enable each State, as far as practicable, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services.” *Beal v. Doe*, 432 U.S. 438, 444 (1977); *cf.* 42 U.S.C. §§ 1396, 1396a(10)(c) (1978). In fact, in *Beal* the Court suggested that “serious statutory questions” would be raised if any state exercised its discretion so as to eliminate necessary medical treatment. *Beal*, 432 U.S. at 444. See also Note, *State Restrictions on Medicaid Coverage of Medically Necessary Services*, 78 COLUM. L. REV. 1491 (1978).

3. For an explanation of the social security and welfare “patchwork” at the time Medicaid was enacted and how Medicaid was tailored to accommodate it, see R. STEVENS & R. STEVENS, *supra* note 1, at 5-41; see also Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 287-90 (1978).

4. See discussion of reimbursement, *infra* notes 39-51.

5. From its very beginning, Medicaid eligibility was restricted to indigent people who were either disabled, blind, over 65 years old, or members of families with dependent children. For a more detailed description of Medicaid eligibility, see *infra* notes 18-33.

6. Among the various options to expand the program allowed to states, each state has the option of providing a “medically needy” or “spend down” program for people who are

ance program—an opportunity for the nation's poor to participate in the mainstream of American medicine.⁷

In implementation, however, Medicaid has been far less. Even under

within the four welfare categories but who have income or resources above the welfare eligibility standards. For a more detailed explanation, see *infra* note 18.

Moreover, under the agency interpretation of the original legislation, federal reimbursement was also available to states that provided a program for the “medically indigent,” or for those noncategorically related people who met only indigency standards. Few states did so, and in any event, the authority for federal participation in “medically indigent” programs was revoked by the Department of Health, Education, and Welfare (HEW) in 1972. For a discussion, see Butler, *Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7, 11-12 (1974).

7. In its original form, the federal Medicaid statute required participating states to provide benefits to the welfare population and allowed states to extend benefits to a broader population of “medically needy.” Theoretically all states could have undertaken rather ambitious programs, establishing, in effect, catastrophic health insurance programs, at least for that portion of the population that was categorically linked.

New York, for example, was eager to maximize its options. The initial Medicaid program devised by New York in 1967 would have potentially covered 45% of that state's population at a cost, of course, that would have nearly broken the entire federal budget anticipated for Medicaid expenditures. See R. STEVENS & R. STEVENS, *supra* note 1, at 92. (Significantly, New York in fact only covered 11% of the eligible population, indicative of the number of eligible people who do not participate in the program.) The Johnson Administration is also reported to have boasted that if all states had fully exercised their Medicaid options in those early years, close to 20% of the nation's population would have been eligible for Medicaid in 1967. *Id.* at 73.

Furthermore, at least if it is viewed apart from its historical and political context, the original Medicaid statute can be read as requiring such expansive programs. The original federal statute included a provision that required participating states to make “efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance,” and to move towards an ultimate goal of “comprehensive care” for all eligible individuals by 1975. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 350 (1965), adding a new § 1902(e) to the original Social Security Act. In addition, the 1965 amendments required states to maintain a fiscal effort, even if program benefits were altered or reduced. Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 348 (1965), adding § 1902(c).

In addition, the original federal guidelines implementing the programs included even bolder and more ambitious language:

The passage of Title XIX marks the beginning of a new era in medical care for low income families. The potential of this new title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose, will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.

Bureau of Family Services, U.S. Dep't of HEW, *Medical Assistance Programs Under Title XIX of the Soc. Sec. Act*, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, Supplement D (1966), as cited in R. STEVENS & R. STEVENS, *supra* note 1, at 88. However, as discussed *supra* note 2, it is doubtful that Congress was fully aware of the implications of this rhetoric at the time the legislation was passed. There is no further indication in the

the most ambitious state programs,⁸ Medicaid has offered medical benefits to only a fraction of the people who lived below the poverty line,⁹ and its benefits have been distributed in a pattern that was neither wholly rational¹⁰ nor fully understood.¹¹

statute of what a "comprehensive program" would actually entail—a further measure of the ambivalence of Congress towards the program at the time it was passed.

As a practical matter, few states were so ambitious in their initial endeavors and, in any event, as soon as the potential cost of such comprehensive programs became clear, Congress acted quickly to restrict the potential scope of the program. *See infra* text accompanying notes 53-56.

Section 1902(c) was effectively amended in 1969 by the addition of a new § 1902(d), specifying procedures by which states could reduce eligibility levels or service coverage, *see* Social Security Amendments of 1969, Pub. L. No. 91-56, § 2(d), 83 Stat. 99 (1969). Both §§ 1902(c) and 1902(d) were repealed in 1972. Social Security Amendments of 1972, Pub. L. No. 92-603, § 231, 86 Stat. 1325 (1972).

As for § 1903(e), the timetable for compliance (which was never seriously enforced by HEW) was first delayed in 1969 to 1977. Pub. L. No. 91-56, 83 Stat. 99 (1969). It was then repealed, rather quietly, in 1972. Pub. L. No. 92-603, § 230, 86 Stat. 1410 (1972), repealing 42 U.S.C. § 1396b(e) (1970).

8. *See, e.g.*, the lengthy descriptions of the programs in New York and California in R. STEVENS & R. STEVENS, *supra* note 1, at 73-114.

9. *See infra* note 17.

10. Since Medicaid eligibility is generally only available to the aged, blind, disabled, or one-parent families with dependent children, Medicaid is not available to many poor people who are arguably more in need than other eligibles. In other words, Medicaid eligibility is not based on need for medical care assistance. Furthermore, there are gaps in eligibility created by the oft-times quixotic welfare eligibility standards established by each state and by the inherent inequities of income and resource tests.

Other inequities are harder to explain. The southern states, for instance, account for one-half of the nation's poor, yet they receive less than one-fourth of the Medicaid dollar. *See* K. DAVIS & C. SCHOEN, *HEALTH AND THE WAR ON POVERTY* 67 (1978). Similarly, there are difficult-to-explain differences from state to state, as much as tenfold, in payment per recipient. *Id.* at 69. Medicaid coverage and eligibility, and consequently Medicaid expenditures, also vary greatly from state to state. Wide variations between the states is evident even when population, relative personal income, and other interstate differences are eliminated. *See* HEALTH CARE FINANCING ADMINISTRATION, HHS, *THE MEDICARE AND MEDICAID DATA BOOK*, 1981, at 111 (1982) [hereinafter cited as 1981 HHS DATA]. These differences in expenditures are magnified by the evidence that utilization of covered services by Medicaid recipients varies greatly from state to state. Recipients in some states, for example, may use physician services as many as five times more often than recipients in other jurisdictions. *See supra* K. DAVIS & C. SCHOEN at 72. There is no obvious relationship between these utilization rates and such factors as relative need that would explain the disparities. For a further discussion of the gaps in coverage, *see* Davis, *Achievements and Problems of Medicaid*, 91 PUBLIC HEALTH REPORT 309, 313 (1976).

11. In plain terms, it is clear that even experts, both those involved in the administration of Medicaid and those who study it from an academic perspective, have difficulty understanding the ever-changing details of Medicaid eligibility, service coverage, reimbursement, and administration. Other commentators have made similar observations. *See, e.g.*, Clark, *The Role of the States in the Delivery of Health Services*, in *ROLE OF STATE AND LOCAL GOVERNMENTS IN RELATION TO PERSONAL HEALTH SERVICES* 151 (1980); *see also* D. WIN-

Medicaid, like any medical care financing scheme, is inherently complicated.¹² The morass of service coverage and exceptions, the limitations on reimbursement, and the terms and conditions of eligibility, virtually defy thorough understanding. In effect, Medicaid is not one, but a series of programs, differing from state to state (and sometimes within a state), and further complicated by the several tiers of governmental responsibilities for its financing and administration.

The minimum requirements for each state's program are outlined in the federal law; beyond that, each state is allowed a series of options in terms of the services offered, the population covered, and the terms of reimbursement.¹³ The federal government shares the cost of each state's program, based on a formula determined by the state's relative wealth. The federal share ranges from 50% to 78%,¹⁴ with no maximum ceiling on federal financial participation.¹⁵

Because of the complexities of the federal and state eligibility requirements, the Medicaid population is difficult to describe with any specificity. Twenty-two million people received Medicaid benefits in 1980,¹⁶ though over 28 million people may have been eligible.¹⁷ Most were recipients of

STON, MANDATE FOR LEADERSHIP: THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 261 (1981).

The sheer mass and range of details, the state and federal regulations, interpretive guidelines and informal explanatory material included in state handbooks and letters is staggering. *See, e.g.,* Butler, *supra* note 6, at 7. The problem is compounded because only aggregate data is available on such important issues as levels of spending or numbers of eligibles.

12. 42 U.S.C. § 1396 (1981).

13. For a detailed description of the services covered in the various states from 1966-1977, see SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, 95TH CONG., 1ST SESS., DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES, 1966-1977, 95-10 (Comm. Print 1977) [hereinafter cited as 1977 HOUSE MEDICAID DATA]. For an update on that data and comparison to figures in later years, see 1981 HHS DATA, *supra* note 10, at 74-79. *See also* discussion of 1981 amendments, *infra* notes 177-213.

14. *See* 42 C.F.R. § 433.10 (1982). For an explanation of the formula for determining the federal share as of 1980, see CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, MEDICAID: CHOICES FOR 1982 AND BEYOND 29 (1981) [hereinafter cited as CBO MEDICAID ANALYSIS]. *See also* state-by-state analysis in 1981 HHS DATA, *supra* note 10, at 113.

The state share is borne by state revenues with a portion paid by the local government in some states. For an explanation, see 1981 HHS DATA, *supra* note 10, at 112-13.

15. *See infra* text accompanying notes 179-83.

16. CBO MEDICAID ANALYSIS, *supra* note 14, at 9; Gibson & Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FIN. REV. 1, 13 (1982)

17. *Id.* Note that this estimate of people who are potentially eligible is still too low. The CBO claims its figures do not include a number of institutionalized people (presumably the few people in public institutions who qualify for Medicaid) and, more importantly, an even larger number of people who qualify for Medicaid in states that have medically needy

Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC), the basic welfare cash grant programs;¹⁸ the vast major-

programs. See explanation of medically needy, *infra* note 18. It should be noted that medically needy people only apply as they need services and thus have high cost per eligible averages. Cf. similar estimates in 1977 HOUSE MEDICAID DATA, *supra* note 13, at 29-31.

Apparently the size of the Medicaid population rose rather steadily in the first decade of the program but growth was much slower in the mid-1970's. Most experts agree that the size of the Medicaid-eligible population grew dramatically in the first decade of the program, fueled initially by the additional states coming into the program, and then later by the growth in the welfare population—principally an increase in the number of AFDC recipients—in the late 1960's and early 1970's. See discussion R. STEVENS & R. STEVENS, *supra* note 1, at 260-63. Cf. Butler, *supra* note 6, at 223; K. DAVIS & C. SCHOEN, *supra* note 10, at 56-59.

Although the exact figures cited in these authorities vary slightly, it is generally agreed that the number of people eligible for Medicaid virtually doubled from 1969 to 1973 in marked contrast to the slower growth rates in the subsequent decade.

Since 1975 there has been little growth in the number of program eligibles and the CBO has predicted that the size of the Medicaid population will decline after reaching a plateau in 1982. See CBO MEDICAID ANALYSIS, *supra* note 14, at 25.

18. Under federal law, participating states must provide Medicaid benefits to the "categorically needy," AFDC recipients (the state administered program of aid to families, usually one-parent families, with dependent children) and to supplemental securities income (SSI) recipients (the program of aid to the blind, elderly, and disabled, the three state-administered welfare programs "federalized" into a single, federally administered welfare cash grant program in 1972). Note, however, that states may use more restrictive eligibility criteria for SSI recipients, if such standards were used prior to the federal takeover of the SSI programs in 1972.

Historically about 80% of Medicaid recipients also receive AFDC or SSI. See CBO MEDICAID ANALYSIS, *supra* note 14, at 10. See also 1977 HOUSE MEDICAID DATA, *supra* note 13, at 31.

States are allowed, but not required, to provide Medicaid benefits to other categories of people who are not eligible for SSI or AFDC. Most significantly, states are allowed to provide Medicaid to those who are generally known as the "medically needy" or "categorically-related medically needy." These people meet the categorical and other requirements for eligibility for AFDC or SSI, except that their income or other resources exceed the maximum allowed for welfare cash grant programs. In states with medically needy programs, such people become eligible for Medicaid when they have incurred liability—or "spend down"—for medical expenses sufficient to lower their net income and resources to a level that is usually equivalent to or below welfare income or resource standards for that state. Over 30 states currently have medically needy programs. See 1981 HHS DATA, *supra* note 10, at 71.

States are also allowed to treat certain categories of people as if they are mandatory eligibles, the so-called "optional categorically needy." That is, the state is not required to cover these people, but if it does, they are entitled to the full range of services of the mandatory eligible. One such option allows states to provide Medicaid to people who are excluded from AFDC or SSI cash grants for noneconomic reasons, e.g., people who are welfare-eligible but who are institutionalized. Another option allows states to provide Medicaid to people who have incomes within 300% of the SSI eligibility standards so long as they are in nursing homes, effectively a generous "medically needy" program solely for nursing home residents. See 42 C.F.R. §§ 435.231, 435.1005 (1981).

For a full explanation of Medicaid eligibility prior to 1974, see Butler, *supra* note 6, at 8-

ity were children;¹⁹ many were disabled or in need of constant nursing care.²⁰ Notwithstanding popular stereotypes of welfare recipients, extremely few were able-bodied adults with any real opportunity to support themselves or to find other means to pay for their medical care.²¹ All were by definition very poor and, in some states, virtually destitute. AFDC families, who account for 63% of the nation's Medicaid recipients,²² rarely receive more than \$200 a month in cash grant assistance, and in some states receive much less.²³

Even so, many poor people are not eligible, eliminated by the "categorical" requirements of the program,²⁴ by stringent income and resource restrictions, or by the various nonfinancial eligibility requirements characteristic of welfare programs.²⁵ In 1980, about one-half of the nation's population living below the federal poverty line were ineligible.²⁶

12; for an update, see Butler, *supra* note 2, at 219. See also R. STEVENS & R. STEVENS, *supra* note 1, at 63-65.

19. See CBO MEDICAID ANALYSIS, *supra* note 14, at 9. But note that while children represent over half of the Medicaid population, they account for less than 20% of program expenditures. See also 1977 HOUSE MEDICAID DATA, *supra* note 13, at 59.

20. CBO MEDICAID ANALYSIS, *supra* note 14, at 9. According to the CBO estimates, over 40% of all Medicaid expenditures are paid for services in nursing homes. *Id.* at xii. See also 1981 HHS DATA, *supra* note 10, at 104. Moreover, historically over 60% of Medicaid expenses go to people over 65 years of age, despite the fact that they represent a small percentage of the Medicaid population. See *id.* at 102.

21. Even in states that exercise their option to provide Medicaid to the "medically needy" or "spend down" population, see explanation *supra* note 18, all Medicaid recipients must be categorically linked, i.e., they must be over 65 years old, blind, disabled, or members of families (usually by state law one-parent families) with dependent children. With regard to this latter category, only 22% (3.4 million) of recipients are adults in AFDC families. 1981 HHS DATA, *supra* note 10, at 73. Recipients must also be sufficiently indigent and must fall within the myriad of nonfinancial eligibility criteria established by each state. And, of course, they must be sufficiently ill or disabled to require medical care, before they receive Medicaid benefits.

22. 1981 HHS DATA, *supra* note 10, at 75.

23. In 1981, the federal SSI income standard for a family of four was set at \$7,467.60. 46 Fed. Reg. 27,076 (1981). See 20 C.F.R. §§ 416.401-416.435 (1981). AFDC income and resource standards vary drastically from state to state. In 1980, income levels for a family of two were as low as \$140 per month in Texas and as high as \$569 per month in Oregon, but in all states AFDC income levels are well below the SSI standard and even further below generally accepted measures of the "poverty-line." See CBO MEDICAID ANALYSIS, *supra* note 14, at 10. See also 1981 HHS DATA, *supra* note 10, at 65-70.

The medically needy income level can be no higher than 133% of the AFDC income standard in that state, 42 U.S.C. § 1396b(f) (Supp. IV 1980).

24. See *supra* note 5.

25. See *supra* note 18.

26. See estimates in CBO MEDICAID REPORT, *supra* note 14, at 13. Some states cover as few as 20% of their population who fall below the poverty line. Clark, *supra* note 11, at 164. For a further description of indigent people not covered by Medicaid, see Davis, *supra* note 10, at 313; see also 1981 HHS DATA, *supra* note 10, at 111.

Nor do all welfare recipients qualify.²⁷

The Medicaid benefit structure is also complicated and difficult to encapsulate.²⁸ Grossly over-simplified, a participant state is required by federal law to provide all "mandatory eligibles" with a basic set of services,²⁹ and is allowed to provide a wide range of additional services.³⁰ States opting to provide Medicaid to the "medically needy" have greater latitude in the range of services offered to these beneficiaries³¹ and some states offer rather limited benefits. In many states, the services covered by Medicaid are generally limited to the federally mandated services³² and are only available to the "mandatory eligibles." Other states could boast that their Medicaid programs cover a broader range of services than most private insurance policies.³³ But in all states, and particularly in recent years, the scope of services covered is a source of continuing controversy. Few states are generous and all are becoming increasingly willing to cut back on Medicaid coverage,³⁴ to impose cost-sharing requirements on recipients,³⁵

27. States are allowed to limit Medicaid eligibility standards used by that state before the "federalization" of welfare for the disabled, blind, and elderly. See *supra* note 18. For the effect of the 1981 amendments, see *infra* note 186.

28. For a summary of state-by-state Medicaid coverage, see 1981 HHS DATA, *supra* note 10, at 74-96.

29. That is to say, in order to receive federal reimbursement, a state must offer a specified list of services to mandatory eligibles. These include outpatient hospital services, inpatient hospital services, physician services, skilled nursing home services, X-ray and diagnostic lab testing, family planning services, and early and periodic screening diagnosis, and treatment (EPSDT) for children. 42 U.S.C. § 1396d(a) (1976 & Supp. V 1980). For discussion see Butler, *supra* note 6, at 12-14. For discussion of the state's discretion and a state-by-state analysis, see 1981 HHS DATA, *supra* note 10, at 4-14.

30. See table 1981 HHS DATA, *supra* note 10, at 76. Typical options include prescription drugs, dental care, and intermediate nursing home care. This latter service, though optional, is offered in all participating states and accounts for approximately 25% of all Medicaid expenditures.

31. As of 1980, if a state covered the medically needy, it had to offer comparable benefits to the categorically needy; these include inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing home services, physician services, and EPSDT (a list virtually the same as that required for mandatory eligibles); or, alternatively, the state may provide any seven of the sixteen services that can be provided to mandatory eligibles. 42 U.S.C. § 1396(a)(13)(c) (1976). See Butler, *supra* note 6, at 12. Note, however, that the list of services offered to the medically needy had to be comparable to those of the categorically needy. See 42 C.F.R. § 448.10(c)(3) (1976). This "comparability" requirement was modified by the 1981 amendments. See *infra* notes 186-88.

32. See Butler, *supra* note 2, at 221.

33. See 1981 HHS DATA, *supra* note 10, at 78.

34. See *infra* note 59.

35. Cost sharing (the requirement of co-payments or deductibles) was originally allowed for all but inpatient services under the original statute, but the 1968 amendments prohibited cost-sharing for cash grant (mandatory eligibles) recipients. Pub. L. No. 90-248,

and to utilize a variety of restrictive administrative techniques,³⁶ all with the effect of limiting the availability and the use of services. Twenty day limits on inpatient hospital use, once a month limits on physician visits, and the elimination of coverage for dental care, hearing aids, or other services are typical Medicaid coverage limitations.³⁷

Even for that portion of the nation's poor that are eligible, Medicaid offers only limited coverage for a restricted list of services.³⁸

For eligible beneficiaries, an equally serious short-coming of Medicaid is the limited reimbursement available in most states and the resulting reluctance of many providers to accept Medicaid patients. States generally reimburse providers on a fee-for-service basis and federal law requires states to allow virtually any provider to participate, securing recipients the right to choose their provider by allowing any qualified provider to participate in Medicaid but not requiring even qualified providers to accept any particular patient.³⁹ On the other hand, the federal law grants each state considerable discretion in determining rates of reimbursement,⁴⁰ authority that states are increasingly willing to exploit as Medicaid costs continue to rise.⁴¹

As of 1980, inpatient hospital services were reimbursed on the basis of "reasonable cost" (and, in most states, on the same basis as Medicare reimbursement), an amount that at least purported to approximate each facil-

§ 235(a), 81 Stat. 821 (1968). See *Chavkin & Cypen, Cost-sharing Under Medicaid: Lessening the Impact on Institutionalized Recipients*, 12 CLEARINGHOUSE REV. 285 (1978).

The 1972 Social Security amendments allowed only nominal but expanded cost-sharing to include all cash grant recipients for optional services. See 42 U.S.C. §§ 1396a(a)(14)(A)(ii) and (B)(ii) (1976). See discussion, *Chavkin & Cypen, supra* at 286-87; see also explanation in 1977 HOUSE MEDICAID DATA, *supra* note 13, at 13. For more recent discussion, see 1981 HHS DATA, *supra* note 10, at 95.

36. See *infra* note 63.

37. 1981 HHS DATA, *supra* note 10, at 80-94.

38. See *id.* at 78. It is extremely important to note that Medicaid coverage is oriented towards certain types of medical services, thus favoring certain populations in a manner that only partially reflects relative need. Historically, nearly 75% of Medicaid expenditures has gone for institutional services, principally inpatient hospital and nursing home services. See *id.* at 104. Significantly, an ever-increasing share of Medicaid expenditures has gone to intermediate care facilities, which now account for over 25% of the Medicaid budget. Taken as a whole, nursing homes account for over 40% of the nation's Medicaid budget. *Id.* See also CBO MEDICAID ANALYSIS, *supra* note 14, at 28. Other types of services, e.g., preventive care, home based services, even such potentially cost effective services as services by nurse practitioners, are generally not covered by Medicaid programs at all.

39. 42 U.S.C. § 1396a(a)(23) (Supp. IV 1980).

40. See CCH, MEDICARE GUIDE §§ 14,722-14,945 (1982).

41. For a summary of each state's reimbursement methods, see 1977 HOUSE MEDICAID DATA, *supra* note 13, at 19; CCH, MEDICARE GUIDE at §§ 15,501-15,660.82 (1982).

ity's actual costs.⁴² States reimbursed nursing homes on a "reasonably cost-related" basis, a standard that generated much controversy and led to the allegation in some states that nursing homes reimbursement fell far below actual costs.⁴³ With regard to physicians—who control access to most other medical services—and all other Medicaid providers, federal law required only that the states pay not more than Medicare reimbursement,⁴⁴ in practice many states used across-the-board fee schedules with the net result that physicians often received far less from Medicaid than from non-Medicaid patients.⁴⁵

42. "Reasonable cost" is a cost-based calculation which approximates a facility's actual cost, but it establishes a level of reimbursement which is still often less than what each facility actually charges private-pay patients. See 42 C.F.R. §§ 447.250-447.261 (1980). For a more detailed explanation, see 1981 HHS DATA, *supra* note 10, at 114-19. This requirement was significantly modified in 1981. See *infra* note 190.

43. Prior to 1980, states were required to reimburse nursing homes according to several criteria and on a "reasonable cost-related" basis. 42 C.F.R. §§ 447.273-447.311 (1980). That is, states were required to relate reimbursement to some estimate of cost, although they are still allowed considerable discretion. Among other things, states were authorized by regulation to consider whether each facility was operated "economically or efficiently." See 1977 HOUSE MEDICAID DATA, *supra* note 13, at 21. That discretion was slightly broadened in 1980, when Congress repealed the "reasonably cost-related" standard and substituted a requirement that states reimburse nursing homes at rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." See Pub. L. No. 96-499, § 962, 94 Stat. 2650 (1980), codified at 42 U.S.C. § 1396a(a)(13)(E) (Supp. IV 1980). For the most recent administrative interpretation of this standard, see *infra* note 190. For a history, see B. SPITZ, G. ENGQUIST-SEIDENBERG, F. TIETELBAUM & R. CURTIS, STATE GUIDE TO MEDICAID COST CONTAINMENT 7 (National Governors Association 1981).

44. 42 C.F.R. § 447.341 (1980). Medicare reimbursement gives physicians the lower of their actual charge, or their "customary, prevailing, or reasonable charge." For an explanation, see D. ROWLAND, PHYSICIAN PAYMENT: ASSURING ACCESS AND CONTAINING COSTS (Legal Services Corp. 1980). This ceiling was lifted in 1981. Pub. L. No. 97-35, § 2174, 95 Stat. 809 (1981).

For a listing of reimbursement for other Medicaid services, (e.g., drugs, diagnostic tests, outpatient hospital services), see 42 C.F.R. § 447.325-447.371 (1980). See also discussion, CCH, MEDICARE-MEDICAID GUIDE § 14,723 (1981). For a state-by-state analysis, see 1981 HHS DATA, *supra* note 10, at 116-19.

Theoretically there is a lower limit on the amount of reimbursement; the federal law requires that Medicaid reimbursement be sufficient to encourage participations by providers "comparable" to that available to the general population. See C.F.R. § 447.204 (1980). But in reality this has been translated into a legally enforceable obligation only in extreme cases. See Parks & Ivie, *Low Provider Participation in Medicaid: A Surmountable Obstacle to Health Care Access*, 14 CLEARINGHOUSE REV. 415, 419 (1980). Notwithstanding this requirement, many states have opted for reimbursement methods for many services that result in lower payment for Medicaid than the payment for comparable services under either Medicare or private insurance.

45. States are given the most latitude with regard to the reimbursement of physicians, and not unexpectedly many states have set rates that are clearly a fraction of the physician's

As a result of these reimbursement policies and several other factors,⁴⁶ the Medicaid recipient's access to covered services is far from assured. Many providers, and particularly private physicians, are reluctant to participate in the Medicaid program.⁴⁷ Medicaid is a voluntary program,⁴⁸ and therefore does not guarantee the availability of services, but rather only assures that providers will be reimbursed for services actually provided. Since reimbursement is limited under the program, in many areas of the country Medicaid is a realistic source of medical care for the eligible poor only through public sector clinics and hospitals,⁴⁹ the so-called "Medicaid mills,"⁵⁰ and the efforts of some dedicated but frequently dis-

charges to private patients. Good data are virtually unavailable on the subject, but the CBO has reported that sample studies indicate that in some states physician reimbursement can be as low as 40% of a physician's usual charge. CBO MEDICAID ANALYSIS, *supra* note 14, at 19.

46. Many providers also claim that their reluctance to participate in Medicaid is due to "red tape" and administrative delays frequently encountered in state-administered Medicaid programs which often delay reimbursement for several months to a year. For a good discussion, see Parks & Ivie, *supra* note 44, at 422. See also Butler, *supra* note 6, at 14. For provider participation problems early in the program, see R. STEVENS & R. STEVENS, *supra* note 1, at 201-02.

47. See Parks & Ivie, *supra* note 44, at 415. Some providers are also reluctant to take Medicare patients, but the problem is mitigated by several factors. First, Medicare reimbursement is sometimes higher (and faster) than Medicaid. Second, Medicare patients are less often viewed as "welfare" recipients, a distinction of considerable political importance. Third, and probably most important, Medicare allows physicians the option of taking Medicare or billing the patients for full charges, leaving the patient to collect reimbursement from the government. In contrast, if a service rendered is covered by Medicaid, the provider must accept payment in full and cannot bill the patient. (The provider can bill a Medicaid recipient for any service rendered but not covered by the Medicaid program.) 42 C.F.R. § 250.30(a)(6) (1980). See Butler, *supra* note 6, at 14 and accompanying text. See also Ferry, Gornick, Newton & Hackerman, *Physicians' Charges Under Medicare: Assignment Rates and Beneficiary Liability*, 1 HEALTH CARE FIN. REV. 49 (1980).

48. No provider is required to participate, but federal law allows almost any provider the right to participate. See 1981 HHS DATA, *supra* note 10, at 80-94. While this statutory provision purports to assure that recipients have the "freedom of choice," in effect it establishes a "freedom to participate" for providers. Historically, this has acted to limit the bargaining power of state program officials in negotiating with providers, or even in sanctioning or eliminating high cost providers.

A significant concession is also made to medical practitioners in the preamble to the original Medicare legislation, which begins with the admonition that the program should not be carried out in such a way as to interfere with the private practice of medicine. 42 U.S.C. § 1395 (1980). This has been interpreted as applying to the Medicaid program as well. See Butler, *supra* note 6, at 222.

49. See Dallek, *The Continuing Plight of Public Hospitals*, 16 CLEARINGHOUSE REV. 97 (1982). Ironically, the Reagan strategy would also eliminate funding for many of these providers and pressure any remaining providers to take fewer Medicaid patients, particularly if states' reimbursement policies are tightened as a result of the proposed cutbacks. See *infra* notes 269-72.

50. For a discussion of "Medicaid Mills," see R. STEVENS & R. STEVENS, *supra* note 1,

gruntled providers.⁵¹

Although Medicaid has proven to be an important source of medical care for millions of people, the implied promise that Medicaid would provide the nation's indigent with access to "mainstream medicine" has been, at best, only partially fulfilled.⁵²

at 180-90; see also Mitchell & Cromwell, *Medicaid Mills: Fact or Fiction*, 1 HEALTH CARE FIN. REV. 37 (1980).

51. See Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401, 1407 (1981).

52. Notwithstanding the limitations of the program, the nation's poor have obviously benefited from Medicaid, at least as measured by traditional indices. For example, prior to 1965, individuals below the poverty line used physician services far less than the rest of the United States population. Since the introduction of Medicaid, both the poor and the nonpoor have increased utilization of physician services, but the traditional disparity has been reversed. The poor now use physician services more often than the nonpoor. See discussion in 1977 HOUSE MEDICAID DATA, *supra* note 13, at 56-59.

The data with regard to that portion of the poor eligible for Medicaid are even more impressive. Analyzing several different studies, Karen Davis has concluded that utilization patterns for various types of medical care services by the Medicaid recipient population have greatly increased since the beginning of the Medicaid program. In fact, they are now roughly equivalent to the utilization patterns of the middle class, and nearly double those of the non-Medicaid poor. See Davis, *supra* note 10, at 312. For a lengthy discussion of more recent data, see CBO MEDICAID ANALYSIS, *supra* note 14, at 19-23 and sources cited therein.

One should also note that these apparent gains in utilization occurred at a time when medical care prices were skyrocketing; thus Medicaid could have been regarded as a significant success even if it had only maintained the preexisting level of utilization of medical services by the poor.

On the other hand, the statistics on increased utilization by the poor disguise certain relevant factors. No one disputes that the health status of the nation's poor, despite the impact of Medicaid and other "War on Poverty" programs, remains below that of the rest of the population. Thus comparisons of middle class consumers to the poor or to the Medicaid population are misleading: The poor most certainly should have higher, not equal, utilization rates. For an interesting study and an attempt to quantify this different level of need, see Aday, *The Impact of Health Policy on Access to Medical Care*, 54 MILBANK MEMORIAL FUND Q. 215 (1976).

Moreover, not all of the relevant data supports the conclusion that the nation's poor have been assured access to medical care since Medicaid was adopted. For example, the poor, at least when taken as a group are still more likely not to have any physician visits during the year. This is perhaps a better approximation of "access" than the average number of physician visits. See CBO MEDICAID ANALYSIS, *supra* note 14, at 21.

Furthermore, the measurable gains in utilization largely reflect the differences between "access" to medical care services before the inception of the program and after it was in full operation—not a continual or continuing growth. With the exception of nursing home services, which may deserve separate examination, there has been no significant growth in the utilization of other services by those people who are eligible for Medicaid in the last decade. Since the mid-1970's, the bulk of the program growth has been a result of the inflating costs of medical services, not increased utilization.

Thus the apparent successes of Medicaid must be viewed against its undeniable limitations. The inequities in eligibility created by the required categorical linkage and the other eligibility requirements, and the wide variations among states in income and resources re-

B. Medicaid 1965-1980

In the eyes of most state and federal legislators, the critical problem with the Medicaid program has not been its inadequacy or its inability to achieve its lofty ambitions; its most troublesome aspect has been its cost. Whatever Congress' original intent, the rapid growth of the program and the annual budget overruns have confirmed Medicaid's status as a somewhat unwanted child.

As early as 1966, even before the program had grown beyond its infancy, some members of Congress, apparently shocked by the program's actual cost, were proposing substantial budget and program cuts.⁵³ By 1967, the illusion that Medicaid would become a comprehensive medical care program for the poor had been all but eliminated. As the potential cost of a fully-blown Medicaid program became a political reality,⁵⁴ Congress moved quickly to limit the states' discretion to expand their programs. At the same time, it allowed the states considerable flexibility in

quirements create a program that allows coverage for only a fraction of the nation's poor. See CBO Medicaid Analysis, *supra* note 14, at 9. For that matter, not even all eligible poor receive benefits. See *supra* note 17. Interstate differences in service coverage and reimbursement levels and the other contours of the Medicaid program have only exaggerated the inherent inequities in the program. Even more disturbing is the fact that there are differences in utilization rates among Medicaid eligibles for rural and urban populations, as well as for whites and nonwhites, that cannot be explained in any but unacceptable terms. See K. DAVIS & C. SCHOEN, *supra* note 10, at 71-83; see also INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS (1981).

53. See R. STEVENS & R. STEVENS, *supra* note 1, at 116-17. Ironically, the most radical of these cutback proposals would have rivaled some of those now proposed by the Reagan Administration. See *infra* notes 132-54.

54. See R. STEVENS & R. STEVENS, *supra* note 1, at 95, 108, 114-17. The potential cost of Medicaid caused considerable confusion and consternation in Congress, as did HEW's apparent inability (or reluctance) to make accurate estimates of program costs, even in retrospect. See, e.g., *id.* at 184-85.

During the 1965 deliberations, congressional estimates of the first year cost of a fully operational program called for just over \$200 million for Medicaid and nearly \$1 billion for all indigent medical care programs. (As Medicaid was being implemented, the preexisting Kerr-Mills program, and a few related programs providing medical care for the poor were gradually being phased out. Thus, the original "Medicaid budget" was generally expressed as an estimate of additional federal expenditures over and above those already being spent on Kerr-Mills and other programs.) HEW later estimated that first year costs would be even lower, \$155 million, apparently assuming that not all states would be participating in 1966. See *id.* at 95. Unfortunately, all of these figures proved to be underestimates. The initial Medicaid program proposed by New York called for an additional \$145 million in federal funds, over and above the federal share of the Kerr-Mills program. *Id.* And by the end of 1966, with only 22 of 52 possible Medicaid programs participating, the actual federal cost of these medical programs was estimated at over \$1.3 billion. HEW was also predicting a \$3 billion federal budget for a fully operational Medicaid scheme, a projection that would again be too low. See *id.* at 108, 116. Not surprisingly, by the end of 1966, congressional leaders were claiming that they had been misled by the Administration, and that they were

limiting the services offered and restricting eligibility, principally at the expense of the medically needy.⁵⁵

dismayed by the program's cost and the prospects for continued growth as additional states began to participate. *See id.* at 184.

Notwithstanding this congressional concern, the federal Medicaid budget continued to grow at an alarming rate even with the phase-out of Kerr-Mills and other related programs. By 1968, with 37 states participating, actual program costs were \$3.54 billion; the Administration had predicted a cost of \$2.25 billion with 48 states participating. *Id.* at 132. By 1970, the total Medicaid budget had swelled to over \$5.5 billion, of which the federal share was \$2.8 billion. *Id.*

In the years that followed, despite the near frantic efforts of the state and the federal governments, this inflationary trend accelerated. According to data published by HEW, total federal and state program costs (including Kerr-Mills and other programs) for the years of 1968 through 1980 were:

1968 —	\$ 3.45 billion
1969 —	4.35 billion
1970 —	5.09 billion
1971 —	6.35 billion
1972 —	7.35 billion
1973 —	8.71 billion
1974 —	9.74 billion
1975 —	12.09 billion
1976 —	13.98 billion
1977 —	16.35 billion
1978 —	17.16 billion
1979 —	19.66 billion
1980 —	21.02 billion

HEW, Medicaid Medicare Management Institute, *Data on the Medicaid Program: Eligibility, Services, Expenditures* (Rev. Ed. 1979) at 28. For discussion of these figures and their basis, see K. DAVIS & C. SCHOEN, *supra* note 10, at 56; *cf.* similar discussion (and slightly different figures) in J. HOLAHAN, *FINANCING HEALTH CARE FOR THE POOR* 3 (1975).

For later years, total state and federal program outlays have been reported as \$23.2 billion for fiscal year 1980, \$30.3 billion for fiscal year 1981, and \$33.7 billion (estimated) for fiscal year 1982. HOUSE COMM. ON WAYS AND MEANS, 97TH CONG., 2D SESS., *BACKGROUND MATERIAL AND DATA ON MAJOR PROGRAMS WITHIN THE JURISDICTION OF THE COMM. ON WAYS AND MEANS* 364-65 (Comm. Print 1982).

55. Pub. L. No. 90-248, 81 Stat. 896 (1968). Although the Medicaid program was expanded in several minor ways by the 1968 amendments, e.g., the addition of early, periodic screening, diagnosis, and treatment for children as required services, the principal thrust of the amendments was to control the federal cost of the program by imposing limitations on the potential expansion of each state's program. *See* summary, R. STEVENS & R. STEVENS, *supra* note 1, at 131-37. It should be noted that much stronger program cuts were actively considered, but not passed.

The most significant of the amendments enacted concerned the state's options for the "medically needy" program. *See supra* note 18. The states were given considerable discretion to limit the scope of services offered to the "medically needy." *See* Pub. L. No. 89-97, tit. I, § 121(a), 79 Stat. 286, 344 (1965) as amended by Pub. L. No. 90-248, § 224(a), 81 Stat. 821, 902 (1967), codified at 42 U.S.C. § 1396a(a)(13)(c) (1980 Supp.). *But see infra* notes 186-88 for 1981 amendments.

The 1968 amendments also imposed a federal ceiling on the "medically needy" income level at 133% of the state's AFDC income standard. This effectively tied Medicaid eligibility

The states readily accepted the congressional mandate. Even while some states were still implementing their initial forays into Medicaid, others were finding it necessary to limit their program growth.⁵⁶ Thus in the early years of the program, the political die was effectively cast. In the decade that followed, Congress and the state legislatures would struggle to devise Medicaid programs that somehow stayed within politically acceptable cost limitations. The result was a hodgepodge of strategies, reflecting a continuing political ambivalence towards providing an adequate medical care program for the poor. Congress, despite the concern over Medicaid's cost, never retreated from the basic concept of a medical care program for the poor, but it wavered in its willingness to commit sufficient resources to fulfill that objective completely. Federal legislation occasionally expanded or reoriented the program expenditures towards more efficient modes of financing⁵⁷ or more cost-effective services.⁵⁸ More often, however, it exhibited a growing tolerance for state cutbacks in Medicaid eligibility or services as a means to control cost.⁵⁹ Moreover, despite its insistence that Medicaid be a state-administered program, Congress became more aggressively cost-conscious in the 1970's, and continually pushed the federal ad-

to welfare cash grant eligibility, the most unpopular of the existing welfare programs, and left Medicaid eligibility largely to the discretion of state legislative prerogative. For current codification, see 42 U.S.C. § 1396b(f) (Supp. IV 1980).

Thus, the 1968 amendments deemphasized the concept of medical indigence—already circumscribed by the requirement that beneficiaries be categorically linked. By tying the “spend-down” eligibility level to a slight increase over the lowest and least popular of the cash grant levels and by allowing states wide discretion in the scope of services offered, Congress virtually eliminated the illusory promise that Medicaid would be a comprehensive program for people who could not afford medical care.

56. See R. STEVENS & R. STEVENS, *supra* note 1, at 156-69. The 1968 maximum ceiling on “medically needy” eligibility became one of the requirements that had to be met in order to begin participation in the program. Yet by 1968, 37 states were already participating, eight of which—representing 90% of the program expenditures—exceeded the newly imposed 133% ceiling. *Id.* at 156-57. Some states reacted to the new federal requirement as a matter of fiscal necessity. See description of Maryland and Virginia, *id.* at 158-59. In many other states conservative politicians took the opportunity to roll back or even eliminate larger portions of the program. See, e.g., description of the New Mexico experience, *id.* at 158.

57. See discussion of health maintenance organizations, *infra* notes 200 & 274.

58. See Butler, *supra* note 2, at 223-24. See also R. STEVENS & R. STEVENS, *supra* note 1, at 262.

59. The legislative deliberations of 1969 provide a good example. Through a series of technical amendments, the Congress in 1969 effectively authorized procedures which allowed states to amend their state plans to include cutbacks in services, in contrast to the original statutory terms that required continuous expansion of the program. These amendments also postponed the requirement of comprehensive program development from 1975 to 1977; later this requirement was repealed altogether. See *supra* note 7. Pub. L. No. 91-56, 83 Stat. 99 (1969); see explanation in R. STEVENS & R. STEVENS, *supra* note 1, at 328; see *id.* at 216 (discussion of the *McNerney Report*).

ministration towards more control over both participating states and participating providers.⁶⁰

At the state level, legislators and program administrators struggled to find a politically acceptable means to limit costs: limiting services and eligibility,⁶¹ imposing stricter reimbursement policies,⁶² imposing further administrative controls,⁶³ and attempting to police, or at least publicize, consumer and provider fraud.⁶⁴ Many of these efforts were crude; others were poorly administered.⁶⁵ Almost all were pointed towards the dominant political theme of containing program costs.

Yet the net result was not control over cost, at least in absolute terms. The Medicaid budget, fueled principally by the growing inflation in the costs of medical care services and, in the early years of the program by an expanding welfare population, continued to grow.⁶⁶ The only remarkable result of these cost control efforts was the creation of increasingly complicated Medicaid programs administered by equally complicated state and federal bureaucracies—with little political support and no cognizable philosophical foundation.⁶⁷ Inadequate in its structure and design, unpopular and expensive, Medicaid in its programmatic adolescence was no more loved than it was wanted at birth.

By 1970, congressional deliberations over Medicaid policy were somewhat obscured by the annual budget battles of which social welfare programs were just one part. In addition, a series of conflicts between the

60. The early 1970's marked a turning point for the federal administration of Medicaid. The Medical Services Administration had been much maligned in the early years of the programs, apparently with some reason. Following some critical congressional hearings and the so-called *McNerney Report*, MSA was substantially reorganized and revitalized. A significant thrust of these changes was to increase the federal supervision over state agency administration and to push the states toward greater control over program costs. For a full description, see R. STEVENS & R. STEVENS, *supra* note 1, at 237-39.

61. For a description of typical state cutbacks, see Blong & Butler, *Developments in Medicaid Cutback Remedies*, 6 CLEARINGHOUSE REV. 723 (1972). Some of the limits on the scope or duration of services offered were almost bizarre, e.g. California offered coverage for psychiatric drugs, but covered only one drug. See R. STEVENS & R. STEVENS, *supra* note 1, at 289. Other states achieved greater cost saving by imposing drastic durational limitations, or severely limiting eligibility. *Id.* at 260-74.

62. Many states chose to adopt across-the-board fee schedules for physicians; others became reluctant to allow rate increases. See *supra* note 45.

63. States attempted in a variety of ways to impose administrative controls on utilization, ranging from requirements of prior authorization for certain kinds of services, to letters to providers urging "restraint." See R. STEVENS & R. STEVENS, *supra* note 1, at 262.

64. For an account of fraud by providers during the early years of Medicaid and attempts to control it, see *id.* at 264-65, 284-85. See also *infra* note 268.

65. See, e.g., R. STEVENS & R. STEVENS, *supra* note 1, at 282.

66. See *supra* note 54.

67. See R. STEVENS & R. STEVENS, *supra* note 1, at 305.

largely Democratic Congress and the Republican White House, some of which were the precursors of the political issues which would play a dominant role on the congressional agenda during the first years of the Reagan Administration, further clouded the discussions.⁶⁸

The beneficial effect was that both liberals and conservatives shifted at least some of their attention away from the cost of Medicaid as a program and towards the underlying reason for the increase: inflation in the cost of medical care services. There was, for example, considerable congressional interest in the promotion of health maintenance organizations, both for the Medicaid population and the general public.⁶⁹ Furthermore, a number of proposals for nationalizing medical care financing were at least one principle focus of congressional attention.⁷⁰ Even Richard Nixon's welfare reform strategy included a vastly reorganized Medicaid scheme, the Family Health Insurance Program (FHIP), supplementing a privately-administered but federally-policed catastrophic health insurance program.⁷¹

On the other hand, Medicaid policy was somewhat overshadowed by these more sweeping proposals and a series of other more politically volatile issues such as social security cash grant levels and the extent of federal control over welfare policy, as Congress considered, and then backed off from, massive reform in the social welfare patchwork.

The resultant Social Security Amendments of 1972⁷² were the culmination of nearly two years of extensive and controversial legislative deliberations, beginning in the first days of the 92nd Congress and ending with a massive (900 page) document representing not systemic reform, but a series of incremental and sometimes contradictory amendments.⁷³ Again, Medicaid bore a resemblance to an unwanted child. Included in these amendments were a scattered assortment of provisions directly and indirectly relating to the Medicaid program which, when pieced together, represented a major shift in federal Medicaid policy.

Perhaps most indicative of Congress' ambivalence towards the program was the establishment of the Supplemental Security Income program (SSI), federalizing, and thereby expanding, three of the four welfare cash

68. For a summary of the legislative deliberations over Medicaid during the 91st Congress and the history of the ill-fated 1970 social security amendments, see *id.* at 331.

69. *Id.* at 228-31.

70. For a summary of the more important national health insurance proposals pending during the 92d Congress, see *id.* at 333.

71. *Id.* at 224-26. For a good discussion, see Holahan, *supra* note 54, at 80-84.

72. Pub. L. No. 92-603, 86 Stat. 1329 (1972).

73. For a broader discussion of these amendments and their legislative background, see R. STEVENS & R. STEVENS, *supra* note 1, at 318-37.

grant programs.⁷⁴ Since Medicaid eligibility is tied to welfare eligibility, the 1972 SSI amendment effectively expanded Medicaid eligibility as well as welfare cash grant eligibility,⁷⁵ particularly in those states where Medicaid and welfare income and eligibility standards had been far below the newly created SSI eligibility standards.⁷⁶ But the 1972 amendments specifically allowed states to retain pre-1972 welfare eligibility standards for determining Medicaid eligibility for SSI recipients, effectively allowing states to restrict their Medicaid population as federal welfare eligibility was expanded, an option some states continue to exercise.⁷⁷

In addition, Congress further loosened the bonds on state discretion with regard to service and eligibility in 1972,⁷⁸ and authorized and, in some instances, mandated a series of cost-containing efforts by states and participating providers,⁷⁹ indicative of its increased willingness to experi-

74. See *supra* note 18.

75. The practical implication of this amendment was at least two-fold. The first was an immediate effect: by federalizing welfare cash grants for the blind, the disabled, and the elderly, Congress effectively raised the cash grant levels in many states (except for AFDC cash grants) to a national level thereby expanding the welfare population to include more people. But second, in the years to follow, it allowed cost-of-living and other adjustments to that standard to be a matter of congressional policy, not individual states which, predictably, would be less likely to respond to inflation and other economic changes than Congress.

76. 42 U.S.C. § 1396a(f) (Supp. IV 1980).

77. The 1972 amendments repealed the 1977 deadline for "comprehensive programs" and the "maintenance of effort" provision, see *supra* note 7. It also expanded the state discretion to impose "cost-sharing" on some Medicaid recipients. See *supra* note 35.

It should also be pointed out that other provisions of the 1972 amendments, albeit in minor ways, broadened the coverage of Medicaid, evidence that Congress was not abandoning the concept of a medical benefits program for the poor in its entirety, only that it was becoming more preoccupied with Medicaid's cost. For example, family planning services were added as a required benefit. Pub. L. No. 92-603, § 299E, 86 Stat. 1329, 1462 (1972), codified at 42 U.S.C. 1396d(a)(4)(C) (Supp. IV 1980). Medicaid eligibility was also extended for four months following a determination of ineligibility based on income increase. Pub. L. No. 92-603, § 209(a), 86 Stat. 1329, 1381 (1972), codified at 42 U.S.C. § 1396a(e) (Supp. IV 1980).

78. As another commentator has pointed out, Congress' ambivalence towards the program is also demonstrated by the rhetoric employed to justify state program cutbacks, frequently arguing that the increased "flexibility" Congress was giving to the states would allow more efficiency and the elimination of waste, and would not necessarily require actual program reductions. See generally Rosenblatt, *Health Care and Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243 (1978).

79. Among the various cost control provisions, states were authorized to use prepayment and other experimental schemes for reimbursement of participating hospitals, and to establish programs which would deny institutional providers reimbursement for costs related to "unnecessary" capital expenditures. Pub. L. No. 92-603, § 223, 86 Stat. 1329, 1393 (1972), codified at 42 U.S.C. § 1395x(v)(1)(A) (1980). See discussion in Wing & Sifton, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, 57 N.C.L. REV. 1423, 1429-30 (1979).

All participating institutional providers were required under the new amendments to col-

ment with direct regulatory controls.⁸⁰

The more significant Medicaid policy message of the 1972 amendments was that Congress, while still committed to a continuation of a Medicaid program, would be increasingly tolerant of state program cutbacks as a means to control program costs. Predictably, the 1972 amendments were followed by a wave of state cutbacks on services and eligibility, limitations on provider reimbursement, and expansions of administrative controls

lect utilization review data. Pub. L. No. 92-603, § 237, 86 Stat. 1329, 1415 (1972), codified at 42 U.S.C. § 1395x (1978).

Professional Standard Review Organizations were also established to (eventually) oversee these utilization review activities of institutional providers. Social Security Amendments of 1972, Pub. L. No. 92-603, § 249f, 86 Stat. 1329, 1429 (1972)(codified at 42 U.S.C. § 1301 (Supp. IV 1980)).

The 1972 amendments also amended the reimbursement scheme by offering financial incentives to states to increase the participation of health maintenance organizations. Pub. L. No. 92-603, § 410, 86 Stat. 1329, 1491 (1972).

For a summary of the 1972 amendments, see R. STEVENS & R. STEVENS, *supra* note 1, at 337-40.

For a broader discussion of the cost control amendments and their legal and political context, see Wing & Silton, *supra* note 79, at 1429-31.

80. There is no doubt that Congress by 1972 was willing at least to experiment with direct regulatory controls over Medicaid (and Medicare) providers, as best illustrated by the establishment of utilization review requirements and the Professional Standard Review Organizations program. But the willingness of Congress to establish regulatory controls over program costs was at best ambivalent. To begin with, despite growing concern over the costs of health care in general—costs which were obviously at the core of the Medicaid cost problem, *see supra* note 54—congressional action was still entirely directed towards imposing controls over Medicaid and Medicare providers only, and only with regard to services by those providers under those programs. *See* discussion in Wing & Silton, *supra* note 79, at 1429-30.

Moreover, subsequent experience would indicate that Congress' apparent willingness to impose regulatory constraints on program costs was hardly resistant to provider or state government pressure. For example, while the 1972 amendments had required states to review utilization of all institutional services under Medicaid, Pub. L. No. 92-603, § 237(a)(1), 86 Stat. 1329, 1415 (1972), HEW was reluctant to force the states' compliance with this requirement. When HEW finally took steps to implement this requirement they met with substantial provider resistance. *See* summary in *Utilization Review/PSRO Litigation*, 8 CLEARINGHOUSE REV. 859 (1975); in apparent response to this political pressure, Congress subsequently diluted those requirements. *See* Pub. L. No. 94-182, §§ 105-112, 89 Stat. 1051, 1052-55 (1976).

Another example of the congressional mentality is provided by the attempt to penalize states that did not impose adequate utilization review requirements on nursing homes. In 1972, Congress mandated HEW to impose a financial penalty on states that had not complied with these review requirements. *See* Pub. L. No. 92-603, § 207, 86 Stat. 1329, 1379 (1972). But when HEW moved towards actually implementing this requirement, Congress repealed the provision. *See* Pub. L. No. 95-59, § 6, 91 Stat. 255, 256 (1977). For background and discussion, see S. REP. NO. 298, 95th Cong., 1st Sess. 430-31 (1977); *see also* Laudicina and Schneider, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977: Implications for the Poor*, 11 CLEARINGHOUSE REV. 843, 848-49 (1978).

over utilization.⁸¹

After 1972, the Medicaid debate was no longer to be obscured. As the program grew to be the second largest portion of the federal health budget,⁸² and the most expensive of the federal welfare programs,⁸³ skyrocketing Medicaid costs became a major part of the debate over inflation in general health care costs, as well as in the rest of the economy. During the same time, it also became clear that political constraints would not easily tolerate either significant program reductions or further regulatory measures, particularly if imposed from the federal level. The result was nearly a decade of political stalemate. There was sufficient support for the program that any major reduction in the federal effort or any retreat from the basic concepts of the program was successfully resisted. On the other hand, reform efforts, particularly those that required mandatory regulatory controls or a restructuring of traditional notions of medical care delivery, had little success, a tribute in great part to increasingly well-organized lobbying efforts by provider organizations.⁸⁴ Thus, until the election of 1980, and the advent of the Reagan strategy, each successive Congress repeatedly debated a range of proposals, but was unable to enact any substantial Medicaid reform.⁸⁵

The 94th Congress, despite giving serious consideration to major reforms of the program, eventually managed to enact only a series of minor amendments, strengthening federal efforts with regard to fraud and abuse, and imposing additional eligibility conditions on participating health maintenance organizations.⁸⁶ Not unexpectedly,⁸⁷ these efforts did little to

81. For a description, see Mullen & Fredenberg, *Coping with Medicaid Cutbacks*, 9 CLEARINGHOUSE REV. 392-93 (1975).

82. See *supra* note 54. For comparison to Medicare, see summary in *Fiscal 1982 Budget: Reagan Calls for \$4 Billion Cuts in Medicare, Medicaid*, 40 CONG. Q. 243 (1982).

83. By fiscal year 1982 when total (federal and state) Medicaid expenditures had exceeded \$30 billion, see *supra* note 54, total welfare (AFDC) outlays were \$12.5 billion. OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE U.S. GOVERNMENT FOR FY 1983 at I-K47 (1982). Federal SSI outlays for fiscal year 1982 were \$7.2 billion. *Id.* at I-K45. Federal Food Stamps benefit outlays were \$11.3 billion. *Id.* at I-E95.

84. It is important to again note the intensive battle behind this legislation, frequently pitting powerful provider groups against a cost conscious Congress; the depth of the controversy cannot be measured by the resulting legislation alone, but also by the proposals considered but not enacted after serious lobbying efforts by providers. See, e.g., Laudicina & Schneider, *supra* note 80, at 847.

85. In the 93d Congress there were several minor amendments to the program including a temporary "grandfather" clause to allow the people that received increased cash benefits under the Social Security cost-of-living increase of 1973 to retain Medicaid eligibility as a result of the increase in income. See Pub. L. No. 93-66, 87 Stat. 153 (1973). See also Pub. L. No. 93-233, 87 Stat. 947 (1974); Pub. L. No. 93-368, 88 Stat. 420 (1974).

86. During the first session of the 94th Congress, Congress only enacted a series of relatively minor amendments to Medicaid (e.g., grandfathering Medicaid eligibility for

check the growth of Medicaid program costs which, fueled principally by

those people who would have lost their eligibility due to the 1975 Social Security increase). See Pub. L. No. 94-182, 89 Stat. 1051 (1975). For a good summary, see Schneider, *The Medicare and Medicaid Amendments of 1975: Implications for Program Beneficiaries*, 9 CLEARINGHOUSE REV. 770 (1976).

During the second session, the 94th Congress grappled with several major Medicaid reform proposals, but again enacted only rather limited amendments. A major administrative and financing measure was proposed by Senator Talmage in March 1976, indicative of the growing congressional support for major programmatic reform. S. 3205, 94th Cong., 2d Sess. (1976). For a summary, see *New Medicaid/Medicare Reform Bill in Congress*, 10 CLEARINGHOUSE REV. 29 (1976).

Congress also developed a strong interest in provider fraud and abuse, sparked by Senator Moss' much publicized hearings and unannounced (and disguised) visits to "Medicaid mills," see *Congress Enacts Medicare and Medicaid Anti-Fraud Legislation*, 10 CLEARINGHOUSE REV. 879 (1977). As a result of this interest, a major fraud and abuse proposal was considered. S. 3801, 94th Cong., 2d Sess. (1976). The version of that bill which was eventually enacted, however, was much more limited in its scope than the original S. 3801, but still included significant attempts to attack provider fraud, principally the establishment of an independent Office of the Inspector General within HEW with substantial investigatorial powers. Medicare-Medicaid Anti-Fraud Act of 1976, Pub. L. No. 94-505, 90 Stat. 2429.

Also during the second session of the 94th Congress, Congress enacted the Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, 90 Stat. 1945, which among other things put tighter restrictions on the eligibility of HMO's to participate in state Medicaid programs. See *Congress Enacts Medicare and Medicaid Anti-Fraud Legislation*, 10 CLEARINGHOUSE REV. 879 (1977). This was only one chapter in a rather protracted experiment testing the viability of a Medicaid-HMO option. Prior to 1973, at least a dozen states had made arrangements by which Medicaid recipients were enrolled in HMOs under the general authority of 42 U.S.C. § 1396a(a)(23) (Supp. IV 1980). For an explanation, see Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U.L. REV. 90, 115 (1975). The experiments were not impressively successful. There were frequent allegations of fraud by participating HMOs and, in any event, only a small fraction of the Medicaid population actually had an HMO option. See, e.g., Chavkin & Treseder, *California's Prepaid Health Plan Program: Can the Patient Be Saved?*, 28 HASTINGS L.J. 685, 713-19 (1977).

In 1973, as part of the Health Maintenance Act of 1973, Pub. L. No. 93-222, 81 Stat. 914, Congress expressly authorized states to contract with HMOs to enroll Medicaid recipients and outlined conditions that states offering an HMO option would have to meet, conditions that gave states considerable discretion. See 45 C.F.R. § 249.82 (1975). The 1976 amendments, however, added further conditions, including the requirement that HMOs contracting with states for enrolling Medicaid recipients had to meet all of the requirements imposed on HMOs qualifying for financial assistance under the 1973 act. Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, § 202, 90 Stat. 1945, 1958, codified at 42 U.S.C. § 300e (1978).

The net result was to restrict the potential expansion of the Medicaid-HMO option. Recent data indicate that less than \$150 million in total Medicaid expenditures nationwide go to HMOs. 1981 HHS DATA, *supra* note 10, at 110. See *infra* notes 273-74.

87. The reasons that Congress in 1976 was not able to enact any major Medicaid reform may be reflected in some of the minor Medicaid conflicts during the 94th Congress. In a rather complicated maneuver in its first session, Congress authorized an amendment to the Medicaid statute requiring participating states to consent to federal court jurisdiction over disputes arising from certain state Medicaid reimbursement policies. Pub. L. No. 94-182, 89 Stat. 1054 (1975). States that did not waive their constitutional immunity were subject to a

inflating costs of medical care services, grew to \$12 billion a year in 1975,⁸⁸ again prompting further state efforts to limit or cutback their programs.⁸⁹

In 1976 the incoming Carter Administration brought with it some rather ambitious health policy initiatives, calling for a mandatory hospital cost containment program, tighter fiscal controls over all federal health spending, including Medicaid and Medicare, and the eventual adoption of a nationalized health financing scheme.⁹⁰ The 95th Congress, however, seemed disinclined to adopt any new policy initiatives. The Carter Administration eventually withdrew its support for national health insurance.⁹¹ The Carter cost containment program was resoundingly defeated.⁹² The Child Health Assessment Program, Carter's only major proposal for expanding the Medicaid program, fared little better.⁹³ The

10% penalty after 1976. But in the second session, the 94th Congress reversed itself and repealed the "consent to suit" provisions of Pub. L. No. 94-182, apparently a concession to pressure from the states. See Pub. L. No. 94-552, 90 Stat. 2540 (1974).

88. See estimates *supra* note 54.

89. See L. MULLEN & A. SCHNEIDER, *MEDICAID CUTBACKS: A HANDBOOK FOR BENEFICIARY ADVOCATES* 1, 11-18 (1976) (available from the National Clearinghouse for Legal Services); see also Rosenblatt, *Lurching Toward the Abyss: Medicaid Cutbacks and Health Care Inflation*, HEALTH L. PROJECT LIBR. BULL. (Part I, Nov. 1975; Part II, Jan. 1976).

90. Carter's original game plan for health policy called for the temporary imposition of mandatory hospital cost controls (better described as mandatory revenue limitations) and, once costs were controlled, the eventual establishment of a nationalized health insurance scheme. For a full description, see Wing & Silton, *supra* note 79, at 1423-25.

Notwithstanding his original ambitions, Carter quickly translated his promises into a more realistic legislative agenda calling for a rather austere health budget, few new health programs, and increased federal regulatory controls; rather than a temporary stopgap, hospital cost containment became the center piece of his revised legislative strategy. *Id.* at 1425-28. For Medicaid, the Carter strategy was basically to "freeze" Medicaid spending, pending his proposed restructuring of the welfare system. He proposed a few modest improvements, most notably the Child Health Assessment Program (CHAP), see *infra* note 93. But Carter was apparently more concerned with reducing Medicaid costs, urging tougher reimbursement policies, increasing efforts to identify fraud and program abuse, and, of course, enacting hospital cost containment, the impact of which could have been substantial on Medicaid (and Medicare). *Id.* at 1427-29, 1434.

91. Characteristic of the legislative deliberations of the 1970's, Congress' focus on such issues as Medicaid reform was continually deflected by the more dominant concern for fiscal policy and broader economic issues, see Schneider, *Congressional Action on Health Issues: 1978*, 13 CLEARINGHOUSE REV. 895, 896 (1979), as well as other, seemingly tangential, but nonetheless dominant issues, such as the volatile debate over federal funding of abortions. *Id.*

Indeed the fight over the abortion amendment to the Labor-HEW appropriations bill nearly resulted in a fiscal crisis in 1977 and 1978. For a summary, see 1977 CONG. Q. ALMANAC 295, 1978 CONG. Q. ALMANAC 105.

92. For a discussion of the politics of hospital cost containment during the 95th Congress, see Wing & Silton, *supra* note 79, at 1431-37.

93. While Carter's general strategy was to limit Medicaid, he did propose several modest but significant expansions of the program. The Child Health Assessment Program

only Medicaid-related legislation passed⁹⁴ included a further strengthening of fraud and abuse penalties⁹⁵ and an expansion of reimbursement for services provided in rural health clinics.⁹⁶ Indeed, Congress, in its deliberations on health policy issues as well as on other economic issues, exhibited concern for controlling costs, but no discernible direction.⁹⁷

The 96th Congress followed the same pattern as the 95th. Congress continued to reject Carter's health policy initiatives and regulatory strategy, while voicing a frantic cry for control over federal health budget costs.⁹⁸

(CHAP) would have offered Medicaid services to all children (up to age 21), amending, among other things, the categorical limitations on eligibility. CHAP, while demonstrating substantial political support, never made it to the floor during either session of the 95th Congress. For a discussion, see Schneider, *supra* note 91, at 897.

94. But note that during the 95th Congress major Medicaid reforms were actively considered, including the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1978, S. 1470, 95th Cong., 1st Sess. (1978) (reported as H.R. 5285 during the second session); Carter's hospital cost containment, *see supra* note 90; and, however short-lived, nationalized health insurance. For background, see 1978 CONG. Q. ALMANAC 630.

95. The Medicaid-Medicare Fraud and Abuse Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175. Among other things, the 1977 amendments increased penalties for fraud, strengthened the prohibition on factoring, required more disclosure of financial and ownership information, and made several relevant administrative changes. They also made some significant changes in the administration of the Professional Standard Review Organizations program. For a full summary, see Laudicana & Schneider, *supra* note 80, at 845.

96. The 95th Congress also passed the Rural Health Services Act, Pub. L. No. 95-210, 91 Stat. 1485 (1977), which authorized both Medicaid and Medicare to reimburse services provided by rural health clinics (effectively creating an "eighth mandatory Medicaid service") and authorized, on a demonstration basis, reimbursement by Medicare of nurse practitioners and physician assistants practicing in urban and medically-underserved areas. For a full summary, see Schneider & Laudicana, *Rural Health Clinic Services Legislation: Implications for the Poor*, 11 CLEARINGHOUSE REV. 851 (1978).

97. By the second session of the 95th Congress, health policy had become even more fragmented by the competing political pressures on Congress and the dominant but elusive objective of controlling costs. Many of the categorical grant programs had been due for reauthorization in 1977, but had been extended for one year with few changes, a kind of "continuing authorization" not unlike the continuing appropriation resolutions that Congress has frequently relied upon to avoid budget crises. *See* Pub. L. No. 95-83, 91 Stat. 383 (1977). In the second session, Congress managed to enact a three-year authorization bill for most health programs with few substantive changes, Pub. L. No. 95-656, 92 Stat. 3551 (1978), but generally at lower levels of authorization, and sometimes at lower levels than those recommended by its own committees. *See* 1978 CONG. Q. ALMANAC 55. For commentary on these programs, see Schneider, *supra* note 91, at 896.

As another indication of prevailing political moods, the authorization for the health planning program virtually lapsed in 1978, but was carried through another year on another temporary authorization. *See* 1978 CONG. Q. ALMANAC 616.

98. The Carter Administration's health policy strategy for the 96th Congress was virtually the same as its strategy for the 95th Congress: budget limitations on most existing programs; few new programs, with the exception of continued support for CHAP; a continuation of existing regulatory programs such as health planning; and a concerted effort to enact a mandatory hospital cost containment program. *See supra* note 90. For back-

Even the pressure of its self-imposed budget process could not bring Congress closer to consensus.⁹⁹ In neither session was Congress able to enact an appropriations bill for the Department of Health and Human Services. Health program funding was extended by a series of continuing resolutions, allowing only incremental growth in health spending.¹⁰⁰ The 96th Congress was virtually paralyzed with regard to substantive authorizations for health programs.¹⁰¹ Following the pattern of nearly a decade, Con-

ground, see summary in WASH. REP. ON MEDICINE AND HEALTH, Jan. 15, 1979, at 3; Jan. 29, 1979, at 3-5.

The Carter strategy met with no more success in the 96th Congress than it had in the 95th. National health insurance, even diluted to a catastrophic health financing scheme, had its champions, but was never seriously considered. See, e.g., 1979 CONG. Q. ALMANAC 537-40. Similarly, hospital cost containment, even as a voluntary program, received little serious support. See 1979 CONG. Q. ALMANAC 512-18. A CHAP bill passed the House, but never made it to the floor of the Senate. H.R. 4962, 96th Cong., 1st Sess. (1979); see 1979 CONG. Q. ALMANAC 499.

99. Increasingly under pressure created by its self-imposed budget process and by inflating health care costs, Congress nonetheless declined to strengthen regulatory controls over health care providers; yet Congress was unable to adopt any alternative political strategy with regard to health policy. It did, however, attempt to follow the procedural contours of the budget reconciliation process, resulting in a centralization of authority in the congressional budget committees. This also tended to dilute the authority of substantive committees thus making independent reform of such programs as Medicaid even more difficult.

100. In the first session of the 96th Congress, the now perennial battle over the "abortion amendment," see *supra* note 91, deadlocked the debate over the HEW-Labor appropriations bill for fiscal year 1980, but all authorized programs were carried forward under a continuing resolution, H.R.J. Res. 440, 96th Cong., 1st Sess. (1979), enacted as Pub. L. No. 96-123, 93 Stat. 923 (1979). See 1979 CONG. Q. ALMANAC 236. The result was a total health budget only slightly higher than Carter's tightly drawn original request, indicating that both Congress and the White House were in a cost-cutting posture. For a summary of the resulting 1980 health budget, see WASH. REP. ON MEDICINE AND HEALTH, Aug. 13, 1979, at 3. For a description of Carter's original 1979 budget request, see WASH. REP. ON MEDICINE AND HEALTH, Jan. 29, 1979, at 3-6.

In the second session, Congress' attempts to finalize an appropriations bill were even less successful. In an effort to avoid the abortion debate, Congress did not enact a Labor-HHS appropriations bill, but included these funds in a continuing resolution including funds for a number of other agencies. This composite resolution passed late in the term, narrowly avoiding a short fall, or crisis, in government agency funding. H.R.J. Res. 644, 96th Cong., 2d Sess. (1980), enacted as Pub. L. No. 96-536, 94 Stat. 3166 (1980) (providing appropriations through June 1981). The continuing resolution set fiscal year 1981 funding levels for health programs at the levels set by H. 7998, 96th Cong., 2d Sess. (1980), a Labor-HHS appropriations bill passed earlier in the year by the House but not the Senate.

The final health budget for fiscal year 1981 carved out by Congress in December 1980 called for \$63.15 billion in spending, only slightly more than fiscal year 1980. This must be read against a double-digit rate of inflation and, most importantly, an ever inflating cost for Medicaid and Medicare. See WASH. REP. ON MEDICINE AND HEALTH, Nov. 24, 1980, at 3.

101. As a result of the tight budget limitations, the final budget reconciliation bill included numerous (but relatively minor) authorization amendments for health and health-related programs, generally intended to tighten control over program costs. Moreover, these amendments were forged more by compromise than by policy objective, and produced noth-

gress gave considerable attention to Medicaid and its continually rising cost, yet was only able to enact a series of incremental amendments, reflecting neither an overall policy direction nor any real effort to bring the cost of the program under control.¹⁰² The 96th Congress did make some rather symbolic gestures indicating a growing dissatisfaction with the states' administration of Medicaid¹⁰³ and exhibiting an increasing willing-

ing in the way of new initiatives. *See generally* The Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599.

Virtually the only major health legislation enacted during the 96th Congress was a three-year reauthorization (with significant modification) of the federal health planning program. Pub. L. No. 96-79, 93 Stat. 592 (1980). For a discussion, see 1979 CONG. Q. ALMANAC 474-80.

For a detailed summary of the health related activities of the 96th Congress, see WASH. REP. ON MEDICINE AND HEALTH, Aug. 25, 1980 (*Special Report*).

102. As in preceding Congresses, several major Medicaid reform measures were seriously considered during the 96th Congress. Hospital cost containment, and several variations on the same theme, once again generated considerable attention. *See* S. 505, H.R. 934, 96th Cong., 1st Sess. (1979); *see also* H.R. 3990, 4000, 96th Cong., 2d Sess. (1980). But not surprisingly, the Medicaid legislation eventually produced by the 96th Congress was not a major reform of the program or its fiscal impact, but a potpourri of substantive and administrative amendments, more or less intended to pull program costs within the tight budget limitations set by the congressional budget process.

The Medicaid and Medicare Amendments of the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, tit. IX, 94 Stat. 2599, 2609, included a series of amendments to the Medicaid authorization that included: (1) a number of minor changes in the methods for reimbursing providers (e.g., adjustment to the procedures for accounting for philanthropic gifts to hospitals, and procedures for the utilization of "swing bed"); (2) authority to exclude from Medicaid (or Medicare) providers who have been convicted of program-related crimes; (3) the removal of the requirement that all nursing homes comply with the Life Safety Code (giving HHS the authority to make exceptions); (4) a series of amendments to the Professional Standard Review Organizations program; (5) expedited procedures for federal recovery of disallowed Medicaid payments to states; (6) expanded discretion for states in determining rates of reimbursement for nursing homes; (7) expanded federal reimbursement for state-administered Medicaid fraud control programs; and (8) mandated inclusion of legally authorized nurse midwives as a covered service. For an extended discussion of these and other Medicaid-related provision in the 1980 legislation, see H.R. REP. NO. 1479, 96th Cong., 2d Sess. 127-54 (1980).

These amendments were estimated by the House committee to allow approximately \$130 million in Medicaid program reductions. *See* H.R. REP. NO. 1167, 96th Cong., 2d Sess. 93 (1980). *Cf.* commentary in 1980 CONG. Q. ALMANAC at 459 (predicting smaller savings). Later in the second session, the 96th Congress also passed a more modest Medicaid bill, Pub. L. No. 96-611, 94 Stat. 3567 (1980), adding several more modifications to the Medicaid authorization, including the authority to deny Medicaid to applicants who dispose of assets without compensation prior to applying to the program. *Id.* § 5.

103. By 1980 Congress was apparently willing to withstand the political pressure of state administrations and legislatures and held fast on several cost-cutting limitations on state programs, *see, e.g.*, the two-year limit on recovery by states of the federal share of expenditures, one of the substantive amendments included in the supplemental fiscal year 1980 appropriations bill. Pub. L. No. 96-304, ch. IX, 94 Stat. 857, 885 (1980).

ness to focus blame on fraud and abuse as major sources of rising cost,¹⁰⁴ but these, like the other efforts to control cost, are best described as a kind of political piqueness, not reflective of an organized or substantial shift in Medicaid policy.

Thus the Carter Administration, like its predecessors, achieved neither its objectives for Medicaid reform nor any measurable control over the program's costs. Congress, it appears, had a continuing commitment to the basic concept of a medical care program for the poor. This commitment was tempered, no doubt, by the political clout of medical care providers, the secondary beneficiaries of the program, and of the state and local governments, whose responsibilities for the medical needs of the poor had been largely relieved by Medicaid's enactment, and for whom Medicaid now represented the largest of the federal revenue transfer programs. There was considerable dissatisfaction from all sides with the growing costs of that commitment,¹⁰⁵ but any suggestion of major reform of the program met with considerable political resistance. Significantly, the major cause of inflating program costs, the rising cost of medical care, proved to be equally resistant to political reform. Congress became extremely tolerant of state limitations and, in some cases, cutbacks in Medicaid program eligibility, services, and reimbursement levels. Congress, by 1980, was opposed to any expansion of the program, whatever the justification. Given the almost continuous challenge to the program and the political and economic climate of the 1970's, Medicaid weathered its first fifteen years remarkably unchanged in its basic outlines, but with each year's budget increase, it posed a more visible dilemma.

II. THE NEW FEDERALISM AND MEDICAID

President Reagan's New Federalism apparently offered a solution to the dilemma which Medicaid represented, at least for the federal government.

104. The so-called "Michel" amendment to the 1979 appropriations required HEW to cut \$1 billion from all department appropriations, in the name of eliminating fraud and abuse, but without further specification. Pub. L. No. 95-480, § 201, 92 Stat. 1567, 1584 (1978). For a discussion of the politics surrounding attempts to implement this amendment, see WASH. REP. ON MEDICINE AND HEALTH, June 24, 1979, at 2. For results of these efforts, see *id.*, Sept. 22, 1980, at 2.

105. In 1979, Medicaid was funded for fiscal year 1980 at approximately \$12.4 billion, the same level as appropriated for 1979. See *supra* note 54. Later in the same session, over \$2.1 billion in supplemental funds were added to fiscal year 1980 Medicaid appropriations. Pub. L. No. 96-304, ch. IX, 94 Stat. 857, 885 (1980). For fiscal year 1981, Pub. L. No. 96-536 included \$15.9 billion for Medicaid under the relevant provision of H.R. 7998. See 126 CONG. REC. 23478 (1980). This was a \$1.3 billion increase over the appropriations for fiscal year 1980. See 1980 CONG. Q. ALMANAC 225 (analysis).

The Reagan prescription for Medicaid would give Congress relief from the uncontrollable inflation in program costs and from the primary responsibility for program policy. It would also offer an alternative to further reliance on the federal regulatory controls attempted by Reagan's predecessors, and therefore avoid at least direct confrontation with provider interests and prevailing public attitudes towards an expansion of federal government authority. Furthermore, while the Reagan proposal would shift much of the congressional burden to the shoulders of the state legislatures, as originally conceived, at least it offered the states relief from the increasing federal oversight and restrictions on state Medicaid programs. Moreover, the Reagan Medicaid scheme would manage to achieve all this in rhetoric that carefully purported to continue the long standing federal commitment to a medical care program for the poor.

Perhaps more importantly, the Reagan Medicaid proposal reached Congress at a time when the political climate had given Congress little choice but to respond quickly and favorably to the newly elected President's proposed legislative agenda. Rather than pursue an independent agenda, the 97th Congress ordered both its sessions largely in response to the priorities established by Reagan. Congressional Medicaid policy, like policy for all other revenue and spending programs, became largely a reflection, with only slight modifications, of the image projected by the administration.

A. *The Original Reagan Strategy*

The essential elements of the Economic Recovery Plan announced to the nation by President Reagan in February 1981¹⁰⁶ were four economic pol-

106. President Reagan's original agenda was presented to the nation in the form of two major addresses to Congress. The President's initial televised address to Congress and the nation, entitled *America's New Beginning: A Program for Economic Recovery*, was delivered on Feb. 18, 1981. See H.R. DOC. NO. 21, 97th Cong., 1st Sess. 1-8 (1981); text of the speech can also be found at 127 CONG. REC. H510 (daily ed. Feb. 18, 1981). This speech was accompanied by several written reports: *A White House Report*, H.R. DOC. NO. 21, 97th Cong., 1st Sess. 19-50 (1981), analyzing the state of the economy and the principles enunciated in the President's speech; *Budget Reform Plan*, H.R. DOC. NO. 21, 97th Cong., 1st Sess. 51-267 (1981), outlining the proposed federal budget; and *President's Proposal for Tax Reduction*, H.R. DOC. NO. 21, 97th Cong., 1st Sess. 269-308 (1981), describing the tax proposals and analyzing their projected economic impact.

The initial address was followed by a second address and accompanying written report to Congress on March 10, wherein the President elaborated on his economic proposals, particularly those regarding budgetary cuts. *Fiscal Year 1982 Budget Revisions—Message From the President*, H.R. DOC. NO. 26, 97th Cong., 1st Sess. (1981); text of speech found at 127 CONG. REC. S1977 (daily ed. Mar. 10, 1981). In his second address, President Reagan also enumerated his proposals for fiscal year 1981 budget rescissions. See *infra* note 112 for details of the rescissions.

These presidential presentations were supplemented by a separately published report

icy commitments: a significant reduction in personal and business income taxes,¹⁰⁷ a stabilization of the monetary supply,¹⁰⁸ a concerted effort to reduce government regulation,¹⁰⁹ and a limitation on the growth of the federal budget.¹¹⁰ Only through these measures, the President warned, could inflation be brought under control, the economy be improved, and the federal ship of state be put back on its proper course.¹¹¹ This was, in his words, our chance for a "New Beginning," for a return to the sound and conservative principles of governmental federalism and the primacy of private enterprise in the determination of our social and economic well-being.

summarizing the Reagan proposals and itemizing the proposed 1982 budget and the reductions and rescissions requested for fiscal year 1981. OFFICE OF MANAGEMENT AND BUDGET, FISCAL YEAR 1982 BUDGET REVISIONS: ADDITIONAL DETAILS ON BUDGET SAVINGS (1981) [hereinafter cited as OMB REPORT], also published as H.R. DOC. NO. 41, 97th Cong., 1st Sess. (1981).

At approximately the same time, the initial Reagan budgetary proposals were analyzed in a report for the use of the congressional committees. CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, AN ANALYSIS OF PRESIDENT REAGAN'S BUDGET REVISIONS FOR FISCAL YEAR 1982 (1981) [hereinafter cited as CBO ANALYSIS]. The CBO analysis took issue with some of the Reagan proposals, particularly the estimated impact of the tax reduction and budget cutting proposals and some of the economic assumptions used to predict that impact.

107. The President's initial proposal, later modified during congressional deliberations, included a cut of personal—both earned and unearned—income tax rates by 10% a year for three years, and allowed businesses, retroactive to Jan. 1, 1981, to accelerate depreciation by shortening estimates of useful life of plant and equipment. See H.R. DOC. NO. 21, 97th Cong., 1st Sess. 169-308 (1981); see also 127 CONG. REC. S1351 (daily ed. Feb. 18, 1981).

The full proposal also included a number of other tax reforms. Among them were indexing income brackets, ending discrimination against married workers, allowing a tuition tax credit, and lowering the inheritance taxes. In total, Reagan estimated that his proposals for reducing personal income tax would save individual taxpayers \$500 billion in five years and that the expedited depreciation would save \$10 billion a year for business. The President's request was quickly approved. See Pub. L. No. 97-34, 95 Stat. 172 (1981).

108. The fourth plank in his economic program was a commitment to establish a monetary policy that would stabilize currency and insure healthy financial markets. For details, see H.R. DOC. NO. 21, 97th Cong., 1st Sess. 7 (1981).

109. President Reagan established a Task Force on Regulatory Relief headed by Vice President Bush to make recommendations on all government regulations. See Exec. Order Nos. 12,291, 12,314 (1981).

110. In the material accompanying his first address, see H.R. DOC. NO. 21, 97th Cong., 1st Sess. 34, and in the text of his second address, see H.R. DOC. NO. 26, 97th Cong., 1st Sess. M-1 (1981), the President added a fifth commitment to his Economic Recovery Plan, an explicit promise to balance the budget by 1984. See also *id.* at 6. While understated in his original presentations, this promise became the critical political standard by which Reagan's success was measured. See *infra* notes 215-19.

111. In his televised address to Congress and the nation in February, see *supra* note 106, the President repeatedly emphasized that the primary goal of his plan was to achieve "a full and vigorous recovery of the economy," making frequent references to such traditional indicators as productivity, the level of employment, interest rates, and, most often, the rate of inflation. See 127 CONG. REC. S1351 (daily ed. Feb. 18, 1981).

The political centerpiece of Reagan's economic gambit was his proposal to cut federal spending or, to state it precisely, to cut the rate of growth in the federal budget. In aggregate terms, the President proposed to hold the growth of federal spending to less than 6% a year, as compared to the annual growth rate of 13% each year since 1977.¹¹² He urged the adoption of a fiscal year 1982 budget of just over \$695 billion,¹¹³ a budget which would represent a \$40 to \$50 billion increase over estimated 1981 spend-

112. See H.R. Doc. No. 26, 97th Cong., 1st Sess. 8 (1981); see also H.R. Doc. No. 21, 97th Cong., 1st Sess. 53 (1981). For a slightly different way of viewing Reagan's proposal, see CBO ANALYSIS, *supra* note 106, at 33.

Reagan predicted that this slowed growth could reduce the size of the federal budget relative to the rest of the economy from 23% of the GNP in 1981 to 19% by 1984. See H.R. Doc. No. 21, 97th Cong., 1st Sess. 33 (1981); see also CBO ANALYSIS, *supra* note 106, at 33.

It is also important to note that the Reagan proposal presupposed the rescission of nearly \$16 billion in fiscal year 1981 appropriations. Under the provisions of the 1974 budget legislation, Congress attempted to limit the ability of the executive to impound appropriated funding. Pub. L. No. 93-344, tit. X, 88 Stat. 297, 332-39 (1974). Among its major provisions is a requirement that whenever the Administration wants to rescind funding for all or part of a funded program, both Houses must pass a rescission bill within 45 days of the Administration's request. Similarly, the President must notify Congress (but not seek its approval) whenever funds are to be deferred from one year to a subsequent one. President Carter issued several such requests in the waning months of his Administration. See *infra* note 115.

Immediately after taking office the Reagan Administration proposed rescissions of \$15 billion in program appropriations for fiscal year 1981 (and withdrew several of President Carter's proposed rescissions), and announced nearly \$2 billion in deferrals, over and above the rescissions requested and deferrals announced by Carter in the last few months of his presidency. See OMB REPORT, *supra* note 106, at 403.

For a further analysis of these figures and a comparison of the two sets of deferrals and rescissions, see CBO ANALYSIS, *supra* note 106, at 33-61.

For an item by item analysis of the Reagan proposed rescissions, see 46 Fed. Reg. 22,161-63 (1981).

Whatever the exact figures, the ball park figures were clear: President Reagan was asking Congress for major reductions in federal spending during the remainder of the current fiscal year, reductions in spending which, consistent with his overall philosophy, would limit the growth of the federal budget to less than 6%, and translate into major cuts in the budgets of federal domestic spending programs.

For health and health-related programs, many of which had been already ear-marked for spending cuts in future years and for rescissions in the current year under the Carter Administration, see *infra* note 115, the deeper cuts proposed by Reagan were tantamount to immediate termination.

Final fiscal year 1981 supplemental appropriations and rescissions were approved by Congress in June 1981. See Pub. L. No. 97-12, 95 Stat. 14 (1981). See S. REP. NO. 67, 97th Cong., 1st Sess. (1981) for details. The legislation also extended the continuing resolution for fiscal year 1981 appropriations until the end of the fiscal year. See Pub. L. No. 97-12, §§ 401-03, 95 Stat. 14, 95-96 (1981).

Pub. L. No. 97-12 included substantial rescissions of health and health related program funding totaling over \$450 million. Pub. L. No. 97-12, tit. I, 95 Stat. 14, 51-5 (1981). However, no Medicaid supplements or rescissions were included.

113. See H.R. Doc. No. 21, 97th Cong., 1st Sess. 60-61 (1981); see also CBO ANALYSIS, *supra* note 106, at 33.

ing,¹¹⁴ but a net reduction from the budget advanced by the out-going Carter Administration¹¹⁵ of approximately \$40 billion.¹¹⁶

Projecting these figures forward at his proposed 6% growth rate, Reagan estimated a budget of \$733 billion for fiscal year 1983 and \$771 billion by 1984, in effect reducing current spending levels by nearly \$100 billion by 1983 and \$125 billion by 1984.¹¹⁷

Stated in these terms, the original Reagan budget proposal may appear to be little more than a call for fiscal restraint, sober in its implications, but hardly surprising given contemporary economic and political trends and traditional Republican dogma. For that matter, the proposed Carter budget, had also been drawn in terms of governmental austerity.¹¹⁸ Reagan's budgetary proposals, however, called for far more than a simple limit on the growth of the federal budget: he proposed to control the growth of

114. See H.R. DOC. NO. 21, 97th Cong., 1st Sess. 60-61 (1981); see also OMB REPORT, *supra* note 106, at 5. The exact figure, of course, depended on several estimates and presupposed fiscal year 1981 reductions. Of the various sources, the figure used most often was \$40 billion.

115. By way of comparison, the Carter Administration budget for fiscal year 1982 submitted in January 1981 according to the budgeting schedule mandated by Congress, called for over \$739 billion in spending. See 127 CONG. REC. H255 (daily ed. Jan. 28, 1981). See also CBO, AN ANALYSIS OF PRESIDENT CARTER'S BUDGETARY PROPOSALS FOR FISCAL YEAR 1982 (1981) [hereinafter cited as CBO CARTER ANALYSIS]. Nonetheless, it was heralded by Carter officials, with understandable exaggeration, as a "bare bones budget." See *Carter's Last Budget: Conservative, But Not Nearly Enough to Suit Reagan*, 13 NAT'L J. 102 (1982). In fact, it called for an increase in spending of over \$85 billion, roughly a 13% increase over fiscal year 1981, figures that must be read against an inflation rate predicted to be at about the same level. See CBO CARTER ANALYSIS, *supra*, at 3. But the Carter budget would have reduced funding for a number of programs in fiscal year 1982 and increased the level of spending for only a few others, most notably military spending; generally most programs would not have been allowed to grow and very few new programs were proposed. See *generally id.* at 59-161. While "bare bones" would have been an exaggeration, "hold the line" might have been a rather accurate epitaph for the Carter fiscal year 1982 budget strategy.

In addition to Carter's proposed budget for fiscal year 1982, there were other signs of austerity in the Carter camp by the end of his Administration. In January of 1981, President Carter requested Congress to rescind \$1.14 billion in fiscal year 1981 appropriations (in addition to \$5.7 billion in appropriation deferrals he had previously announced). See 46 Fed. Reg. 6364 (1981). Among these rescissions were \$8 million for health services research and other health-related programs.

116. The Reagan Administration used two figures to estimate the differences between the Carter budget and the Reagan budget: a saving of \$41.4 billion in spending for fiscal year 1982, see H.R. DOC. NO. 21, 97th Cong., 1st Sess. 53 (1981), and \$48.6 billion, a figure that includes some savings also proposed by Carter. See OMB REPORT, *supra* note 106, at 6. The Congressional Budget Office estimates were slightly different. Cf. CBO ANALYSIS, *supra* note 106, at 2.

117. See H.R. DOC. NO. 26, 97th Cong., 1st Sess. 5, 95-96 (1981); cf. different figures in H.R. DOC. NO. 21, 97th Cong., 1st Sess. 57 (1981).

118. See *supra* note 115.

federal spending while reordering national spending priorities in accordance with the Administration's conservative ideology. Thus, while many federal programs would face substantial reductions in funding, spending for others, most notably military programs, would be substantially increased.¹¹⁹ Moreover, while some Americans would bear the burden of the spending reductions, others would be the beneficiaries of the largest tax cuts in the nation's history.

President Reagan envisioned a federal budget which would establish, in concert with the other elements of his recovery plan, a new federal order, one which would be both reduced in magnitude and substantially altered in character. Indeed, with a clarity of purpose rarely seen in politics, the Administration produced a set of principles by which it proposed to contain all federal spending within the 6% growth ceiling.¹²⁰ The President's

119. Reagan's initial estimates for his first term in office targeted military spending for sizeable growth, from 24% of the federal budget to 32% by 1984; he also claimed the intent to allow at least moderate growth in an enumerated list of "social safety net" programs (*see infra* note 121) from 37% to 41%; this would require a decrease in all other spending programs from 29% to 18%. The remaining portion of federal spending would be for service of the national debt, estimated to decrease slightly from 10% to 9%. *See* H.R. DOC. NO. 26, 97th Cong., 1st Sess. 53-54 (1981).

120. As cited in the OMB REPORT, *supra* note 106, at 6, the President decided that achievement of his budget targets would require an end to the proliferation of new federal programs and a reversal of the trend toward a greater federal role in planning and controlling economic and social decisions.

He directed that all federal programs be subjected to thorough scrutiny. However, in doing so he decided that:

A margin of safety must be created by rebuilding the Nation's defense capabilities.

The Social Safety Net of income security measures erected in the 1930's to protect the elderly (including cost of living protection for the elderly), unemployed, and poor, as well as veterans, must be maintained.

Eight basic criteria were used in evaluating and making decisions on programs:

1. Entitlement Programs must be revised to eliminate unwarranted beneficiaries and payments.
2. Subsidies and benefits for middle and upper income levels must be reduced.
3. Allocable costs of government programs must be recovered from those benefiting from the services provided, such as airports and airways, inland waterways and Coast Guard services to yacht and boat owners.
4. Sound economic criteria must be applied to economic subsidy programs such as synthetic fuels, Export-Import Bank loans, and subsidized loans.
5. Capital investments in public sector programs—such as highways, waste treatment plants and water resource projects—must be stretched out and retargeted.
6. Fiscal restraint must be imposed on programs that are in the national interest but are lower in priority than the national defense and safety net programs. Examples include NASA, National Science Foundation, and the National Institutes of Health, which would be allowed to grow at lower rates than planned.
7. Larger numbers of categorical grants must be consolidated into block grants

budgetary blue print made no attempt to disguise the necessary implications of limiting federal spending to a rate less than half of the expected rate of inflation while increasing such items as military appropriations. His economic and political goals were to be accomplished almost entirely at the expense of federal domestic spending programs viewed by the Reagan Administration as either inappropriate or unaffordable.

Curiously, the President's commitment to fiscal austerity and to limiting the role of the federal government in domestic affairs was accomplished by a commitment to preserve certain domestic spending programs, described as the "social safety net" for the "truly needy." Included in this net were Social Security cash benefits, unemployment benefits, Medicare, the railroad retirement program, and veteran's pensions, among the most expensive of the existing social welfare programs.¹²¹

permitting less Federal administrative overhead, greater flexibility for State and local governments, greater efficiency in management and reduced overall costs. The principal examples are elementary and secondary education, and health and social services.

8. Federal personnel and overhead costs, and program waste and inefficiency must be reduced.

A slightly different statement of criteria appears in other sources. *See, e.g.*, H.R. Doc. No. 21, 97th Cong., 1st Sess. 32 (1981). A full analysis of each of these points can be found *id.* at 64-79.

121. In his first address, and in all succeeding policy statements, President Reagan carved out a list of programs to be exempt from proposed budgetary cuts and established a rationale for their maintenance:

We will continue to fulfill the obligations that spring from our national conscience. Those who through no fault of their own must depend on the rest of us, the poverty stricken, the disabled, the elderly, all those with true need, can rest assured that the social safety net of programs they depend on are exempt from any cuts.

127 CONG. REC. H511 (daily ed. Feb. 18, 1981).

As a consequence, Reagan promised to "fully fund" a \$216 billion list of programs, specifically enumerating Social Security cash benefits (including a cost of living increase), Supplemental Security Income (cash welfare grants to the old, blind, and disabled), veteran's pensions, school lunch and breakfast programs (although he later qualified this to mean only for the "truly needy" and therefore justified a cutback in funding for this strand of the safety net, *id.* at H512), nutrition and special services for the aging, Head Start, and summer youth jobs. *Id.* at H511. *See also* OMB REPORT, *supra* note 106, at 6.

There are a number of problems with this "social safety net" commitment. First, and most obvious, the programs enumerated are not a collection of either *all* programs for the maintenance of the "truly needy," or *only* programs for the truly needy. Including Medicare and excluding Medicaid is hardly consistent with the objective of maintaining necessary support for those who cannot care for themselves. *See* H.R. Doc. No. 21, 97th Cong., 1st Sess. 66 (1981). Obviously Medicaid is much more of a "safety net" program than Medicare. Similarly, despite repeated assertions that cash benefits for the "chronically poor" would be exempt from the budget reductions, *see, e.g.*, H.R. Doc. No. 21, 97th Cong., 1st Sess. 33 (1981), the enumeration of programs within the "social safety net" omits reference to AFDC, the only Social Security welfare program created in the original 1930 legislation

The Administration justified its commitment to continue these “safety net” programs, estimated to represent over \$216 billion in annual expenditures, in the rhetoric of social justice. By preserving these programs, the Administration argued, the “truly needy” would be exempt from the impact of the reductions in federal spending that were inherent in Reagan’s budgetary scheme, while others whose support was no longer justified would necessarily be called upon to share the temporary “belt tightening” incident to economic recovery and the reestablishment of conservative spending priorities.¹²²

While the Administration later recanted on this promise by proposing reforms in such programs as Social Security and Medicare,¹²³ the initial consequences of this promise for the nonexempted domestic spending programs were abundantly clear. Far more than limiting their growth, the bottom line effect of Reagan’s conservative reordering of priorities would mean a reduction by at least one-third of the proportionate share of the federal budget allocated to nonexempt domestic spending programs,¹²⁴

not federalized by the creation of Supplementary Security Income, the welfare program for the blind, aged, and disabled, in 1972. In fact AFDC, unlike other social welfare cash grant programs, was targeted for major reductions—even below 1981 expenditures—in fiscal year 1982, a feat to be accomplished by increasing work requirements and changing eligibility rules with regard to available income. See OMB SUMMARY, *supra* note 106, at 139. For an analysis of impact, see CBO ANALYSIS, *supra* note 106, at 93.

It is also unclear whether maintenance of these programs means maintaining current levels of funding, or maintaining these programs at equivalent levels taking into account the rate of inflation. Singling out social security benefits for a cost of living increase may indicate that Reagan’s promise did not intend to secure corresponding increases for other safety net programs.

But from the Administration’s perspective, the major problem with this commitment may be that it will prove impossible, whatever the intent, to maintain these programs unchanged. Indeed, the maintenance of these programs at current levels, or anything close to it, was exactly the kind of federal policy that the Reagan strategy intended to avoid—funding programs with expenditures that were largely uncontrollable from year to year.

As a consequence of these and other problems, the Administration showed early signs of waffling on the “social safety net” promise. Throughout the first session of the 97th Congress, the Administration sponsored proposals which would have effectively cut expenditures for these programs, despite the Administration’s earlier promise, e.g., proposals to reduce the minimum payment for social security payments. Some of these efforts proved to be costly for the administration.

Moreover, the Administration’s fiscal year 1983 budget made no pretense of maintaining the social safety net programs, particularly Social Security and Medicare, and the “social safety net” exemptions to the New Federalism’s budget cuts became only a political relic. See *infra* notes 215-49.

122. See, e.g., H.R. Doc. No. 21, 97th Cong., 1st Sess. 32 (1981); H.R. Doc. No. 26, 97th Cong., 1st Sess. 1-10 (1981).

123. See *infra* note 141.

124. See *supra* note 119. Expressed in different terms, the Reagan March budget called for a limit of nondefense spending to \$506 billion, a slight increase over projected 1981

translating into a \$50 to \$60 billion reduction in these programs in fiscal year 1982¹²⁵ and, assuming the Reagan strategy would be accepted and continued,¹²⁶ a total of over \$475 billion in program cuts by 1985.¹²⁷

In his first address to Congress and the nation Reagan proposed reductions in over 80 domestic spending programs, estimated to save over \$40 billion in fiscal year 1982.¹²⁸ In his budget message of March 1981, he detailed 200 additional cuts for an estimated additional fiscal year 1982 savings of over \$13.8 billion.¹²⁹ The proposed cuts extended across many federal domestic programs, including those for education, alternative energy sources, highway construction, housing, community and regional development, food stamps, job training, and even parts of the space program and federal support for the humanities.¹³⁰ In addition, Reagan proposed

spending and a sizeable net loss against inflation. H.R. Doc. No. 26, 97th Cong., 1st Sess. 124 (1981).

125. CBO ANALYSIS, *supra* note 106, at 33. As a further implication of these budget reductions, about one half of the federal programs slated for reduction involved federal support to state and local governments. For the effect on state and local government revenues, see *infra* notes 262-63.

126. It must be noted that the Reagan budget was based on an unstated caveat: these reductions all presupposed a "return" to a healthy economy. The Reagan budget recommendations relied on a series of economic assumptions and forecasts by the Administration. The CBO argued that the Reagan/OMB analysis was economically optimistic about such things as future revenues, improvement in the economy, and program outlays. See generally CBO ANALYSIS, *supra* note 106. As a consequence, even the original cuts proposed by President Reagan may have been too small to achieve his budgetary goals.

The success of the Reagan budget was inextricably involved with the success of his tax reforms, attempts to balance the budget, the general health of the economy, and the underlying validity of so-called "supply-side economics."

127. H.R. Doc. No. 21, 97th Cong., 1st Sess. (1981).

128. In his first speech, Reagan specifically enumerated 83 major program cuts, including outright reduction or elimination of many programs, and the effective reduction of others by consolidation into block grants. (For an explanation of block grants, see *infra* note 131.) Reagan estimated these would result in a budget reduction of \$41.4 billion in fiscal year 1982 (and total \$49.1 billion when "user fees" and "off-budget" considerations are included in the accounting). See 127 CONG. REC. H511 (daily ed. Feb. 18, 1981).

As he pointed out, this would still exceed fiscal year 1981 projected spending by \$40.8 billion. *Id.* As he did not point out, this was a net figure, not including a healthy increase in military spending and thus a gross understatement of the reductions in the nonexempted programs.

129. In his second speech, Mr. Reagan proposed 200 more reductions for added savings of \$13.8 billion in 1982. See 127 CONG. REC. S1977 (daily ed. Mar. 10, 1981). The total for domestic appropriation reductions proposed by Reagan including other adjustments was over \$60 billion in 1982, and, by his estimate, over \$475 billion by 1986. *Id.* at S1978.

130. The cuts were anything but arbitrary; each of the proposals was referenced to the budget criteria discussed *supra* note 120. For example, citing the traditions of private philanthropy, Reagan called for a cut in aid to the humanities. In the name of free enterprise, he called for an end to a number of government loan programs, the program for the development of synthetic fuels, the economic and regional development commissions, the NASA

to consolidate, many programs into block grants to state and local government.¹³¹ Other programs were simply to be phased out or eliminated altogether. The pattern of proposed budget cuts left no doubt that Reagan intended to change both the form and substance of federal domestic assistance, deferring to the primacy of the private sector and shifting much of the responsibility from the shoulders of the federal government to those of state and local entities. This was the essence of what became popularly known as the New Federalism.

B. *The Reagan Strategy for Medicaid and other Health Programs*

Health and health-related programs appeared prominently among the targets of the Administration's list of the unnecessary and the unaffordable. Reagan asked Congress for an immediate rescission of over \$600 million in funds appropriated for 1981, following on the heels of a series of rescissions that had been ordered by the Carter Administration.¹³² For fiscal year 1982, Reagan's budget for health programs¹³³ called for a \$2.6 billion reduction from Carter's tightly-drawn proposal.¹³⁴

space program, and the trade adjustments assistance program. Citing fraud and abuse, he called for limits on food stamp assistance, for tightening restrictions on welfare eligibility, and for adding work incentives to welfare eligibility. See 127 CONG. REC. H511-12 (daily ed. Feb. 18, 1981).

For a summary and discussion of each proposed budget cut, see generally H.R. DOC. NO. 26, 97th Cong., 1st Sess. (1981). For additional details, see OMB REPORT, *supra* note 106.

131. The concept of block grants, used only sparingly in the past, was one of the favorite budgetary devices of the new Administration, although it turned out to be the source of much political controversy. In addition to his overall budget limitations and the specific recommendations for program reductions or eliminations, Reagan repeatedly relied on shifting responsibility to the beleaguered states, counties, and cities. The Reagan Administration frequently argued that the consolidation of grants into blocks at an overall reduced level of funding was offset at least in part by the reduction in administrative costs and the promotion of efficiency that was inherent in the increased flexibility that would be available to the states. See, e.g., 127 CONG. REC. H512 (daily ed. Feb. 18, 1981); see also OMB REPORT, *supra* note 106, at 148-49.

132. See *supra* note 115.

133. H.R. DOC. NO. 26, 97th Cong., 1st Sess. 69-71, 128-29 (1981).

Expressed in terms of agency budgets, the Reagan proposal was for an HHS appropriation of \$227.6 billion in 1981, and \$250.7 billion in 1982 (this included welfare and social security cash payments, and many other social programs in addition to Medicaid, Medicare, and other health programs). See OMB REPORT, *supra* note 106, at 110.

134. The \$2.6 billion decrease broke down to the following items for fiscal year 1982:

Medicaid	\$1.2 billion decrease
Medicare	.1 billion decrease
block grant programs	.5 billion decrease
other health services	.5 billion decrease
research	.1 billion decrease
training	.1 billion decrease
other	.1 billion decrease

Following the general pattern of all his proposed domestic spending cuts, Reagan's health budget did not offer an across-the-board limitation on funding; while virtually no health programs were spared the budgetary axe, many health programs were targeted for outright elimination, and others for sizable reductions, in accordance with the Administration's conservative philosophy of which fiscal restraint was only one key part. All of the federal regulatory and cost control measures relied on during the Carter, Ford and Nixon Administrations, clearly incompatible with Reagan's philosophy, were slated for repeal.¹³⁵ The National Health Service Corps, public health service hospitals, and other programs that smacked of socialized medicine were also to be phased out or eliminated.¹³⁶

Virtually all of the discretionary health service and public health service programs were to be consolidated into block grants, initially set at roughly 75% of the fiscal year 1981 funding levels.¹³⁷ The significance of these block grant proposals was found not just in the drastic reduction in the level of federal spending and the likely elimination of some programs,¹³⁸ but in the effective transfer of governmental responsibility for these functions to the state level. The federal government would be left with some financial responsibility, but a drastically reduced role in ordering priorities, administering their implementation, and, most importantly, insuring their future fiscal integrity.

The remaining budget goals would be achieved under the Reagan recommendations by at least minor cuts in all health programs,¹³⁹ a major

See H.R. Doc. No. 26, 97th Cong., 1st Sess. 69 (1981).

Of the \$739 billion projected by Carter for fiscal year 1982, approximately \$86.1 billion were slated for health care services. See estimates in CBO CARTER ANALYSIS, *supra* note 106, at 128.

Note that the Carter proposals were also tightly drawn. The Carter budget called for a continuation of most health programs, with only slight adjustments, but a funding limitation or reduction on virtually all programs. For a political analysis of the Carter proposal for 1982 budget and its impact on health programs, see WASH. REP. ON MEDICINE AND HEALTH, Jan. 19, 1981, at 1-3.

135. See H.R. Doc. No. 26, 97th Cong., 1st Sess. 135-37 (1981).

136. *Id.* at 70-71.

137. The original projections were for a funding of a "basic health services" block grant at \$1.138 billion (\$399 million reduction from the projected Carter budget for the programs to be consolidated) and \$260 million for preventive services (\$93 million less than the Carter projections). For an itemized analysis and a list of these programs, see Gottshlich, *Millions May Lose Care: The Administration's Proposed Budget*, 6 HEALTH L. PROJECT LIBR. BULL. 51, 52 (1981).

138. This also has considerable impact on beneficiaries of the Medicaid program. See *infra* note 294.

139. See H.R. Doc. No. 26, 97th Cong., 1st Sess. 69-71 (1981). Other smaller but signifi-

reorganization of the administrative structure of the Department of Health and Human Services (HHS),¹⁴⁰ some reduction in Medicare despite indications that it was part of the safety net,¹⁴¹ and major surgery on the Medicaid program.

As with the rest of his initial fiscal policies, the President's proposal for Medicaid sounded at first to be little more than a commitment to fiscal austerity. And the proposal came wrapped in some impressive justifying statistics. Total state and federal Medicaid costs have inflated from \$5.2 billion in 1970 to nearly \$29 billion in fiscal year 1981 and at a healthy 15% increase per year for the last five years.¹⁴² The federal government, under the open-ended terms of the federal legislation, has been obligated to pay

cant budget cuts were proposed for biomedical research programs, occupational health, mental health and alcoholism programs. For a textual description of each of these programs and a rationale for their reduction, see H.R. Doc. No. 21, 97th Cong., 1st Sess. 198-209 (1981).

140. Health care was also slated to appear prominently in the Administration's plans to reorganize the function and administrative organization of the federal executive. In fact, the Administration preferred in its early statements to characterize the Economic Recovery Plan as a first step, to be followed by a more structural reorganization once spending programs were under control. The testimony of OMB Director Stockman before the Senate Budget Committee, for example, indicated that among the other items the Administration planned were basic structural changes in the entire system of health care reimbursement and the government's role therein. *President Reagan's Economic Program: Hearings Before the Senate Budget Comm.*, 97th Cong., 1st Sess. 44 (1981) (statement of David Stockman).

141. The history of the Medicare program changes and budget reductions enacted during the first two years of the Reagan Administration cannot be fully recounted in this article, but they merit at least brief attention.

Despite his claims that Medicare would be exempt from his domestic spending reduction proposals, *see supra* note 122, the President in fact urged Congress to adopt nearly \$1.2 billion in Medicare budget reductions in 1981. *See CBO ANALYSIS, supra* note 106, at B-28. Congress basically concurred with the President; the first concurrent budget resolution projected a Medicare budget reduction of slightly less than \$1 billion for fiscal year 1982. *See WASH. REP. ON HEALTH LEGISLATION*, May 13, 1981, at 2, and the eventual 1981 reconciliation legislation included a series of cost-limiting program modifications. *See Omnibus Reconciliation Act of 1981*, Pub. L. No. 97-35, tit. XXI, 95 Stat. 357, 783.

Neither the President nor the Congress were apparently satisfied with the budget savings adopted in the first session of the the 97th Congress. In Reagan's call for additional domestic spending reductions in 1982, he included a wide range of Medicare reforms that would reduce program expenditures by as much as \$15 billion by 1985. *See infra* notes 219-20. Again Congress and the President were of a like mind. *See infra* notes 231-32. The eventual fiscal year 1983 budget projected Medicare savings of nearly \$3 billion in fiscal year 1983 and \$12 billion by 1985. *See infra* notes 233-36; table at 128 CONG. REC. H3729 (daily ed. June 22, 1982). The reconciliation bill that passed later in the term carried out these projections through a variety of program changes, but most notably by tightening the terms of Medicare reimbursement for hospital and hospital-related services. *See Tax Equity and Fiscal Responsibility Act of 1982*, Pub. L. No. 97-248, §§ 101-128, 96 Stat. 324, 331-67. For a discussion, *see WASH. REP. ON MEDICINE AND HEALTH*, Aug. 16, 1982 ("Perspectives").

142. *See supra* note 54.

50% to 78% of each state's costs with no maximum ceiling on federal liability.¹⁴³ To control the impact of this inflation on the federal budget, Reagan's original proposal called for a sizeable reduction in current spending levels, starting with a \$370 million rescission in fiscal year 1981 spending,¹⁴⁴ a "cap" on fiscal year 1982 Medicaid outlays of 5% over the revised fiscal year 1981 Medicaid budget, and an adjustment for inflation in each of the following years.¹⁴⁵ Reagan estimated that this would allow a \$1.2 billion decrease in the federal budget for fiscal year 1982, from the \$18.8 billion proposed by Carter to \$17.6 billion, and at least a \$5 billion reduction by fiscal year 1984.¹⁴⁶

The Medicaid "cap" was philosophically and structurally similar to the block grant concept: states would only be given a fixed amount, a maximum federal outlay. In return, the federal Medicaid authorization would be modified to allow states considerable discretion to amend or curtail their programs with a minimum of federal oversight.¹⁴⁷ Translated into realistic terms, this would effectively give states unprecedented discretion to limit the kind or scope of services offered, to reduce or restrict eligibility, or to alter the terms or amount of reimbursement in a manner not allowed under the preexisting Medicaid program.¹⁴⁸ Or, to say it differently, the Reagan Medicaid proposal would leave to each state the responsibility of either absorbing future inflation in program costs or making the difficult allocation decisions inherent in substantial Medicaid program reductions.

Projected forward, this scheme would mean far more than a limit on growth of federal responsibilities. Recent trends indicate that the cost of a Medicaid program maintained at current levels will rise at least as much as inflation, and very likely much higher.¹⁴⁹ Even if states would continue to contribute their share, which is unlikely,¹⁵⁰ an apparent 5% lid is better

143. See *supra* note 14.

144. H.R. Doc. No. 26, 97th Cong., 1st Sess. 69 (1981). Reagan proposed the withdrawal of Carter's request for minor expansion of services and called for an acceleration of the collection of erroneous payments to states at a savings of over \$270 million, for a total of \$370 million reduction in the remaining months of fiscal year 1981.

145. *Id.* at 70. Reagan proposed using the GNP deflator as a measure of future inflation.

146. See explanation in OMB REPORT, *supra* note 106, at A-57. In terms of federal outlays, the maximum federal expenditure would be \$17.2 billion (approximately \$1 billion less than Carter's estimated outlay for fiscal year 1982). See H.R. Doc. No. 26, 97th Cong., 1st Sess. 69 (1981).

147. See H.R. Doc. No. 26, 97th Cong., 1st Sess. 68-69 (1981).

148. See *supra* notes 38-47.

149. Medicaid expenditures grew over 15% a year for the five years preceding 1981 while inflation was one-half to one-third that figure. See OMB REPORT, *supra* note 106, at 160.

150. The Administration argued that its 5%-10% cut was only a 3%-6% cut, since a 5% cut in the federal share would only represent a 3% cut in total Medicaid costs, including that of state and local government. This, they argued, could easily be absorbed by a reduction in

described as a 10% reduction in federal effort against a predicted inflation in program costs which could be 15% or higher. Depending on the estimate of inflation used thereafter, a 5% lid on capped fiscal year 1981 expenditures plus an annual increase adjusted for inflation would mean a sizeable reduction of program expenditures each year, possibly a 30% to 40% reduction in the Medicaid program funding by 1985.

It is hard to conceive of a Medicaid program, already expensive and pared in many states to cover a fraction of the poor for only part of their medical needs,¹⁵¹ surviving any substantial budgetary reduction, let alone a 30-40% budget cut in the span of four to five years. As discussed earlier, states have already gone through periodic rounds of eligibility and service limitations, reimbursement limits and reductions, and other cost limiting efforts. As analyzed more fully in Section III, belt-tightening is hardly descriptive of the cost containing strategies available to the states, if cuts of 10% a year are required, particularly in light of the political restraints on such strategies. Indeed, given the history of the program,¹⁵² it would be hard to interpret such a reduction in federal effort as anything other than an invitation to states to severely curtail their participation.¹⁵³

On the other hand, the Administration continually downplayed the potential impact on Medicaid of the original Reagan proposals, as well as the necessity of projecting Medicaid program reductions too far into the future. As with his other fiscal policies, Reagan initially insisted that "belt-tightening," the short term consequences of budgetary limitations, and reductions in governmental responsibility, would be more than outweighed by the return of a prosperous economy and a more conservative ordering of government. Moreover, the Administration's rhetoric and supporting documentation made several references to a conservative alternative to Medi-

fraud and abuse, and by the efficiency created by the "flexibility" to be allowed the states. See H.R. Doc. No. 26, 97th Cong., 1st Sess. 110 (1981). Note, however, that efficiency and the elimination of fraud and abuse have proven to be elusive objectives for state Medicaid programs, however appealing they appear. See *infra* note 282. Any annual reduction, read against an inflation rate that has averaged 15% for the last five years, can only mean fiscal crisis for the states and, consequently, their programs. It is unlikely that states would be willing to either make up the federal share or continue to spend state dollars no longer matched by 50%-80% federal dollars, particularly given the other pressures on state revenues created by the New Federalism.

151. See *supra* note 9.

152. See *supra* note 53-105.

153. See *infra* note 282-86. It is also worth noting that Reagan's federal Medicaid strategy parallels his state strategy developed while he was the governor of California. For a summary, see Ensminger, *Beware the Medicaid Cap: Ronald Reagan Wants to Sell His California Turkey*, 12 HEALTH PAC BULL. No. 8, at 7 (1982).

caid.¹⁵⁴ There was also some discussion within the Administration of a reordering of all health care financing, presumably to include Medicaid and Medicare, also along conservative lines.¹⁵⁵ These proposals held out at least the possibility that the reduction of Medicaid might coincide with the development of an alternative program to provide for the medical needs of the poor. The Administration's Medicaid strategy was also amended in early 1982 to include an offer to federalize the Medicaid program.

None of these reform measures proved to be politically viable. And, of course, the economy did not show immediate signs of prosperity. Instead, the real meaning of Reagan's New Federalism translated primarily into proposals for major budget and program reductions and for a shifting of responsibility for Medicaid to state and local governments. These were the principle issues that concerned the deliberations of the 97th Congress.

C. *The First Session of the 97th Congress*

As noted above, the Reagan proposals were received by a Senate eager to respond, and respond favorably, to the new president, and by a House which ultimately showed little inclination to do other than follow suit. The original Reagan budget proposal received an unusually warm reception in the Republican dominated Senate.¹⁵⁶ In the House, the President faced an initial challenge from the Democratic leadership. After a brief political scuffle, however, a first current budget resolution was enacted by Congress that followed the contours of the Reagan budgetary prescription rather closely, at least in financial terms.¹⁵⁷

154. See OMB REPORT, *supra* note 106, at 159. A more intriguing proposal was put forth by the "Winston Report": the phase-out of Medicaid and Medicare over a 12 year period and complete reliance on "vouchers," private health plans, and the free market "to serve the poor and the aged." See D. WINSTON, *supra* note 11, at 269.

Other Administration proposals were less ambitious. A top Reagan aide even went so far as to suggest in a June 1981 speech that the administration intended to get the federal government out of the health field altogether, turning most programs over to the states and turning Medicaid into a "no strings attached" block grant. See WASH. REP. ON MEDICINE AND HEALTH, July 1, 1981, at 2. *But see* a later proposal to federalize Medicaid, *infra* notes 224-27.

155. See *infra* note 210.

156. The Senate passed a slightly revised version of Reagan's budget resolution. S. Con. Res. No. 19, 97th Cong., 1st Sess. (1981); see 127 CONG. REC. S4875 (daily ed. May 12, 1981). For details of the Senate-adopted budget, see SEN. COMM. ON THE BUDGET, FIRST CONCURRENT RESOLUTION ON THE BUDGET--FY 1982, S. REP. NO. 49, 97th Cong., 1st Sess. (1981).

157. In the House the President faced an alternative budget proposed by the Democratic leadership, paralleling the President's budget, but calling for a more moderate reduction in spending and, more importantly, relying on a different set of economic assumptions. See

Having bound itself to the Reagan-designed budget limitations, the first session of the 97th Congress set itself to the more difficult task of fashioning adjustments in program authorizations to meet the budgetary objectives which, under the Reagan scheme, principally required a \$40 billion reduction in fiscal year 1982 spending for selected domestic spending programs.¹⁵⁸ As the complicated budget reconciliation process began in April and May of 1981, it became apparent that Congress was less eager to enact Reagan's specific budgetary reductions than it was to accede to the overall directives of the President. As a consequence, there was substantially more political controversy during the reconciliation process, particularly within

HOUSE COMM. ON THE BUDGET, FIRST CONCURRENT RESOLUTION ON THE BUDGET--FY 1982, H. REP. NO. 23, 97th Cong., 1st Sess. (1981). The House Republicans, together with conservative Democrats, out-manuevered the House leadership and amended the Democrats' budget bill, substituting an entirely new bill dubbed the "Gramm-Latta amendment," exactly paralleling the President's budget. 127 CONG. REC. H2273 (daily ed. May 18, 1981). The resulting budget resolution only differed with the Senate's initial budget in minor respects; the aggregate budget figures were virtually identical. See H.R. Con. Res. 115, 97th Cong., 1st Sess. (1981).

In conference, the massive budget resolutions were quickly brokered; the differences between the two bills were virtually averaged. The resulting bill was rather difficult to read in terms of specific items, but the bottom line figure was quite clear, a victory for the President and his proposed budget. See H.R. REP. NO. 46, 97th Cong., 1st Sess. (1981); S. REP. NO. 86, 97th Cong., 1st Sess. (1981).

The first concurrent budget resolution, H.R. Con. Res. No. 115, as amended, passed in both Houses in late May. See 127 CONG. REC. S5440 (daily ed. May 21, 1981); 127 CONG. REC. H2340-41 (daily ed. May 20, 1981). In the aggregate, the first concurrent budget resolution outlined a fiscal policy for the 97th Congress that read as follows:

For fiscal year 1981, budget authority of \$717 billion, estimated outlays of \$661.4 billion, and a projected deficit of \$58 billion.

For fiscal year 1982, budget authority of \$770.9 billion, estimated outlays of \$695.5 billion, and a projected deficit of \$37.7 billion.

For fiscal year 1983, budget authority of \$813.8 billion, estimated outlays of \$732.3 billion, and a projected deficit of \$19.3 billion.

For fiscal year 1984, budget authority of \$866.5 billion, estimated outlays of \$773.8 billion, and a slight estimated budget surplus.

See H. REP. NO. 46, 97th Cong., 1st Sess. 10 (1981). For a discussion, see 127 CONG. REC. H2278 (daily ed. May 18, 1981).

This original projection of a gradual evolution towards a balanced budget by 1984 was a major thrust of the Reagan strategy. See *supra* note 110. Indeed, the need to balance the budget was one of the major justifications for the domestic program cuts sought by Reagan. Later when the likelihood of this projected balanced budget and the estimates upon which it was based were questioned, the Reagan political strategy was dealt a major blow and Reagan was forced to delay his timetable for reaching a balanced federal budget. In the parlance of federal politics, the balanced budget shifted from an "objective" to a "goal." Later this goal was abandoned altogether. See *infra* note 217.

158. The conference report accompanying the resolution, based on various estimates of current spending, called for cuts in existing domestic programs of just under \$40 billion. See H.R. REP. NO. 46, 97th Cong., 1st Sess. 38 (1981).

each committee.¹⁵⁹

With regard to health programs generally and particularly with regard to the proposals for Medicaid cuts, there was far from the unanimity in committee that the first budget resolution had reflected on the floors of both Houses.¹⁶⁰ A variety of alternatives surfaced from both sides of the political aisle.¹⁶¹ Significantly, neither house seemed particularly inter-

159. The first concurrent budget resolution was certainly a victory for Reagan's proposed health budget, in aggregate monetary terms. Final health budget figures reflected in H.R. Con. Res. No. 115 read as follows:

1981:	\$72.2 billion	budget authority
	89.6 billion	outlays
1982:	\$83.5 billion	budget authority
	73.4 billion	outlays
1983:	\$90.9 billion	budget authority
	81.2 billion	outlays
1984:	\$99.3 billion	budget authority
	89.6 billion	outlays

See 127 CONG. REC. H2278 (daily ed. May 18, 1981). This was virtually the budget Reagan had requested. See *supra* note 112.

There was, however, no specific reference to any of the Reagan proposed program changes in the resolution or in the conference (or committee) reports. Nor was there specific reference to Medicaid or Medicare in the conference report or the resulting bill. There were, however, specific instructions to the relevant committees on their aggregate budget ceilings that at least implied marching orders for each of the committee's programs, especially when read in light of the President's original budget proposals. See H.R. REP. NO. 46, 97th Cong., 1st Sess. 30-37, 45-46. (1981).

160. Even in the Republican-dominated Senate, eager to cut federal spending and to play team ball with the President, the reception was cool for the Reagan Medicaid proposal, especially the 5% cap on federal Medicaid expenditures. The Senate Budget Committee report on the first resolution acceded to the Administration's budget figures, but with no mention of any specific programmatic cuts. See S. REP. NO. 23, 97th Cong., 1st Sess. 160-62 (1981). These pronouncements in the legislative history of the House bill, however, were effectively mooted when the Democrat-sponsored budget was replaced on the House floor by the "Gramm-Latta Amendment." See *supra* note 157.

In short, virtually the same Medicaid budget figures emerged from the House and the Senate and were included in the original budget resolution bill, but with virtually no concrete instructions as to the means for achieving these cuts. The resolution instructions ordered the authorization committees to cut \$917 million from the fiscal year 1982 Medicaid budget, the price estimate Reagan put on his 5% cap proposal, although, again, no specific program cut or amendment was mentioned in either the resolution or the accompanying reports. See discussion in WASH. REP. ON MEDICINE AND HEALTH, May 18, 1981, at 1.

161. Once the budget figures were sent back to committees, interest group politics, as well as personalities, once again reared their familiar heads. In both Houses, Congress had trouble with the terms of the President's recommendations, at least in the details if not the general configuration. In the Senate, for example, Senator Edward Kennedy submitted his own health budget resolution, S. 1102, 97th Cong., 1st Sess. (1981), a move of some interest, but a rather futile one, given his role as a member of the minority party.

Of more interest was Senator Orrin Hatch's health block grant bill, adopting the Reagan approach but with a few personal twists; in particular, a slightly higher level of funding, with

ested in the specific Medicaid program reforms urged by the President,¹⁶² although they were willing to cut program expenditures in accord with his budget proposals.¹⁶³

Despite this disagreement, in the end the budget reconciliation process resulted, again, in a virtual victory for the Reagan budget proposals, although the specific terms by which funding cuts were achieved were somewhat modified.¹⁶⁴ The floor battle over the budget reconciliation followed

increased state accountability, as well as an increase in federal legislative oversight authority. See S. 1027 and S. 1018, 97th Cong., 1st Sess. (1981).

In the Democrat controlled House, Reagan faced more direct opposition. Representative Henry Waxman, the Chairman of the Subcommittee on Health and the Environment of the House Committee on Commerce, introduced a number of alternatives to Reagan's health budget, and to the block grant proposals for health programs. See, e.g., H.R. 2562, H.R. 2807, H.R. 2943, 97th Cong., 1st Sess. (1981).

162. Even before the first budget resolution had been enacted, the Senate Finance Committee had approved Medicaid authorization amendments estimated to reduce fiscal year 1982 spending by more than \$1 billion, slightly more than Reagan had proposed. However, it modified Reagan's proposal by imposing a 9% cap on federal expenditures, and by lowering the federal share of program to 40% for the wealthiest states. The Senate Finance Committee also recommended that states be given far greater administrative flexibility and be given accelerated federal approval for state program changes to enable them to absorb the anticipated funding reduction. *Finance Committee Votes \$10.3 Billion Cuts*, 39 CONG. Q. 795 (1981).

In the House, the Waxman subcommittee proposed to abandon Reagan's Medicaid budget cap altogether and opted to reduce federal expenditures to states by 3% in fiscal year 1982, 2% in fiscal year 1983, and 1% in fiscal year 1984. It also proposed financial incentives for states for (a) hospital cost review programs or (b) fraud and abuse programs; increased aid for states with high unemployment; and made allowance of prospective reimbursement for hospitals and competitive bidding for lab services, medical devices, and drugs. For a discussion of these and other Waxman-sponsored Medicaid cuts, see WASH. REP. ON MEDICINE AND HEALTH, June 15, 1981, at 3. These proposals were never reported but found their way into the House reconciliation bill by a circuitous route. See *infra* note 165.

163. For example, in both Houses the President's block grant proposals were watered down and many programs exempted from the scheme altogether. For discussion, see *Education Block Grants Meet Stiff Opposition*, 39 CONG. Q. 1005 (1981).

164. Despite a certain amount of sound and fury in the authorization committees, by early June all congressional committees, except the House Energy and Commerce Committee, had submitted proposed bills to the two budget committees essentially meeting their reconciliation goals. See *Reconciliation Changes Still Face Tough Hill Battles*, 39 CONG. Q. 1027 (1981).

Significantly, the House Energy and Commerce Committee was the only committee not to meet its reconciliation deadline. The Waxman Subcommittee on Health and the Environment was unable to mark up a reconciliation bill and merely sent its recommendations to the full committee via a letter from the Chairman. See WASH. REP. ON MEDICINE AND HEALTH, June 15, 1981, at 3.

The full committee was also unable to reach a consensus on any of its reconciliation recommendations, including the health program recommendations. Consequently, Congressman Dingell, the chairman of the committee, sent a letter to the House Budget Committee outlining proposed program cuts instead of a committee bill, including Waxman's recommendations for health care programs and Medicaid. The minority members of the commit-

the script of the first budget resolution battle almost line for line: the Democratic leadership managed to develop an alternative reconciliation proposal but a coalition of conservative Democrats sided with the Republicans in the House, and the final result was a reconciliation bill reflecting Reagan's economic terms with only slight modification.¹⁶⁵ The Senate bill followed the same economic outline but with slightly different terms.¹⁶⁶

Following a somewhat chaotic conference process, during which the final terms of virtually all spending legislation authorized during the first session of the 97th Congress were brokered, a compromise reconciliation bill was enacted,¹⁶⁷ giving Reagan the third major legislative victory in his

tee sent a similar letter outlining alternatives. While each letter differed in its terms, both met the \$5.2 billion requirement for cuts in fiscal year 1982 outlays required of the committee by the first budget resolution. *Reconciliation Scorecard*, 39 CONG. Q. 1074 (1981).

165. As with the first budget, the Democrats had trouble controlling the reconciliation bill on the House floor despite their titular majority. Republicans and conservative Democrats expressed their dissatisfaction with the House reconciliation bill, claiming that the cuts would not achieve the budget goals and, in particular, calling for bigger cuts in entitlement programs. *Republicans Press Reconciliation Alternative*, 39 CONG. Q. 1079 (1981).

The conservative coalition, as it had on the first budget resolution, *see supra* note 157, effectively replaced the pending bill with a substitute, quickly dubbed "Gramm-Latta II" closely following the Senate's companion bill. 127 CONG. REC. H3926 (daily ed. June 26, 1981).

The House, in a major victory for the President, voted to adopt a bill that had no report, no hearing, and had not even been seen by many members, by a vote of 232-193. 127 CONG. REC. H4035 (daily ed. June 26, 1981). The final bottom line figure called for program changes estimated to produce savings of \$38.2 billion for fiscal year 1982.

Ironically, the Dingell-sponsored Energy and Commerce committee recommendations, *see supra* note 162, including most of the health programs cuts, as modified by Waxman, emerged as the only piece of the Democrat-sponsored reconciliation bill to be included in "Gramm-Latta II." Dingell had apparently secured sufficient support for these reconciliation amendments in the House even though he could not get his committee to back them, as part of the behind-the-scenes horse trading. For an explanation, see *Reconciliation Conferences Face Slim Choices*, 39 CONG. Q. 1167-69 (1981). The first vote on "Gramm-Latta II" omitted the energy and health program provisions. 127 CONG. REC. H3927 (daily ed. June 26, 1981). House Republicans attempted to amend their own provisions into "Gramm-Latta II," but, surprisingly, backed off. *See* 127 CONG. REC. H3982 (daily ed. June 26, 1981). The final vote on the bill included the Dingell recommendations, 127 CONG. REC. H4035 (daily ed. June 26, 1981). Thus many of the liberal alternatives to the Administration's health proposals forged by Congressman Waxman in the Subcommittee on Health of the House Energy and Commerce Committee, *see supra* note 162, survived the conservative victory on the House floor despite the fact that they did not have the support of their own committee or subcommittee.

166. The Senate approved its reconciliation bill more easily, 80-15, making only minor revisions in the committee's bill. 127 CONG. REC. S7094 (daily ed. June 25, 1981). *See also* Senate Finance Committee proposals, *supra* note 162.

167. Needless to say, the conference process was near chaos, as the conferees from the two Houses broke into over 50 subcommittees to try to iron out the differences between the two massive bills.

Finally, the House conference report, H.R. REP. No. 208, 97th Cong. 1st Sess. (1981), was

first year of office.¹⁶⁸

The program cuts finally authorized reflected the overall Reagan blueprint, cutting across federal domestic programs from agriculture to science and technology programs, reducing federal funding for virtually all federal domestic spending programs save the "protected" social safety net programs.¹⁶⁹ With regard to health programs, the result was a mixed victory, but best viewed as a victory for the New Federalism. The reconciliation conferees agreed to cut an estimated \$8.5 billion from the health program budget over the next three years, essentially the aggregate cut that Reagan had originally proposed, although the cuts were accomplished by a modified list of program changes, withholding some of the programmatic and structural modifications that Reagan had sought.¹⁷⁰ The block grant scheme that Reagan had proposed was substantially modified.¹⁷¹ Some of

approved by a voice vote in the House on July 31, 1981. 127 CONG. REC. H5834 (daily ed. July 31, 1981). The Senate concurred later the same day by a vote of 80-14. 127 CONG. REC. S9074 (daily ed. Aug. 1, 1981). Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357.

168. In addition to the first budget resolution and the reconciliation bill, Reagan also effectively managed his tax reform proposal through Congress in a similarly speedy fashion. See Economic Recovery Tax Act of 1981, Pub. L. No. 97-34, 95 Stat. 172.

169. For a line-by-line analysis, see *Final Reconciliation Savings*, 39 CONG. Q. 1465-66 (1981).

The final reconciliation bill enacted by both Houses was estimated to cut over \$130.6 billion in program outlays over the next three years, somewhat less than the total budget reductions originally envisioned by Reagan, as well as those in the instructions of the first budget resolution; but the \$740 billion fiscal year 1982 budget was projected to meet the \$35 billion in outlays cuts for fiscal year 1982 called for by the first resolution. 127 CONG. REC. S8987 (daily ed. July 31, 1981). Congress reauthorized a few programs that Reagan had hoped to eliminate and, particularly in health and social welfare programs, showed some preference for its own variations on Reagan's budget cutting themes. See *infra* notes 171-73. But the overall pattern was much the same as Reagan's original request: a major reduction in the federal role in social welfare programs and in the flow of federal funds for domestic programs to state and local government. For a brief summary, see *Reconciliation Spending Cut Bill Sent to Reagan*, 39 CONG. Q. 1371, 1377 (1981).

Perhaps of equal importance, Congress demonstrated in 1981 that major changes in governmental programming can be quickly accomplished by the skillful manipulation of the congressional budget process.

170. See WASH. REP. ON HEALTH LEGISLATION, August 5, 1981 ("Commentary"). For an item-by-item summary of the health-related provisions, see *id.* at 4-15.

171. The reconciliation bill effectively gave the President his overall cut of 25% in authorization levels for discretionary health programs, but weaved these cuts into a vastly modified block grant program only vaguely resembling Reagan's original block grant scheme. See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 901-906, 95 Stat. 357, 535-63. Essentially Congress created four block grant programs: a maternal and child health block grant (combining seven previously authorized programs); a preventive health block grant (combining seven programs); a block grant for mental health centers, alcohol abuse services centers, and drug abuse services; and a single block grant for community health centers. The block grants were also encumbered with a series of conditions,

the regulatory programs such as health planning and Professional Standard Review Organizations were reduced in funding, but were extended at least temporarily, again in opposition to the Reagan strategy.¹⁷² Educational assistance for health professionals was substantially reduced although most programs were continued.¹⁷³ Public health service hospitals were scheduled for termination at the end of 1982.¹⁷⁴ Congress actually rejected the Reagan proposal on only a few programs,¹⁷⁵ and managed

restricting states' use of the funds, since Congress was reluctant to entirely give up federal control over the funded health services. For a good summary of these block grants and the terms of the funding, see WASH. REP. ON HEALTH LEGISLATION, Aug. 12, 1981, at 3-8.

Many other programs originally slated for block grants were left as categorical programs: these included programs for family planning; childhood immunization; tuberculosis; venereal disease; migrant health centers; primary care research and development (funded at \$3 million but to be repealed altogether at the end of fiscal year 1982); and developmental disabilities. All of these programs, however, were authorized at levels below their fiscal year 1981 funding. See Pub. L. No. 97-35, §§ 911-913, 95 Stat. 357, 563-64; §§ 928-931, 95 Stat. 357, 569-70 (1981).

172. Rejecting Reagan's call for a three year phase out of PSROs, the program was reauthorized through fiscal year 1984, but the new legislation amended the program allowing the elimination of up to 30% of existing PSROs by fiscal year 1984 and allowing states to contract with PSROs for other utilization functions. Pub. L. No. 97-35, §§ 2112-13, 95 Stat. 357, 793 (1981).

The health planning program was refunded, but at a reduction from the funding level for fiscal year 1981 and with a series of amendments to restrict federal control over the state programs and to reduce the scope of the agencies' responsibilities. Pub. L. No. 97-35, §§ 933-36, 95 Stat. 357, 570-72 (1981).

173. Health professional educational assistance programs were cutback dramatically, but still funded at a level higher than that requested by President Reagan. Most capitation payments were eliminated, but other programs, including student loans and funding for Area Health Education Centers, physician assistants, general practitioner and family medicine specialists, and nurse training were reauthorized. Pub. L. No. 97-35, §§ 2700-2756, 95 Stat. 357, 902-31 (1981).

Significantly, the National Health Service Corp. was reauthorized with modifications for three years at a higher level of funding than Reagan had requested, but still at a greatly reduced authorization. Pub. L. No. 97-35, § 2709, 95 Stat. 357, 908 (1981). For a good summary, see WASH. REP. ON HEALTH LEGISLATION, Aug. 19, 1981, at 3-10.

174. On at least one issue Reagan got all that he wanted: all Public Health Service hospitals were to be closed by the end of 1982 and the free medical care entitlement for merchant seamen was terminated. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 985-988, 95 Stat. 357, 602-05 (1981).

175. Despite Reagan's opposition, federal assistance to HMOs was extended for three years, but with a substantial decrease in the level of authorization. Pub. L. No. 97-35, §§ 940-49, 95 Stat. 357, 572-78 (1981). See *infra* note 200 for discussion of 1981 HMO amendments to the Medicaid program.

The Senate had attempted to set authorization limits on the National Institute for Health and the Food and Drug Administration, see S. REP. NO. 139, 97th Cong., 1st Sess. 881-82 (1981), but this proposal was dropped by the conferees and the agencies were continued as permanently authorized (with their funding to be set by yearly appropriations as it had been previously). See H.R. REP. NO. 208, 97th Cong., 1st Sess. 796, 798 (1981).

Some programs nearly escaped the budgetary knife altogether: the National Institute of

new initiatives of its own on even fewer.¹⁷⁶

Ironically, Medicaid emerged as the major health program over which Congress most adamantly refused to give in to the President's directives. While attempting to stay within the budget reduction established by the original budget resolution,¹⁷⁷ and that asked for by Reagan, Congress flatly rejected the Reagan 5% budget cap and the proposed reduction of the federal share, and refused to grant many of Reagan's proposals to give states broader flexibility in the administration of their programs. Instead, Congress enacted a series of alternative program changes, with some resemblance to the Reagan program alterations, although the specific list of changes that was finally adopted was principally the handiwork of the House Subcommittee on Health and Environment with some concession to the alternatives originally proposed by the Senate.¹⁷⁸

Foremost among these amendments was a progressive reduction in the federal share of Medicaid costs. Rather than a fixed ceiling leaving states with full responsibility for program inflation, as Reagan had proposed, Congress authorized that 3% in 1982, 4% in 1983, and 4.5% in 1984 would be deducted from the amount for which the federal government would otherwise be liable.¹⁷⁹ States would be allowed to recoup these lost federal dollars to the extent that the federal share of the overall programs costs did not exceed 109% of the previous year's program costs;¹⁸⁰ states would also be allowed to recover one percentage point of each year's reduction if they maintained a pre-existing hospital cost review program,¹⁸¹ if the state had

Health, the National Center for Health Care Technology (which Reagan wanted to eliminate), the National Center for Health Services Research, and the Center for Health Statistics were all reauthorized at funding levels higher than the Reagan budget request. Pub. L. No. 97-35, §§ 916-24, 95 Stat. 357, 564-69 (1981).

176. The bill authorized a very few new programs, including an adolescent family life program to promote teenage chastity (and to replace the adolescent pregnancy program that was repealed). Pub. L. No. 97-35, § 955, 95 Stat. 357, 578-92 (1981).

177. See *supra* note 157.

178. Pub. L. No. 97-35, §§ 2161-2184, 95 Stat. 357, 803-18 (1981).

179. Pub. L. No. 97-35, § 2161(a), 95 Stat. 357, 803 (1981). Note that these percentage reductions are higher than those proposed by the Waxman subcommittee, see *supra* note 162, but reflect the cost containing alternatives developed by that committee, not the budget cap proposed by the Administration and adopted in the Senate.

180. Pub. L. No. 97-35, § 2161(b), 95 Stat. 357, 804 (1981). Essentially, a state is entitled to a dollar-for-dollar offset in the required federal reduction up to the amount of that reduction. The target amount for fiscal year 1982 set by the statute is 109% of the total federal share. For fiscal year 1983 and 1984, that total is to be inflated by the medical care expenditure category of the CPI. See § 2161(b); see also 42 C.F.R. § 433.217 (1982). For discussion of computation, see 46 Fed. Reg. 47,999 (1981).

181. A state qualifies for a one percentage point reduction for the required federal reduction for each quarter in which the state has a qualified hospital cost containment program. Pub. L. No. 97-35, § 2161, 95 Stat. 357, 803 (1981) (codified at 42 U.S.C. § 1396b(s)(2)(A))

an unemployment rate over 150% of the national average,¹⁸² or if a state had third party payor or fraud and abuse recoveries for any quarter exceeding 1% of the total federal payments due for that quarter.¹⁸³

Essentially this amendment makes states increasingly—but not fully—responsible for inflating program costs above the 109% level, while forcing the states to opt for the particular political and administrative choices to achieve these limitations.¹⁸⁴

Another major program modification included in the reconciliation bill was the removal of virtually all previous requirements imposed on states opting to provide services to the medically needy.¹⁸⁵ Essentially, states are no longer required to cover all categories of medically needy individuals,¹⁸⁶ and are given greater discretion in determining income and other

(1982)). According to the statutory terms, a state must meet specified criteria, among them (a) the program must have been in effect as of July 1, 1981; and (b) the state's rate of increase for hospital costs must be at least two percentage points lower than the national average. For other requirements, see § 2161(a).

The federal regulations issued in September 1981, do not further interpret these requirements. See 42 C.F.R. § 433.209 (1982). However, there is some discussion of the agency interpretation of the statute in the materials that accompanied their issuance. See 46 Fed. Reg. 47,997-98 (1981). It is also clear from the legislative history that this particular exemption was intended to apply to only a very few states. H.R. REP. NO. 208, 97th Cong., 1st Sess. 961 (1981).

182. Pub. L. No. 97-35, § 2161, 95 Stat. 357, 803 (1981) (codified at 42 U.S.C. § 1396b(s)(2)(B) (1982)). A state is entitled to a one percentage point reduction from the required federal share reduction in each quarter for which the state's unemployment rate for the preceding quarter was over 150% of the national average. See 42 C.F.R. § 433.207(b) (1982).

183. Pub. L. No. 97-35, § 2161(a), 95 Stat. 357, 803 (1981) (codified at 42 U.S.C. § 1396b(s)(2)(C) (1982)). A state receives a one percentage point reduction from the required federal share reduction in each quarter for which the recovery or diversion of funds by the state from fraud and abuse activities or, in 1982 only, third party liability (e.g., insurance companies) recoveries equal one percent of the federal share. Recoveries that exceed one percentage point in any quarter can be carried over to the subsequent quarter.

For a discussion of the activities that qualify as fraud and abuse recoveries, see 42 C.F.R. §§ 433.203 & 433.213(b) (1982); see also 46 Fed. Reg. 47,998-99 (1981).

184. See examples cited *infra* notes 264-81.

185. See *supra* note 18.

186. Section 2171(a)(3) repealed the requirement that a state which opts to have a medically needy program must cover all medically needy groups. Under the new amendments, states now have the option, with certain restrictions explained below, to provide Medicaid to the aged, the blind, the disabled, or children under 21 and their caretaker relatives as medically needy. For administrative implementation, see 42 C.F.R. § 435.300 (1982).

The September 1981 regulations also extended this option to the so-called "209(b)" states, those who choose to determine Medicaid eligibility using pre-1972 welfare eligibility standards (for explanation see *supra* note 18). 42 C.F.R. § 435.330 (1982). This administrative interpretation, however, may be invalid, as the federal statute, unchanged by the 1981

eligibility standards,¹⁸⁷ and most states are given almost complete discre-

amendments, appears to require "209(b)" states to have "spend down" eligibility for *all* categories of persons. *See* 42 U.S.C. § 1396a(a)(10) & § 1396a(f) (1981).

While the new statutory amendments clearly indicated an intent to give the states wide discretion in fashioning their Medicaid eligibility, particularly medically needy programs, the amendments put some limits on that discretion. First of all, the new statutory changes made some modest changes in the federal definition of the categorically needy (those who are mandatorily eligible). States are required to include any person participating in the newly authorized AFDC work supplementation program, or dependent or person living in the same household thereof, as eligible for Medicaid as categorically needy. Pub. L. No. 97-35, § 2171(a)(1), 95 Stat. 357, 807 (1981) (as implemented by 42 C.F.R. § 435.115(d) (1982)). States must also continue to provide Medicaid to anyone excluded from AFDC eligibility solely because their cash grant would have been \$10 or less. *See* 42 C.F.R. § 435.115(b) (1982), clarifying Pub. L. No. 97-35, § 2316, 95 Stat. 357, 856 (1981). On the other hand, people who were denied Social Security benefits by the 1981 repeal of the minimum benefit provision but declared eligible for SSI payments, were denied eligibility for Medicaid. *See* Pub. L. No. 97-35, § 2201, 95 Stat. 357, 830-33 (1981) (implemented by 42 C.F.R. § 435.120(b) (1982)). (This statutory provision was later partially repealed. Pub. L. No. 97-123, § 2, 95 Stat. 659, 1660-61 (1981)).

In another expansion of Medicaid coverage, Medicaid coverage throughout pregnancy is mandated for all pregnant women who are eligible for AFDC (although AFDC cash grant payments can only be made during the last four months). *See* Pub. L. No. 97-35, § 2171(a), 95 Stat. 357, 807 (1981) (as implemented by 42 C.F.R. § 435.115(c)(1) (1982)). In any of these cases, the beneficiary is considered categorically needy, and therefore assured the full scope of mandatory benefits.

Also, if a state has a medically needy program, it must cover pregnant women who would be eligible but for income and resource limitations. Pub. L. No. 97-35, § 2171(a)(1), 95 Stat. 357, 807 (1981). For implementation, *see* 42 C.F.R. § 435.301 (1982). Moreover, prior to 1981 states could extend AFDC to children under the age of 21 if they were attending school. States were required to provide Medicaid coverage to such individuals as categorically needy, and also had to cover any child who would have qualified for AFDC but for the school attendance requirement. States could also provide Medicaid coverage to children under 21 who would have qualified for AFDC financially but were not eligible because they were not deprived of parental support. The 1981 amendments made several changes to these requirements, basically intended to limit the AFDC coverage of such individuals. Pub. L. No. 97-35, § 2311, 95 Stat. 357, 852-53 (1981). *See* explanation 46 Fed. Reg. 47,981 (1981). At the same time, the 1981 statutory amendments allowed, but did not require, states to provide Medicaid eligibility for these individuals as categorically needy, and also allowed states to limit this coverage to individuals under 21, 20, 19, or 18 years of age, or according to any reasonable classification. For HCFA's interpretation of "reasonable classifications" and the other options now available to the state, *see* 42 C.F.R. § 435.222 (1982).

Under § 2171, if a state has a medically needy program, it must provide some coverage for children under the age of 21, subject to the same discretion discussed above with regard to the categorically needy. HCFA, however, has defined this discretion even beyond the terms of the statute. In the regulations issued in September 1981, HCFA allows states to make further classifications based on institutionalization or other factors not apparently allowed by the statute. *See* 42 C.F.R. § 435.308(b) (1982).

187. Before 1981, the comparability language in the Medicaid statute had been interpreted to require that income and resource standards be the same for all medically needy groups, and for the categorically needy and the medically needy, except for "spend down" requirements. *See* 42 U.S.C. §§ 1396a(a)(10)(c), 1396a(a)(17) (1980). The 1981 statutory amendments intended to loosen the statutory basis for that requirement. *See* H.R. REP. NO.

tion in determining the scope of coverage and the services to be offered.¹⁸⁸

208, 97th Cong., 1st Sess. 971 (1981). However, the language of the statute still requires that the eligibility standards for each group be "reasonable" and "comparable." The federal statute also continues to require that the medically needy income level be no lower than the highest of the cash grant income levels, but no higher than 133% of the AFDC payment level. 42 U.S.C. § 1396b(f) (1982).

HCFA has interpreted these provisions to allow the medically needy income level to vary from group to group, but to require the MNIL to be the same within an eligible group. 42 C.F.R. §§ 435.811, 435.814 (1982). Note that this interpretation, which allows considerable discrimination between categories of medically needy, may go beyond the "comparability" requirement imposed by § 1396a(a)(17), particularly the language which apparently limits inter-group variations to differences based on variations in shelter costs. For a judicial interpretation of this requirement, see *Hodecker v. Blum*, 525 F. Supp. 867 (N.D.N.Y. 1981), *aff'd*, 685 F.2d 424 (2d Cir. 1982).

Nonetheless HCFA apparently intends to give the state nearly unlimited discretion in fashioning medically needy income levels for each group and in interpreting the "comparable" and "reasonable" requirements of the federal statute. See 42 C.F.R. § 435.812 (1982). For an explanation, see 46 Fed. Reg. 47,980 (1981).

The statutory amendments' impact on resource standards for eligibility has been interpreted in a similar fashion. Before 1981, the comparability requirements were interpreted to mean that resource standards had to be the same for all medically needy groups, and at least equal to the highest standard in the state's cash grant assistance programs. 42 C.F.R. §§ 435.840-435.841 (1980). Under HCFA's new interpretation, resource standards must be the same within a medically needy group, but can differ from group to group, and the states are given considerable discretion in interpreting the statutory requirements of reasonableness and comparability. See 42 C.F.R. §§ 435.840-435.841 (1982).

In all cases, under the new regulations interpreting the 1981 amendments, neither the income nor the resource standards or the methodology for their interpretation for the medically needy have to be related to those used for the categorically needy; the standards and methodology need only be reasonable, except for certain statutorily required income disregards, again granting virtually unlimited discretion to each state. 42 C.F.R. §§ 435.851-435.852 (1982). Again this may be in violation of the statutory comparability requirements of § 1396a(a)(17).

188. Virtually all of the service requirements imposed on states opting to provide a medically needy program, see *supra* note 31, were modified by the 1981 statutory amendments. Pub. L. No. 97-35, § 2171(a)(3), 95 Stat. 357, 807-08 (1981). The net result was to greatly increase the states' discretion, although a few states, as explained below, actually had to expand their coverage to comply with the new federal requirements.

Prior to 1981, states had to provide the medically needy a mix of institutional and noninstitutional services, and a minimum level of services. 42 C.F.R. § 440.220 (1980). See discussion 46 Fed. Reg. 47,982 (1981). The federal statute also required that all categories of medically needy be offered the same scope of services. 42 U.S.C. § 1396a(a)(10)(c)(ii) (1980); 42 C.F.R. § 440.240(b) (1980).

In the September 1981 regulations, HCFA interpreted the amended statutory language to require that the scope, amount, and duration of the services provided to any member of a group be the same within the group but to allow differences among groups. 42 C.F.R. § 440.240(b) (1982). However, certain specific limitations were imposed on state discretion by the 1981 statutory amendments. If the state has a medically needy program, it must cover ambulatory care for individuals under the age of 18 and for individuals entitled to institutional care. For an interpretation of ambulatory care, see H.R. REP. NO. 208, 97th Cong., 1st Sess. 971 (1981). It must cover prenatal care and delivery services for pregnant women and home health services for anyone entitled to skilled nursing home services. Further, if

The 1981 amendments also significantly changed the terms of hospital reimbursement by repealing the requirement that Medicaid programs use Medicare cost reimbursement principles in setting rates for reimbursing hospitals.¹⁸⁹ Instead states must now reimburse hospitals at a rate “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,¹⁹⁰ making the statutory standard for reimbursement of hospitals identical to that established for

the medically needy plan covers intermediate care for the institutionalized mentally retarded, it must offer the services to all groups covered prior to the 1981 amendments. *See* Pub. L. No. 97-35, § 2171(a)(3)(C)-(D), 95 Stat. 357, 807-08 (1981).

189. *See supra* note 42.

190. Pub. L. No. 97-35, § 2161, 95 Stat. 357, 803-05 (1981) (codified at 42 U.S.C. § 1396a(13)(A) (Supp. V 1981)). The statutory definition was expanded somewhat by the federal regulations issued in September 1981. According to those regulations, the state plan must provide that “the state finds, and makes assurances satisfactory to the Secretary (that the rates established) are reasonable and adequate to meet the cost that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulation, and quality and safety standards.” 42 C.F.R. §§ 447.250, 447.252(a)(1) (1982).

The new reimbursement requirements significantly loosen federal control of state discretion. Under previous law, states were required to reimburse each hospital on the basis of its reasonable cost, using methods and standards developed by each state but subject to the direct review and approval of HCFA. *See supra* note 42. Reimbursement of nursing homes allowed a slightly broader standard but were nevertheless subject to direct federal oversight. *See supra* note 43. Providers could also challenge individual rates determinations to HCFA. 42 C.F.R. § 447.261(d)(6) (1980).

It is not even clear from the new regulations if HCFA intends to make any independent judgment whether the methods and standards chosen by each state are in conformity with the federal law, or whether the information submitted is adequate. Reading the regulations literally, HCFA may simply assess whether the assurances themselves are made adequately. *See* 42 C.F.R. §§ 447.252(c), 447.256 (1982).

This intent to maximize state discretion (and minimize federal oversight) is bolstered by the fact that the new regulations allow that amendments to the state plan and accompanying assurances shall be deemed accepted by HCFA if the state is not notified to the contrary within 60 days. 42 C.F.R. § 447.256(a) (1982).

However, the explanatory material that accompanied the issuance of the September 1981 regulations claimed, “[HCFA] will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State’s assurances.” 46 Fed. Reg. 47,966-67 (1981).

Other provisions of the September 1981 regulations strongly suggest that HCFA intends to leave most discretion for reimbursement in the hands of the state Medicaid agency. The new regulations deleted the detailed record keeping requirements for participating providers, 42 C.F.R. § 447.277 (1980), leaving only the general record retention requirements of 45 C.F.R. pt. 74 (1982), effectively leaving further record keeping requirements to the discretion of each state. *See* 46 Fed. Reg. 47,967 (1981). HCFA also deleted most of the audit requirement previously imposed on state agencies. 42 C.F.R. §§ 447.290, 447.296 (1980). States are now required only to conduct periodic audits according to their own discretion. 42 C.F.R. § 447.265 (1982). Note that these regulations merely repeat the statutory requirement without attempting to specify their meaning.

long term care facilities in 1980.¹⁹¹ This seemingly technical change in the statutory authority for reimbursement effectively removes the "reasonable cost" floor under Medicaid reimbursement for hospitals, allowing, indeed inviting, states to offer some hospitals substantially less than their usual charges or actual estimates of their costs.¹⁹² However, states's reimbursement standards must now take into account "the situation of hospitals which serve a disproportionate number of low income patients with special needs,"¹⁹³ and establish rates "adequate to assure that recipients have reasonable access (taking into account geographic location and reasonable time) to inpatient services of adequate quality,"¹⁹⁴ a significant concession to the needs of Medicaid recipients.¹⁹⁵

The amendments authorized, virtually for the first time, considerable discretion with regard to the historically sacrosanct "freedom of choice" requirements.¹⁹⁶ States may now request waivers of the statutory "freedom of choice" requirements, thereby restricting recipients to obtaining services from providers who have demonstrated effectiveness and efficiency, rather than allowing recipients freely to choose their provider of services.¹⁹⁷ States are also allowed to solicit competitively-bid contracts

191. This means that the basic federal standards determining reimbursement for both nursing homes and hospitals are identical.

192. See *infra* notes 269-72. States are also permitted to limit future rate increases for health facilities to price increases for goods and services purchased as measured by acceptable inflation indices. See H.R. REP. NO. 208, 97th Cong., 1st Sess. 962 (1981).

193. Pub. L. No. 97-35, § 2173(a)(1)(B)(ii), 95 Stat. 357, 808 (1981).

194. Pub. L. No. 97-35, § 2173(a)(1)(B)(iii), 95 Stat. 357, 808 (1981).

195. Unfortunately, the new federal regulations did not explain the additional statutory requirement that such methods and standards for hospital reimbursement take into account "the situation of hospitals that serve a disproportionate number of low income patients with special needs" or the requirement that the rates must be "adequate to assure that recipients have reasonable access to inpatient services of adequate quality." See 42 C.F.R. § 447.252(a)(3) (1982); see also 46 Fed. Reg. 47,970 (1981). Therefore, some question remains as to the real impact of these statutory provisions and the willingness of the federal government to enforce them.

196. Pub. L. No. 97-35, § 2175, 95 Stat. 357, 809 (1981), recodifies the preexisting "freedom of choice" requirement along with the newly created exceptions as 42 U.S.C. § 1396n (1982).

197. In addition to the exceptions listed in *infra* note 199, under Pub. L. No. 97-35, § 2175, 95 Stat. 357, 809 (1981) (codified at 42 U.S.C. § 1396n(b) (1982)) states may also obtain waivers of any of the requirements imposed on state plans necessary to (a) implement a case management or specialty physician services arrangement which restricts the providers from whom an individual beneficiary can receive primary care, so long as the restriction does not substantially impair access to services of adequate quality; (b) allow a locality to act as a central broker in selecting among competing health plans; (c) share any cost saving from use of more cost-effective medical care with the beneficiary by providing additional services; (d) restrict the providers from whom an individual can obtain services to those providers who comply with reimbursement, quality, and utilization standards as long as such restric-

for certain medical supplies and services,¹⁹⁸ to lock in frequent service recipients to one or more providers, and to lock out providers who have abused the program.¹⁹⁹

In addition, the amendments authorized increased flexibility in contracting with health maintenance organizations for services to Medicaid recipients,²⁰⁰ authorized HHS to pay for the costs of closure or conversion of underutilized hospital facilities participating in Medicaid (or Medicare),²⁰¹ and added a long series of other amendments. These measures increased the states' flexibility to determine the size and scope of their programs and to eliminate costly or arguably unnecessary services.²⁰²

In one of the few provisions that attempts to broaden coverage of the program or, perhaps more accurately, to rechannel the expenditure of Medicaid funds, the 1981 amendments allowed states to provide a wide

tions are consistent with access to and quality of efficient and economic provision of care and do not discriminate among classes of providers. In order to implement these waivers, states must seek prior HCFA approval, and submit to considerable HCFA monitoring and oversight. 42 U.S.C. § 1396n(c)-(d) (1982).

The federal statute, however, allows that all requests for waivers not specifically denied within 90 days shall be deemed granted. 42 U.S.C. § 1396n(f) (1982).

198. Pub. L. No. 97-35, § 2175, 95 Stat. 357, 809-11 (1981) (codified at 42 U.S.C. § 1396n(a)(1)(B) (1982)).

The language of the statute allows that a state will not be deemed out of compliance with the federal law solely because it engages in competitive bidding. HCFA has interpreted this to mean no formal waiver or approval by HCFA is required for implementation. *See* 42 C.F.R. § 431.54(d) (1982) as explained at 46 Fed. Reg. 48,525 (1981).

199. Pub. L. No. 97-35, § 2175(b), 95 Stat. 357, 809-11 (1981) (codified at 42 U.S.C. § 1396n(a)(2) (1982)), allows restriction for a reasonable time (a) of the providers from which a recipient can receive services after the state has found the recipient has utilized medically unnecessary services, or (b) of the participation of a provider who has provided medically unnecessary services or services that do not meet professionally acceptable standards. Under the statute, however, beneficiaries must have, under either restriction, "reasonable access to services of adequate quality taking into account geographical location and reasonable travel time." For legislative history, see H.R. REP. No. 208, 97th Cong., 1st Sess. 964 (1981).

In both cases, states may implement such "lock-in" requirements without prior HCFA approval. 42 C.F.R. §§ 431.51, 431.54(e)-(f) (1982).

200. Pub. L. No. 97-35, § 2178, 95 Stat. 357, 813-14 (1981) (codified at 42 U.S.C. § 1396b(m) (1982)). The new amendments obviously intend to encourage states to rely more heavily on HMOs. Previously, only federally qualified HMOs could participate in the Medicaid program. *See supra* note 86. The new amendment allows the state much broader discretion in selecting HMOs. Prior law also limited HMOs to a maximum of 50% Medicaid enrollment; the new law increases that to 75%. For public HMOs, the 75% maximum can be waived.

201. Pub. L. No. 97-35, § 2101(a)(1), 95 Stat. 357, 785-87 (1981) (codified at 42 U.S.C. § 1395uu (1982)).

202. For a full discussion of Medicaid and Medicaid-related 1981 amendments, see WASH. REP. ON MEDICINE AND HEALTH, Aug. 3, 1981, at 8-10.

range of home and community-based services²⁰³ to people who would otherwise receive institutionally-based services.²⁰⁴ By allowing waivers of the statutory definition of "medical services"²⁰⁵ and various other statutory requirements imposed on state programs,²⁰⁶ the federal law now allows states, under strictly specified conditions, to pay for various home and personal care services, meal preparation, activity assistance, respite services, and other essentially nonmedical services except for room and board.²⁰⁷ These waivers are intended to allow the shifting of Medicaid recipients from nursing home and other institutional settings to more appropriate and more economical home and community settings.²⁰⁸

Following reconciliation, another round of budget cuts complicated the final configuration of the fiscal year 1982 budget and its impact on social welfare programs. The President first proposed a second reconciliation bill including a sizeable cut in domestic welfare spending.²⁰⁹ When the poli-

203. Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-13 (1981) (codified at 42 U.S.C. § 1396n(c) (1982)).

204. The federal regulations issued in October 1981 interpret this provision as an optional service that states may provide to the categorically needy, the medically needy, and the optional categorically needy, including institutionalized persons eligible for Medicaid under 42 C.F.R. § 435.231 (1982). See 42 C.F.R. § 435.232 (1982), as explained by 46 Fed. Reg. 48,537 (1981).

205. Prior federal law had severely limited the circumstances under which nonmedical long term care services could be provided outside an institution. See 42 C.F.R. pt. 440 (1980).

206. See 46 Fed. Reg. 48,533 (1981).

207. Neither the statute nor the interpretive regulations issued in September 1981 exclusively define the range of services a state may opt to offer. See 42 C.F.R. § 440.180 (1982); see also 46 Fed. Reg. 48,533 (1981). As interpreted by HCFA, each recipient is to have an individual plan negotiated with the state agency outlining the services for which Medicaid will pay. See 42 C.F.R. § 441.301(b)(1)(i) (1982).

208. In effect, states can now provide the various health and social services that will allow many institutionalized (and potentially institutionalized) people to live outside of nursing homes but still receive necessary assistance. However, in order to have a waiver approved a state must make assurances to HCFA that:

(a) it will take the safeguards necessary for the protection of the health and welfare of the beneficiary and assure financial accountability of funds expended;

(b) it will evaluate the need for institutionalization of each recipient who receives services;

(c) it will give recipients who would be institutionalized an informed choice of the home or community alternative (although no documentation is required);

(d) the average per capita expenditure under those alternatives will not exceed the average per capita cost of institutionalized services. For an explanation of this calculation, see 42 C.F.R. § 441.303(d)(1) (1982) and 46 Fed. Reg. 48,535-36 (1981). 42 U.S.C. § 1396n(c) (1982).

209. It was becoming clear by the Fall of 1981 that the economy was not responding as predicted to the Reagan tax and budget cuts. In October, Reagan called for a further round of fiscal year 1982 budget cuts. The bulk of the new savings were to come from a 12% across-the-board reduction in virtually all nondefense federal programs, which would result

tics of the season made Congress unwilling to consider these new proposals,²¹⁰ the President proposed to force comparable savings by vetoing any appropriations bill that exceeded his budget projections—a promise to which he rigidly adhered.²¹¹

in reducing the 1982 fiscal year budget authority by \$18.7 billion at an estimated reduction in outlays of \$8.4 billion. See *Stiff Fight Over New Reagan Budget Cuts*, 39 CONG. Q. 1820-23 (1981).

210. Virtually lost in this political shuffle was the second—and binding—concurrent budget resolution. Congress demonstrated little visible interest in meeting the September 15 deadline. After the President withdrew his second round of proposed budget cuts, the House moved to reduce the second resolution to a virtually meaningless act. The House Budget Committee voted on November 12 to adopt the first budget resolution, H.R. Con. Res. 115, as the second resolution despite the fact that the earlier resolution's economic predictions were no longer credible. See H.R. REP. NO. 369, 97th Cong. 1st Sess. 1 (1981), reprinted in 127 CONG. REC. H9205 (daily ed. Dec. 10, 1981).

The Senate Budget Committee begrudgingly followed suit. S. REP. NO. 279, 97th Cong., 1st Sess. 1 (1981), reprinted in 127 CONG. REC. S14,053 (daily ed. Nov. 24, 1981).

The Senate narrowly approved the resolution with minor amendments, S. Con. Res. 50, 97th Cong., 1st Sess., 127 CONG. REC. S14,845 (daily ed. Dec. 9, 1981). Language added by the Senate did, however, ask the President to propose new budget cuts in order to reaffirm the Administration's commitment to a balanced budget by 1984. See *Deficit Dispute Highlights Budget Debate*, 39 CONG. Q. 2430 (1981). The amended resolution was passed by the House. 127 CONG. REC. H9204 (daily ed. Dec. 10, 1981).

211. Unable to pass any of the 13 agency appropriation bills pending, Congress passed a continuing resolution on October 1, 1981, to continue federal government operations pending resolution of appropriation bills. 127 CONG. REC. S10,890 (daily ed. Sept. 30, 1981). Pub. L. No. 97-51, 95 Stat. 958 (1981). The temporary resolution emerged from the joint conference the night before government operations theoretically would stop for lack of funding.

In an effort to postpone the expiration on November 20 of the appropriations authorized by Pub. L. No. 97-51, H.R.J. Res. 357 was passed in the House to extend all appropriations (except congressional pay) until individual appropriation bills could be passed. 127 CONG. REC. H8819 (daily ed. Nov. 20, 1981). For an explanation of funding levels, see *Veto Confrontation in View as House Committee Reports New Stopgap Funds Measure*, 39 CONG. Q. 2224 (1981).

The Senate passed a similar bill, but added a 4% across-the-board reduction (with several major exceptions), estimated to give Reagan \$6 billion of his requested \$8 billion in cuts and imposed a March 30 deadline. 127 CONG. REC. S13,951 (daily ed. Nov. 22, 1981). For a full explanation, see *Fiscal 1982 Funding Crisis Goes Down to the Wire*, 39 CONG. Q. 2272-74 (1981).

After a compromise was reached and a quick conference agreement written, both houses passed H.R.J. Res. 357 on Nov. 27. 127 CONG. REC. H8796, S13,960 (daily ed. Nov. 22, 1981). Among other things, it called for a 2% reduction in funding levels for most agencies (including Defense). White House and congressional experts could not agree on the actual savings, but all agreed they were much less than Reagan had hoped for. See discussion in *One Spending Crunch Ends, Another Looms*, 39 CONG. Q. 2323-25 (1981).

President Reagan vetoed this compromise and a three-week extension of funding was quickly passed by both Houses (after a brief shutdown of the government). H.R.J. Res. 368, enacted as Pub. L. No. 97-85, 95 Stat. 1098 (1981).

On December 10, the House passed another continuing resolution, H.R.J. Res. 370, 97th Cong., 1st Sess. (1981), extending funding through March 31 for all agencies without appro-

For health and health-related programs, the impact of these end-of-session politics was mixed. The final appropriations figures included a 4% cut from the totals originally fixed by Congress.²¹² Medicaid, along with other entitlement programs, however, was exempted from this last budget skir-

priations legislation. 127 CONG. REC. H9155 (daily ed. Dec. 10, 1981). The Senate approved the bill on December 11, 127 CONG. REC. S15,063 (daily ed. Dec. 11, 1981).

This bill was estimated to give Reagan about one-half of the \$8 billion in "second round" outlay reductions he had requested, 127 CONG. REC. S15,060 (daily ed. Dec. 11, 1981). There were, however, no specific budget reductions as Reagan had requested. Instead, through a complicated compromise, the bill allowed the Administration to cut up to 4% from virtually all federal departments but no more than 6% from any individual program. H.R.J. Res. 370, § 142, 97th Cong., 1st Sess., 127 CONG. REC. H9155 (daily ed. Dec. 10, 1981).

212. The House Appropriations Committee approved an appropriations bill for Labor, HHS, and Education on September 23. See H.R. REP. NO. 251, 97th Cong., 1st Sess. (1981). While the \$87 billion bill was \$1.2 billion below fiscal year 1981 expenditures, it was nearly \$1 billion above the first budget resolution and \$4 billion over the President's request. *House Committee Approves \$87.3 Billion for Health, Welfare, Education, Labor*, 39 CONG. Q. 1841 (1981).

On October 6, the House approved H.R. 4560 as recommended by the Appropriations Committee by an 81 vote margin, 127 CONG. REC. H7097 (daily ed. Oct. 6, 1981), a significant rebuff to both the President's original budget goals and to his second round of budget recommendations. See *supra* notes 117, 209. The House recommended only slight reduction in the \$87 billion-plus price tag on the committee's bill, bringing the bill's total close to the first budget resolution ceiling. The final House bill included \$17.6 billion in Medicaid spending and funding for health programs, exceeding Reagan's requests. For an analysis of the cost of this bill as passed, see *House Hands Reagan Defeat on Budget*, 39 CONG. Q. 1948-49 (1981).

In the Senate, the Republican-dominated Appropriations Committee was hesitant to break ranks with the President. Following the President's plea for a second round of 1982 cuts via appropriation reductions, see *supra* note 211, the Republicans on the Appropriations Committee indicated a willingness to reduce health program appropriations but not as much as the President wanted. See *Hatfield Claims His Place in Budget Politics*, 39 CONG. Q. 1946 (1981).

On November 5, the Senate Appropriations Committee approved H.R. 4560 at a total budget authority of \$85 billion—less than the House version, but over \$2 billion more than Reagan's original request and in virtual disregard of the second round budget requests. See *\$85 Billion Bill Approved for Nation's Social Programs*, 39 CONG. Q. 2203 (1981). See S. REP. NO. 268, 97th Cong., 1st Sess. (1981).

The Senate committee increased appropriations set by the House for several block grants programs and provided for the transition of public health service hospitals to local control. Significantly, the committee also added nearly \$700 million to Medicaid appropriations, arguing that the reconciliation cuts would not meet projected budget goals. See S. REP. NO. 268, 97th Cong., 1st Sess. 92-93 (1981). However, these increases were offset by some reductions in other health programs. See *id.* at 114.

The final bill established a base rate for Labor-HHS appropriations at the lower of the levels set by the House and the Senate versions of the pending, but not passed, H.R. 4560, and then reduced spending by 4% across-the-board for all programs, although it added to the specific bases of some programs. See Pub. L. No. 97-92, § 101(a), 95 Stat. 1183, § 142(a), 95 Stat. 1201 (1981).

mish and was funded for fiscal year 1982 at \$17.6 billion.²¹³

D. The Second Session of the 97th Congress

The political machinations of the fall of 1981 set the stage for the opening of the second session of the 97th Congress. By January 1982, even the Administration's experts were speaking of economic recession and \$100 billion federal deficits.²¹⁴ But the President's commitment to his Economic Recovery Plan apparently did not waiver. In his budget proposals for fiscal year 1983,²¹⁵ he urged Congress to "stay the course" that it had established the previous year.²¹⁶ With only a slight variation from his original blueprint, he boldly proposed to restore the nation's health with additional doses of the same economic and social policies,²¹⁷ including a

213. This was the level of the pending House HHS-Labor appropriations bill. See H.R. REP. No. 372, 97th Cong., 1st Sess. (1981); see also *Major Cuts in Programs for the Poor Required by Reconciliation Bill*, 39 CONG. Q. 1834 (1981).

214. See *infra* note 217.

215. President Reagan presented the outlines of his economic strategy for fiscal year 1983 in his State of the Union Address delivered January 20, 1982. H.R. DOC. No. 133, 97th Cong., 2d Sess. (1982), reprinted in 128 CONG. REC. H51-H55 (daily ed. Jan. 26, 1982). This presentation was supplemented by additional documentation elaborating on his proposed economic strategy: *The Economic Report of the President and the Annual Report of the Council of Economic Advisors*, H.R. DOC. No. 123, 97th Cong., 2d Sess. (1982), reprinted in 128 CONG. REC. S728 (daily ed. Feb. 10, 1982); U.S. Office of Management and Budget, *The Budget of the United States Government for Fiscal Year 1983*, H.R. DOC. No. 124, 97th Cong., 2d Sess. (1982) (including "The Budget Message of the President") reprinted in 128 CONG. REC. S428 (daily ed. Jan. 20, 1982); U.S. Office of Management and Budget, *Appendix to the Budget of the United States Government for Fiscal Year 1983*, H.R. DOC. No. 125, 97th Cong., 2d Sess. (1982); U.S. OFFICE OF MANAGEMENT AND BUDGET, MAJOR THEMES AND ADDITIONAL BUDGET DETAILS: FISCAL YEAR 1983 (1982) [hereinafter cited as MAJOR THEMES].

216. The President's political intentions were best summarized in remarks included in his budget message to Congress. The President said: "The task before us now is a different one, but no less crucial. Our task is to persevere; to stay the course; to shun retreat; to weather the temporary dislocations and pressure that must inevitably accompany the restoration of national economic, fiscal, and military health." H.R. DOC. No. 124, 97th Cong., 2d Sess. M-11 (1982).

217. As he did in his initial proposals to Congress in 1981, Reagan premised his budget on his "firm resolve and unwavering adherence" to his commitments to reduce personal and business taxes, reduce regulatory controls over personal and business activity, maintain a sound monetary policy, and reduce federal spending. H.R. DOC. No. 124, 97th Cong., 2d Sess. M-4 (1982).

In order to carry out this commitment, he called for a budget of \$802 billion, outlays estimated at \$757.6 billion, *id.* at 3-6, 3-33; and a budget that would limit the growth of federal spending to an austere 4% for fiscal year 1983. See *id.* at 3-2.

Significantly, while he called for a 4% lid on federal spending, the President also renewed his commitment to a strong national defense, asking for \$221.3 billion in outlays for 1983, an increase of over \$33 billion, *id.* at 3-21, and budget authority of \$258 billion, an increase of

\$239 billion "deficit reduction program."²¹⁸ This program would again require sizable reductions in targeted domestic spending programs, although these cuts would be paired with a modest list of non-income tax increases.²¹⁹

For health and health-related programs, Reagan's renewed commitment translated into terms that were virtually identical to those of his original budget forecast: substantial reductions in federal support following the same economic and ideological principles that had been enunciated before.²²⁰ For Medicaid in fiscal year 1982 the President proposed \$17.8 billion, virtually the same amount budgeted in 1982 with no allowance for

\$44 billion. *Id.* at 3-17. This would expand the portion of the federal budget for military affairs to at least 29%, with a projection of over 37% by 1987. *Id.* at 3-4. *See supra* note 119.

The only major difference between the overall Reagan spending strategy in 1981 and the game plan announced in January 1982 was the conspicuous postponement of a return to a balanced budget. As noted earlier, the Administration's original commitment to an immediate balanced budget had been downgraded during 1981. *See supra* notes 110, 157. By January 1982, Reagan was proposing a budget that would produce a deficit which even by the Administration's optimistic estimates would add at least \$100 billion to the national debt. H.R. Doc. No. 124, 97th Cong., 2d Sess. M-12 (1982).

218. In addition to his austere budgeting, Reagan proposed over \$239 billion in policy changes, minor tax revisions, and major budget reductions over the next three years, termed "deficit reductions" by the President, effectively supplementing his 1981 reduction proposals with a second round of budget cuts. *See* H.R. Doc. No. 124, 97th Cong., 2d Sess. M-16 (1982).

The additional budget cuts called for by Reagan focused on the biggest items in the domestic welfare budget, except social security. Various entitlements would be reformed to tighten eligibility, reduce errors and abuse, and curtail unwarranted benefits in medical, welfare, and nutrition programs. Guaranteed student loans and federal retirement programs were also to be reduced and reformed. These cuts would save \$12 billion in 1982. *See* H.R. Doc. No. 124, 97th Cong., 2d Sess. 3-9 (1982). Reductions in other domestic programs, such as agricultural research, job training and housing subsidies, would save \$14 billion in 1982 and \$76 billion by 1985. *Id.*

While principally a call for a second round of spending cuts, not all of the deficit reductions were to be program cuts. Other deficit reductions were to be achieved by a list of other reforms, including shifting more government costs to user fees, more efficiency in government, better collection of debts owed to the government, the sale of government surplus, and modest nonincome tax increases. *See id.* at M-17 to M-19. The tax increases later were to become a larger part of the President's strategy. *See infra* notes 238-39.

219. The budget reductions again were targeted at specific programs viewed by the Administration as either unaffordable or inappropriate. *See supra* note 120. They also were presented in rhetoric which suggested that Reagan would honor his commitment to the so-called "safety net" programs. *See supra* note 121; H.R. Doc. No. 124, 97th Cong., 2d Sess. M-17 (1982). However, the actual terms of his budget called for at least modest reductions in most of the previously exempt programs and, particularly, major reductions in Medicare, previously enumerated as among the exempted safety net programs. *See id.* at 5-143 to 5-155, and a brief analysis in *More Cuts in Social Programs*, 40 CONG. Q. 240 (1982).

220. The combined effect of the continuation of President Reagan's economic recovery plan and the deficit reduction proposals for health and health-related programs was abundantly clear. Reagan proposed outlays for all health programs of \$78.1 billion, an increase

inflation.²²¹ This *de facto* program reduction was to be achieved by a series of legislative and administrative changes intended to reduce potential Medicaid expenditures by \$2 billion, in addition to the over \$1 billion in program reductions enacted in 1981.²²²

of only \$4.5 billion, and budget authority of \$77.8 billion, a slight reduction from the fiscal year 1982 figures. H.R. Doc. No. 124, 97th Cong., 2d Sess. 5-129 (1982).

This austere budget was to be achieved in large part by major reductions in the Medicare program. But the budget also added health programs to the four block grants created in 1981, at additional levels of funding for the block grants, but at funding levels lower than the combined totals for these programs prior to fiscal year 1982. Thus, the budget effectively achieved substantial program fund reductions. *See id.* at 5-134 to 5-135. For budget figures, *see id.* at 5-130. *See also* MAJOR THEMES, *supra* note 215, at 27. As in previous budgets, many other programs also were slated for either reduction in funding or outright repeal. Following the blueprint of his earlier proposal virtually line for line, Reagan proposed a repeal of both the PSRO and health planning programs; a phase out of the HMO program; drastic reductions in health manpower assistance; and limitations on funding for virtually all other discretionary health programs. *See* discussion H.R. Doc. No. 124, 97th Cong., 2d Sess. 5-130 to 5-137 (1982); MAJOR THEMES, *supra* note 215, at 100-01; *see also* original proposals at *supra* notes 132-41.

For an excellent discussion of Reagan's 1983 health budget and an item-by-item analysis, *see* WASH. REP. ON MEDICINE AND HEALTH, Feb. 15, 1982 ("Perspectives"). *See also* discussion of Reagan's proposed "turnback," *infra* notes 227-29.

221. Reagan's fiscal year 1983 budget proposal called for Medicaid budget authority of \$16.995 billion, and actual outlays of \$17.76 billion. *See* H.R. Doc. No. 124, 97th Cong., 2d Sess. 5-129 to 5-130 (1982).

222. The various program changes proposed by Reagan included the following:

- 1) A 3% reduction in the federal match for optional services provided to the categorically needy and a 3% reduction for all services provided to the medically needy. This was estimated to save \$600 million in 1983 and \$2 billion by 1985.
- 2) A required imposition of \$1 per day copayment for hospital visits and \$1 per visit for outpatient services for the categorically needy; and a \$2 per day and \$1.50 per visit copayment for the medically needy. This was estimated to save \$329 million in 1983 and \$1.114 billion by 1985.
- 3) Elimination of the federal payments for Medicaid "buy-ins" to Medicare Part B and limitation of all special Medicaid matching payments, e.g., family planning, and certification of nursing homes. This would save \$267 million in 1983 and \$864 million by 1985.
- 4) Several legislative and administrative changes in the authority for states to recover Medicaid payments from relatives and estates of beneficiaries. This was estimated to save a total of \$283 million in 1983 and \$948 million by 1985.
- 5) A reduction of Medicaid eligibility for people dropped from the AFDC roll from the current four months to one month. This would save \$75 million in 1983 and \$255 million by 1985.
- 6) A "phased in" elimination of the federal match for benefits due to eligibility errors. This would save \$59 million in 1983 and \$414 million by 1985.
- 7) Elimination of the utilization review requirements and the PSRO program. This would save \$16 million in 1983 and \$50 million by 1985.
- 8) Reductions in AFDC and SSI that would reduce Medicaid eligibility. This would save \$329 million in 1983 and \$1.544 billion by 1985.
- 9) Changes in the Medicare program that would save Medicaid program funds in 1983 (\$25 million) but increase Medicaid spending by 1985 (\$40 million in 1984 and \$54 million in

President Reagan's budget proposals also raised the possibility of even more significant changes in the Medicaid program than simply limiting program expenditures. Committing himself to "a major effort to restore American federalism,"²²³ the President augmented his budget proposals and his vision for economic recovery with the announcement of a two-fold political offer:²²⁴ a \$20 billion federal-state "swap" under which the federal government would take full responsibility for Medicaid and the states would accept full responsibility for the food stamps and AFDC programs;²²⁵ and a federal "turnback" of over \$25 billion in program and taxing authority to state control.²²⁶ Under this turnback, the states would eventually accept full responsibility for the administration of various education, community development, transportation, social welfare and non-entitlement health programs.²²⁷

The political feasibility of the plan, as initially proffered, was far from

1985). See H.R. Doc. No. 124, 97th Cong., 2d Sess. 5-133 (1982). For a more complete discussion, see MAJOR THEMES, *supra* note 215, at 55-56.

An additional administrative change in the Medicaid, AFDC, and food stamp programs was part of Reagan's initial proposal for fiscal year 1983. The President proposed that the administration of all these programs at the state level be consolidated into a block grant funded at 95% of the 1982 level. This would result in a savings to the Medicaid program of \$218 million in 1983. See H.R. Doc. No. 125, 97th Cong., 2d Sess. I-K48 (1982) for discussion. For budget estimates, see MAJOR THEMES, *supra* note 215, at 56.

For a discussion of all these changes, see WASH. REP. ON MEDICINE AND HEALTH, Feb. 15, 1982 ("Perspectives").

223. H.R. Doc. No. 124, 97th Cong., 2d Sess. M-22 (1982).

224. See H.R. Doc. No. 133, 97th Cong., 2d Sess. 6-7 (1982); see also H.R. Doc. No. 124, 97th Cong., 2d Sess. M-22 to M-23 (1982).

225. For further explanation, see MAJOR THEMES, *supra* note 215, at 17.

226. For further explanation, see *id.* at 18-19.

227. According to the terms of the original "swap" and "turnback" proposal, the initial funding would come from a trust fund established with federal revenues from a windfall oil profits tax, and from various excise taxes on gasoline, tobacco, alcohol, and telephone service. The federal share of this trust fund would be reduced 25% per year over four years following four years of funding at roughly current levels. At the same time, the states gradually would be given the authority to levy the windfall and excise taxes. During the initial four years, the states would be given considerable discretion in allocating the federal trust funds among the various programs and eventually they would have full discretion over the maintenance of these programs. In effect, the President was proposing a four-year block grant of \$28 billion in domestic welfare programs, to be followed by a total takeover by the states of both the revenue raising and programmatic authority. See *id.* at 20-21. With regard to the fiscal implications of the "swap," the original Reagan proposal billed the plan as a financial "wash." As presented by Reagan, the states were to lose nothing, at least initially. Whatever gain or loss a state suffered financially by the trade of AFDC and food-stamp programs for Medicaid would be made up by an adjustment in the state's allotment of

clear, as were the specific terms of the scheme.²²⁸ But even in its vague outlines, Reagan's proposal for a federal takeover of Medicaid clearly implied further reductions in the long-term federal commitment to maintaining a Medicaid program.²²⁹

While the first session of the 97th Congress had been eager to please the President, the second session gave a cooler reception to the President's economic and social game plan. Legislators from both sides of the aisle were quick to offer alternatives to the President's budget cuts and deficit projections.²³⁰ The first budget resolution, however, indicated that political sup-

the federal trust fund used to finance the turnback programs. See H.R. DOC. NO. 124, 97th Cong., 2d Sess. 21 (1982).

For a good analysis of this original scheme, see WASH. REP. ON MEDICINE AND HEALTH, Feb. 22, 1982 ("Perspectives").

According to Administration estimates, the bottom line figures on the original "swap" and "turnback" would be as follows:

STATE COSTS (1984)		STATE REVENUES (or savings)	
AFDC	8.1 billion	Medicaid Savings	18.3 billion
		Excise taxes	11.6 billion
		(trust fund)	
Turn back programs	30.6 billion	General Revenue	8.8 billion
		(trust fund)	
	<u>38.7 billion</u>		<u>38.7 billion</u>

These figures were cited in WASH. REP. ON MEDICINE AND HEALTH, July 19, 1982, at 1. Note that the estimate of 1984 Medicaid costs assumes virtually no program cost inflation from 1982 to 1984. See figures *supra* note 54.

While the initial "turnback" might appear to be a "break even" proposal, within five years the federal budget's share of domestic welfare would be sharply reduced and continued funding of many programs would be left to the ability of the state to impose excise taxes to support these programs.

228. Apparently, even some of Reagan's own staff were surprised by the new plan and, not unexpectedly, many of the critical elements of both the "swap" and the "turnback" were only vaguely outlined in the initial documentation. See WASH. REP. ON MEDICINE AND HEALTH, Feb. 1, 1982, at 1.

229. It appeared that Reagan was proposing a continuation of current funding levels, albeit at the limited levels suggested by his 1983 budget. The offer, however, raised several distinct possibilities relating to the future of Medicaid. Following federalization, the federal government would be likely to consolidate, in whole or in part, the administration of Medicaid and Medicare. This would give the federal administration a stronger hand in mandating cost containment by participating providers, but it also would create a greater incentive to limit overall spending for both programs. Thus, a federalized program could mean a program much more limited than the current one, assuming that a continuation of some level of fiscal effort were not made part of the bargained swap. In fact, the terms of the Medicaid "swap" were such that the actual results of the federalization of Medicaid might well parallel the original Reagan "5% cap," see *supra* note 145, limiting the federal commitment to a fixed level of effort.

230. The initial Reagan budget proposal for fiscal year 1983 sparked a series of counterproposals from both sides of the political aisle—reflecting a variety of alternative policies. In general, the size of the proposed fiscal year 1983 deficit drew the strongest criticism. But

port for the President's political course was still basically intact. Both the Senate²³¹ and the House²³² eventually adopted budgets similar to that of

while some critics would have made additional budget cuts in domestic welfare programs, others called for limitations on military spending. Still others questioned whether the nation could afford the tax reductions that had been scheduled to take effect in 1982 and 1983. For a lengthy analysis of the prevailing political climate, see *Congress and the White House Play a Waiting Game on the 1983 Budget*, 14 NAT'L J. 488 (1982). For a similar analysis of subsequent events, see *Budget Battle Erupts as Compromise Talks Fizzle*, 40 CONG. Q. 967 (1982).

The Senate Budget Committee rewrote the Reagan budget and adopted an alternative proposal for the first budget resolution. S. REP. NO. 385, 97th Cong., 2d Sess. (1982), reprinted in 128 CONG. REC. S4776 (daily ed. May 10, 1982).

The Senate proposal set slightly different spending limits for fiscal year 1983: outlays at \$779.1 billion, budget authority at \$831.7 billion, and projected revenues at \$667 billion. While this would still mean a deficit of over \$100 billion in fiscal year 1983, comparable to that contained in the President's budget proposal, the Senate report called for various additional spending reductions, including reductions in both entitlement programs and military programs, as well as a series of substantial tax increases over the following three years, a scheme which would reduce the federal deficit to \$40 billion by 1985. See S. REP. NO. 385, at 13. For a brief analysis, see *Party Conflicts Threaten 1983 Budget Plans*, 40 CONG. Q. 1091 (1982).

The House Budget Committee also proposed an alternative to the Reagan proposal. Following the President's lead, the House report called for a budget of over \$780 billion and revenues of \$677 billion, but as with the Senate, the House projected deficits that rapidly would diminish over the next three years according to a different mix of spending priorities. H.R. REP. NO. 521, 97th Cong., 2d Sess. 21 (1982).

The House committee sought to achieve this deficit reduction by larger increases in revenues, greater reductions in military spending, and only modest reductions in domestic welfare spending, see H.R. REP. NO. 521, at 31-32.

Thus, while the President, the House Budget Committee and the Senate Budget Committee all projected similar revenue and spending figures for 1983, each adopted significantly different strategies for reducing the federal budget, principally focusing on such basic and familiar issues as whether to impose tax increases (or postpone reductions), whether to fashion further domestic welfare spending limits (and whether to exempt social security and other entitlements), and whether to continue to increase military expenditures, i.e., the issues at the heart of Reagan's original blueprint. See *supra* notes 118-22.

231. On May 19, the Senate adopted S. Con. Res. 92, essentially following the Senate Budget Committee's recommendations with only slight modifications. 128 CONG. REC. S5882 (daily ed. May 21, 1982). The resolution allowed a record-breaking \$116 billion deficit in 1982, but called for modest reductions in defense outlays, substantial tax increases, and budget reductions in virtually all domestic welfare spending, except Social Security. See figures cited 128 CONG. REC. S5882-84 (daily ed. May 21, 1982). See also *The Fiscal 1983 Budget Equation: Election Plus Recession Equals Frustration*, 14 NAT'L J. 948 (1982).

For health programs, the Senate called for major budget reductions, 128 CONG. REC. S5883 (daily ed. May 21, 1982), including \$18 billion in cuts from Medicare over three years. See *supra* note 41. For a full discussion of the Senate-enacted budget and its impact on health programs, see WASH. REP. ON MEDICINE AND HEALTH, June 14, 1982 ("Perspectives"). For Medicaid, the Senate prescription was milder, but still called for \$700 million in additional budget reductions. See *id.*

232. The House deliberations followed a new variation of a familiar scenario. The final House vote came after weeks of debate and numerous floor votes. In late May, the House

the President, and the first budget resolution differed from Reagan's scheme only with regard to the terms and timing of the deficit reduction measures and, notably, by calling for substantial tax increases.²³³ None-

considered and rejected at least eight budget proposals, including three major plans, one favored by the Democratic leadership, one favored by the Republicans, and one labeled "bipartisan." For a description of these proposals, see 128 CONG. REC. H2757-88 (daily ed. May 25, 1982); see also *Fractured House Votes Down All Eight Budget Alternatives*, 40 CONG. Q. 1243 (1982).

However, the final version of the first concurrent budget resolution passed June 10 by the House, H.R. Con. Res. 352, as it had been the year earlier, was a substitute fashioned by Rep. Latta and other conservatives. 128 CONG. REC. H3400 (daily ed. June 10, 1982). As a consequence, the general terms of the House budget were similar to both the President's original proposal and to those adopted by the Senate: \$765 billion in outlays, \$800 billion in budget authority, and a deficit of almost \$100 billion. See 128 CONG. REC. H3270 (daily ed. June 8, 1982); see also analysis in *GOP Version of 1983 Budget Narrowly Approved by House*, 40 CONG. Q. 1387 (1982). Following the Senate approach, the House called for modest limits on the defense spending projected by Reagan. The House approved a continuation of the scheduled tax reductions with no additional taxes. Both Houses projected sizeable reductions in domestic welfare spending, although there were significant differences between the House and the Senate programs for spending reductions. See 128 CONG. REC. H3270-71 (daily ed. June 8, 1982); 40 CONG. Q. at 1388.

The House budget called for \$77.8 billion in spending for health programs in 1983, \$86.25 billion in 1984, and \$98.83 billion in 1985. This would require substantial budget reductions in 1983 and a total of \$21.1 billion in spending cuts over the three-year period. See 128 CONG. REC. H3271 (daily ed. June 8, 1982). See also WASH. REP. ON MEDICINE AND HEALTH, June 14, 1982 ("Perspectives").

The House reductions called for smaller Medicare reductions than those proposed by the Senate, \$3.2 billion in 1983, but larger cuts in Medicaid: \$1.3 billion in 1983, \$2.5 billion in 1984, and \$2.8 billion in 1985.

233. Following a lively but relatively short joint conference, the House adopted a compromise budget resolution, S. Con. Res. 92, 128 CONG. REC. H3748 (daily ed. June 22, 1982). The Senate adopted S. Con. Res. 92 one day later—and over one month after the supposed deadline for a first concurrent budget resolution. 128 CONG. REC. S7359 (daily ed. June 23, 1982).

The final terms of the budget resolution were a compromise, but the spending projections followed more closely those of the House, while the tax increases followed more closely those of the Senate. Overall the resolution called for outlays of \$769.8 billion, budget authority of \$822.39 billion, projected revenue of \$665.9 billion, and a budget deficit of \$103.918 billion. See H.R. REP. NO. 614, 97th Cong., 2d Sess. 19 (1982). This deficit rapidly would disappear over the three years covered by the resolution. For projected spending and revenues for the ensuing three years, see tables at 128 CONG. REC. H3728 (daily ed. June 22, 1982). See also H.R. REP. NO. 614, at 20.

Significantly, the budget called for increases in defense spending, but in terms more modest than those proposed by Reagan, a difference totalling over \$25 billion by 1985. See 128 CONG. REC. H3728 (daily ed. June 22, 1982). It also called for tax increases of over \$95 billion by 1985, including \$21 billion in fiscal year 1983, although the conference report anticipated continuing the business and personal income taxes that had been scheduled (in 1981) to begin in 1982 and 1983. See H.R. REP. NO. 614, at 21.

Thus, the congressional strategy in final form varied considerably from Reagan's proposal. The major part of the deficit reduction was to come from reductions in domestic welfare, significant increases in revenues, and modest defense spending limits.

theless, echoing the terms of the budget set one year earlier, and the President's commitment to "stay the course," the 97th Congress set austere budget goals for its second session that required significant reduction in domestic spending, particularly for social welfare programs.²³⁴ As a result, as in 1981, health and health-related programs were slated for substantial budget cuts.²³⁵ Most specifically targeted were Medicaid and Medicare.²³⁶

The Medicaid and Medicare program reductions were not considered as part of an omnibus reconciliation bill. Instead, the terms of the first budget resolution and the complexities of the congressional budget process resulted in their inclusion in a separate authorization bill that also included the new tax increases. The resulting politics had some ironic twists. The Democratic House refused to send the Senate version of the bill²³⁷ through committee or to the House floor, but instead authorized a confer-

234. The budget resolution assumed a reduction in the so-called entitlement programs of \$6.6 billion in fiscal year 1983 from the level of expenditures in 1982, exempting, at least temporarily, the Social Security program. It also assumed over \$6 billion in cuts from other domestic welfare programs, figures that must be read against the cuts established in 1981 and the prevailing rate of inflation. See H.R. REP. NO. 614, at 24-26.

The congressional budget, as did Reagan's original proposal, also optimistically assumed sizeable "management savings," including such things as the sale of federal property, elimination of administrative waste and inefficiency, a reduction of the federal work force, and other administrative changes that would save \$36.6 billion by 1985. See *Congress' "House of Cards" Budget May be Constructed on Quicksand*, 14 NAT'L J. 1120 (1982); *Congress' Budget Resolution Only a Guide to the Hard Tasks that Confront the Committees*, 14 NAT'L J. 1124, 1125 (1982).

235. While the aggregate terms of the spending reductions targeted by the first concurrent budget resolution were far less than those set in 1981, see *supra* note 157, mandating even modest budget limits in the face of expected inflation posed serious budget reductions for health and health related programs. The resolution basically followed the House bill's prescription for health programs: \$77.8 billion in 1983, \$86.2 billion in 1984, and \$98.83 billion in 1985. 128 CONG. REC. H3728-29, (daily ed. June 22, 1982). This was estimated to translate into \$5 billion in reductions from current spending levels in 1983. For a summary of program cuts, see WASH. REP. ON MEDICINE AND HEALTH, June 14, 1982, at 3.

236. The resolution specified \$4.4 billion in cuts from programs under the jurisdiction of the Senate Finance Committee, principally Medicare, and \$675 million from programs under the jurisdiction of the House Energy and Commerce Committee, principally Medicaid. See tables at 128 CONG. REC. H3729 (daily ed. June 22, 1982).

According to the conference report, these cuts were to be achieved by the authorization of minimal copayments on all Medicaid recipients, except pregnant women, children, and institutionalized elderly; elimination of Medicaid buy-in to Medicare Part B; modification of the lien provisions to cover state expenditures; and the reduction of the eligibility error rates. See H.R. REP. NO. 760, 97th Cong., 2d Sess 434-41 (1982).

237. Following the adoption of the first budget resolution, the Senate Finance Committee quickly forged a reconciliation proposal to achieve the proposed savings for Medicaid and Medicare and other entitlement programs, as well as the tax increases required by the first resolution. On June 14 the committee approved a tax increase and program reduction bill, that included program cuts of over \$17 billion, exceeding the reductions of the reconcili-

ence committee to negotiate the final bill with the Senate.²³⁸ The conference and the congressional debate followed the familiar themes of deficit reduction and government austerity. The focus, however, was on revenue increases, not program reductions, thereby placing both the President and congressional leadership in the somewhat awkward position of advocating \$100 billion in new taxes during a time of economic recession (as well as in an election year).²³⁹

ation instructions by more than \$1 billion, and including the nearly \$100 billion in new tax revenues. H.R. 4961, 97th Cong., 2d Sess. (1982).

The bulk of the reductions were to come from the Medicare program. Senate Finance projected savings of over \$13 billion in Medicare by 1985, with cuts of \$3 billion in 1983. See S. REP. NO. 494, 97th Cong., 2d Sess. 7 (1982). For a further discussion of the Medicare cuts, see *supra* note 141.

For Medicaid, Senate Finance proposed a 1983-85 reduction of \$2.2 billion. This figure is somewhat lower than what was anticipated in the first budget resolution, but was offset by the larger than expected Medicare reductions proposed by Senate Finance. See S. REP. NO. 494, at 9.

Most of the proposed Medicaid savings would come from two proposals paralleling those proposed in the first budget resolution: first, Senate Finance would eliminate federal matching payments to states that purchase Medicare Part B for elderly Medicaid patients. Second, states would be allowed to place liens on the property of Medicaid recipients in nursing homes. Senate Finance also proposed two other changes: allowing states to impose nominal copayments for Medicaid services except those provided to children and pregnant women; and requiring a reduction of the error tolerance rate allowed to states in determining eligibility. *Id.* at 35, 39. For a discussion of these changes and estimates of their impact, see WASH. REP. ON MEDICINE AND HEALTH, June 28, 1982 ("Perspectives").

H.R. 4961 was adopted by the Senate on July 23, 1982. 128 CONG. REC. S9046 (daily ed. July 23, 1982). The final version of H.R. 4961 included cuts in Medicaid adopted by the Senate Finance Committee, and followed the budgetary outlines of the Senate Finance Committee proposal, although the specific terms of the Medicare reductions were somewhat modified.

238. The House, in a strange but understandable move, decided not to debate the merits of the Senate-forged tax increase and budget cutting proposals on the floor, but to go directly to conference on the Senate bill, using only the dictates of the budget resolution as the conferee's instructions. 128 CONG. REC. H4787 (daily ed. July 28, 1982).

Thus, the House had no explicit reconciliation instructions for Medicaid, Medicare, or other health programs. However, the House Energy and Commerce Committee had previously reported a Medicaid and Medicare amendment bill. See H.R. 6877, 97th Cong., 2d Sess (1982); 128 CONG. REC. H4807 (daily ed. July 28, 1982).

The terms of this proposal included nearly \$500 million in Medicaid cuts for fiscal year 1983; closely paralleling the Senate proposals, the committee approved authorization for states to impose nominal copayments on a narrowly defined list of beneficiaries, and authorization to impose liens on institutionalized beneficiaries. In addition, it also would increase inducements for states to establish rate setting commissions; allow states to offer home health services to children who would be otherwise institutionalized; and allow states to give Medicaid to people who lose their AFDC eligibility because of stricter income standards. For a discussion, see WASH. REP. ON MEDICINE AND HEALTH, June 28, 1982, at 1.

239. Largely as a result of the \$100 billion tax increases, the conference process was held against a highly visible political background, featuring a President stumping both Congress and the public for a bill that, despite its origins in the Congress, was seen as "Reagan's

Despite these new twists, the net result for domestic spending programs during the second session of the 97th Congress was much the same as it had been a year earlier.²⁴⁰ Congress again imposed severe reductions on many programs, most notably the Medicare program that had once been included in the so-called "social safety net."²⁴¹

Relatively speaking, Medicaid fared rather well. Congress once again rejected Reagan's original proposal and opted for more moderate reductions in Medicaid. Largely because of the drastic Medicare cuts, the conferees were able to adopt Medicaid program changes projected to cut "only" \$860 million over three years and \$275 million in fiscal year 1983—even less than that mandated under the first congressional budget resolution.²⁴²

These new program changes included most of the proposals that had been originally set forth in the first budget resolution with some modifications: under the 1982 amendments (1) states are allowed to impose nominal co-payments on all Medicaid services, except ambulatory services for children, services in medical emergencies, family planning services, services to pregnant women, services to elderly patients in institutions, and services to patients in health maintenance organizations;²⁴³ (2) states are allowed to put liens on the property of permanently institutionalized Medicaid beneficiaries (unless "needed by the patient or his dependents");²⁴⁴ (3) states may deny benefits for a limited period of time to recipients who sell their property for less than actual value or may penalize recipients who sell their property within twenty-four months of entering a

proposal." For background, see *President Hawks Tax Increase as Congress Haggles Over Bill*, 40 CONG. Q. 1947 (1982).

240. The final conference report included \$98.3 billion in new taxes, \$15.17 billion in spending reductions (which with an added \$2 billion in projected management savings met the first budget's terms). H.R. REP. NO. 760, 97th Cong., 2d Sess. 464, 691 (1982).

The final version passed the Senate 52-47, 128 CONG. REC. S10946 (daily ed. Aug. 19, 1982); and the House 226-207, 128 CONG. REC. H6636 (daily ed. Aug. 19, 1982). See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (1982).

Note that the Omnibus Budget Reconciliation Act of 1982, carrying an additional \$13 billion in program changes not included in H.R. 4961, was adopted by both Houses. Pub. L. No. 97-253, 96 Stat. 763 (1982). Reflecting Reagan's original requests, most of the reductions were in domestic welfare spending programs. For further analysis, see *After A Brief Panic Over Pay, Congress Clears Bill Cutting Expenditures By \$13 Billion*, 40 CONG. Q. 2047-51 (1982).

241. Of the spending cuts, the lion's share came from Medicare program changes projected to save \$12.8 billion by 1985. See *supra* note 141.

242. See H.R. REP. NO. 760, 97th Cong., 2d Sess. 465 (1982).

243. Pub. L. No. 97-248, § 131, 96 Stat. 324, 367 (1982).

244. Pub. L. No. 97-248, § 132, 96 Stat. 324, 370 (1982).

nursing home;²⁴⁵ (4) states are required to lower their error rate for eligibility determinations to less than 3% in fiscal year 1983, although the penalties previously imposed have been revised;²⁴⁶ (5) states are prohibited from considering burial insurance as an asset in determining Medicaid eligibility;²⁴⁷ and (6) states are allowed to provide home health services to children who would otherwise be institutionalized (the so-called "Katie Beckett amendment").²⁴⁸

With these 1982 program changes, and despite another congressional stalemate over the enactment of the appropriations for fiscal year 1983,²⁴⁹ Medicaid was eventually budgeted for \$19.3 billion in fiscal year 1983,²⁵⁰ a notable \$1.7 billion increase over the federal expenditures for the previous year. This figure, however, still represents a reduction in the level of federal effort for the program of at least \$1.2 billion for fiscal year 1983 and \$1.5 billion for fiscal year 1985 under the budget projections that would have resulted if the 1981 and 1982 program cuts had not been made.²⁵¹

E. Future Options For Medicaid

In the banal parlance of Washington insiders, the Reagan Administration "hit the ground running." By playing the congressional budget and reconciliation process with unprecedented alacrity, the new Administra-

245. *Id.*

246. Pub. L. No. 97-248, § 133, 96 Stat. 324, 373 (1982).

247. Pub. L. No. 97-248, § 185, 96 Stat. 324, 406 (1982).

248. Pub. L. No. 97-248, § 134, 96 Stat. 324, 375 (1982).

249. Unable to enact appropriations bills for virtually any of the federal agencies before the expiration of the 1982 fiscal year, Congress enacted a continuing resolution in late September, nominally extending the funding for all HHS and other federal agency programs at their fiscal year 1982 level through December 17, 1982. Pub. L. No. 97-276, 96 Stat. 1186 (1982). Note, however, that the provisions of Pub. L. No. 97-276 increased funding for some health programs and mandated federal policy changes for others. *See, e.g.*, §§ 131-136. More importantly, the funding level for Medicaid established in 1982 had been supplemented in early September 1982 to add an additional \$112 million. Pub. L. No. 97-257, tit. I, ch. IX, 96 Stat. 818, 845 (1982).

250. Unable to enact appropriations bills for most of the agencies before the expiration of Pub. L. No. 97-276, Congress passed a second continuing resolution, extending fiscal year 1983 funding for the remaining agencies. The total HHS appropriation was \$61 billion. Medicaid was set at \$19.3 billion, through the end of the fiscal year, the figure that was included in the pending HHS appropriations bill, H.R. 7205, 97th Cong., 2d Sess. (1982), thus allowing for some increase in the level of Medicaid expenditures over the previous year. Pub. L. No. 97-377, tit. II, 96 Stat. 1830, 1888 (1982).

251. According to the 1983 estimates of the Congressional Budget Office, the 1981 Medicaid program cuts actually reduced federal outlays for Medicaid by \$900 million in fiscal year 1983, and by \$1 billion in fiscal year 1984. Telephone interview with Hinda Chaikind, Congressional Budget Office, (Sept. 13, 1983). These figures should be compared to the additional budget cuts enacted in 1982.

tion managed to rewrite the revenue and spending priorities of the federal government in the short course of two sessions of Congress—an impressive track record. Prior to 1982, few people would have anticipated that by 1982 federal domestic spending would be so sharply reduced and that the responsibilities of the federal government would be so drastically reshaped.

Anticipating the immediate future may be equally difficult. By the fall of 1982, President Reagan's conservation revolution no longer commanded the obedient attention of Congress. There were divisions among the ranks, even within the President's own party, and an emergence of both partisan and bipartisan efforts to reassert congressional control over the legislative agenda. As the momentum of what no longer could be called "America's New Beginning" slowed in response to increased political friction, it became unclear whether Reagan's vision of a new federal order would be carried forward through the remainder of his tenure in office.

On the other hand, it was also clear that the Reagan philosophy had not been abandoned by a large portion of the American public, at least by the time of the elections of 1982, and that the underlying conditions that spawned the Reagan philosophy had not disappeared. Thus the policies implemented by the 97th Congress seem likely to be played out, if not expanded, at least through the middle of the decade. Dominant trends, particularly the shift of responsibility from the federal to the state government for many programs and the overall limit on federal spending for domestic affairs, may be counter-balanced by a host of new political influences. But those trends have already forged permanent changes in many programs and have laid the philosophical foundation for what are likely to be further federal program changes and domestic spending reductions. Even if the political support for Reagan's domestic policies abates, other elements of Reagan's strategy, most particularly the reduction of personal and business income tax and the commitment to increased military spending, may not lose the substantial political appeal they now hold. Even a Congress less enthusiastic for domestic spending program cuts may have little choice but to continue program reductions if revenues are not available or other spending programs demand higher political priority. And, of course, the economy, the principle constraint on all spending policies, may continue to create conditions that make it unlikely that the role of the federal government in maintaining domestic programs, particularly those for social welfare, will be recast in its prior dimensions. Whether the federal budget is to be literally balanced or not, the incredible possibility of a federal deficit in excess of \$150 billion by 1983 must certainly translate into a more balanced budget, most likely at the expense of domestic

spending.²⁵²

As the 98th Congress begins its deliberations, it may find political pressure from the Reagan Administration to continue the President's course more resistable. It will, however, also find an unprecedented federal deficit, an economy which is still less than prosperous, and an American public unlikely to be receptive to either increasing income or business taxes or reducing military spending as a means to resolve their economic woes, let alone to revive spending for social welfare programs.

For the Medicaid program such conditions are likely to mean further program changes and are certain to mean federal budget reductions. Medicaid has demonstrated that it has substantial political support, principally from state and local government and from provider groups. It has survived two decades of political controversy, and while it did not escape the budget cuts of the 97th Congress, it did at least survive, and did so, relatively speaking, better than many other domestic programs. Most critically, it retained its political and legal identity as an entitlement program.

Nonetheless, the budget reductions sought by Reagan and mandated by the 97th Congress were sizable, and they are likely to be only the first two rounds of federal spending cuts. Already states will lose an accelerating percentage of their annual Medicaid budgets through 1984, and have been authorized to reduce services and eligibility, and impose a variety of service and reimbursement limiting cost controls. The underlying strategy of limiting the federal share of Medicaid is likely to continue, particularly if these cost containing measures are unable to bring total program costs within politically acceptable limits. Drastic measures, such as a fixed lid on federal financial participation, as originally proposed by Reagan, or simply a conversion of Medicaid to a block grant program, are likely to be actively considered. Simply failing to increase federal outlays each year to meet program inflation or to supplement annual appropriations, as has been done in years past, will mean *de facto* program reduction. If political and economic pressure to cut domestic spending continues, Congress, as well as the Reagan Administration, can hardly avoid focusing in even more deliberate terms on an uncontrollable welfare expenditure approaching \$25 billion per year in federal outlays. Likewise they cannot ignore the political convenience of reducing federal fiscal effort under the guise of increased federalism.

The "worst case" estimate of a 30% to 40% reduction in Medicaid financing by 1985 made earlier in this article²⁵³ is speculative, but it is not

252. *New Deficit Estimate*, 40 CONG. Q. 2226 (1982).

253. *See supra* notes 150-51.

an unrealistic possibility. Substantial budget limitations imposed on the existing Medicaid program are virtually certain to materialize.

As mentioned earlier in the article,²⁵⁴ limitations on federal Medicaid program funds were originally proposed by the Reagan Administration in a manner suggesting that the initial rounds of Medicaid funding reductions were to be followed by a conservatively-designed alternative to Medicaid, *e.g.*, a system of federally-funded vouchers to assist the Medicaid population to purchase private health insurance.²⁵⁵ There has also been a continuing discussion within the Administration of a pro-competition proposal to restructure all of health care financing, including, presumably, that portion now funded by Medicaid and Medicare.²⁵⁶

A conservatively designed alternative mechanism to finance medical care for the poor is intriguing because it holds out the possibility that the impact on Medicaid of the Reagan policies, even if played out to their fullest extent, could be mitigated if the restructuring of the program could result in either a more efficient or more equitable use of government funds, as some authorities have argued.²⁵⁷ Even critics must admit that if the conservatively-designed alternative proved to be only a limited success, a good faith attempt by the federal government to maintain a recast program would be preferable as a matter of policy to the "worst case" scenario of annual federal reductions imposed on the existing program.

But whatever its merits, a conservative restructuring of Medicaid appears unlikely. First, the prevailing politics of the New Federalism tend to make it unlikely that any new spending program will be directly formulated at the federal level, particularly a program saddled with a "welfare" image. Second, such structural reform, whether made in the name of equity or efficiency, would have to address the politically sensitive issues that have inhibited Medicaid reform in the past. The interests of providers in continuing fee for service and cost-related reimbursement mechanisms and in avoiding regulatory controls over their practice, whether in the form of "command and control" regulation or in the form of coerced competition, pose substantial political barriers to any restructuring of Medicaid or health care financing. State and local governments, however displeased as they are with reduced federal funding for Medicaid, will not easily surrender their current role in Medicaid, or the flow of federal Medicaid funds through state administrations.

254. *See supra* note 210.

255. *Id.*

256. *See, e.g.*, H.R. DOC. NO. 124, 97th Cong., 2d Sess. 3-22 (1982).

257. *See, e.g.*, C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 416-18 (1982).

The substantial political constraints that have forestalled major health care financing reform for at least two decades will likely forestall other reform proposals, whatever their merits, for at least the immediate future. While the Reagan Administration has been remarkably successful in achieving federal funding reductions, it has not yet demonstrated sufficient political acumen to warrant a prediction that these funding reductions will be carried out as part of a restructured financing scheme for either Medicaid or for health care financing in general. It should surprise no one that despite the rhetorical flourishes of the Reagan Administration, there has been remarkably little activity concerning a conservative alternative to Medicaid. There has been some activity on Reagan's pro-competition proposals for health care financing, but the concept has demonstrated no political viability unless reduced to modest, almost token, initiatives.²⁵⁸

Ironically, the only Administration reform proposal which has demonstrated any likelihood of political survival runs against both the grain of Reagan's conservative philosophy and what would appear to be the prevailing political constraints. During the early weeks of the second session of the 97th Congress, Reagan's surprising offer to federalize Medicaid as part of his "welfare swap" and domestic spending "turnback" proposals demonstrated sufficient political viability to prompt predictions that a legislative proposal would soon be submitted to Congress.²⁵⁹ While the details of the Administration's amended proposal were never fully unveiled, the gist of the Reagan plan for Medicaid would have involved a conversion of long term care services into the form of a federally-financed and state administered block grant and the federalization of both the financing and administration of "routine medical care."²⁶⁰

258. For an analysis of the competition-related Medicare amendments enacted in 1982 and a prognosis for Reagan's competition initiatives, see WASH. REP. ON MEDICINE AND HEALTH, July 19, 1982 ("Perspectives").

259. For a discussion of the original proposal, see *supra* note 227. HHS and White House representatives, the National Governor's Association, and other representatives of state and local government emerged as the negotiators in a protracted bargaining session that ran through the Fall of 1982. See WASH. REP. ON MEDICINE AND HEALTH, July 19, 1982 ("Perspectives").

260. By late July, an apparent—but undisclosed—agreement had been forged between the representatives of the states and the Reagan Administration. According to published reports, the "turnback" programs had been pared to a \$20 billion package, omitting some of the more politically popular programs. A \$20 billion trust fund would still be established for four years and phased out thereafter, as originally proposed, but the states would have less discretion during the initial four years than Reagan's original scheme allowed. In addition, the Reagan Administration agreed to finance the trust fund with general revenue funds as well as excise taxes on alcohol, telephone service, tobacco, and gasoline (but not oil profits), although it is not clear what would happen to the federal revenue funds after the four years had expired. The "swap" remained intact in its broadest outlines, but under the new agree-

If this proposal, survives the political constraints outlined above and into the 98th Congress, it would drastically revise the context in which future Medicaid funding reductions will be carried out.²⁶¹ By itself, however, it would do little to alter the basic policy dilemmas created by annual

ment only AFDC would be transferred to the states. Food stamps would remain a federal program. For a full explanation of this agreement, see WASH. REP. ON MEDICINE AND HEALTH, July 19, 1982 ("Perspectives").

The major change from the original proposal with regard to Medicaid was that the Administration would now only fully federalize the routine medical care portion of Medicaid, leaving the administration of the long term care portion of Medicaid to the states, which would receive federal block grants set at 100% of 1984 costs indexed (at an unspecified rate) thereafter for inflation.

Certain key details of the proposal that had been left unanswered in the original offer were clarified by the new agreement. With regard to services covered, all currently mandated services except family planning would be covered, as well as prescription drugs, currently an optional service. See *supra* note 30. However, the agreement indicated that more stringent durational limitation will be imposed by the federalized program on covered services, along with additional cost sharing and other cost controlling mechanisms. Most optional services would not be covered at all.

With regard to eligibility, current SSI and AFDC recipients would be covered, even in "209(b) states," see *supra* note 18, although Medicaid eligibility based on AFDC eligibility would be frozen (at the level of AFDC on an as yet unspecified date). Additional groups of children would be covered, but all other nonmandatory, categorically needy people would not be eligible under the federal program.

Long term care funding would be in the form of a block grant, but would still carry some federally imposed limits: (1) states would be required to cover SSI beneficiaries; and (2) states would have to cover a range of services including ICF, SNF, home health, mental health, and personal care.

Notwithstanding these additional details, the new agreement still left many details unspecified and failed to address several major points. It is not clear, for example, whether this agreement would include either coverage for the medically needy, or for only currently eligible medically needy. It is also unclear whether the final service and eligibility standards would be comparable to the least or greatest of the various state programs, and what would happen to states that are above or below the new federal standards. Also, the details of the cost sharing and other cost limitation measures that would be allowed to the federal government after the swap, important determinants of the program, were not specified in this agreement.

Most importantly, the new agreement made no clear commitment to a specified level of federal effort following the swap, either with regard to routine medical care or the long term care block grant. For that matter, it is not even clear whether the final federal program would be reformed or patterned after the existing program.

For a full discussion of this agreement as of July 1982, see WASH. REP. July 6, 1982, at 1-15 (newsletter of the National Health Council).

261. There are several other possibilities for a major restructuring of Medicaid that could be offered as part of a reduction in federal funding that deserve mention for their policy implications, although they are unlikely to be adopted given the current political climate.

Congress could reorient the structure of Medicaid in a more equitable way. The formula for determining the federal share of each state's cost could be modified to establish greater equity by, for example, lowering the percentage of federal funds to be made available to the wealthier states. Such a proposal was made during the first session of the 97th Congress by

funding limitations. For that matter, federalization of Medicaid may only increase the likelihood that Congress will seek additional program and funding reductions.

Whether administered or financed by federal or state government, the critical determinants for the near future of Medicaid, barring more affirmative reformation, will be the cost containing and program limitation strategies adopted by Medicaid program administrators in their attempts to stay within the limits of dwindling program funding.

III. THE IMPACT OF THE NEW FEDERALISM ON THE ADMINISTRATION OF MEDICAID PROGRAMS

Paralleling the Administration's strategy with regard to other domestic spending programs, the Reagan-inspired Medicaid changes managed to resolve the federal Medicaid dilemma created by the competing demands to continue the program and to control federal costs. It deftly shifted the focus of responsibility to state and local governments and, to a lesser extent, private providers. By avoiding any major service or eligibility cuts, except those achieved indirectly by AFDC reductions, pairing the federal spending reductions with increases in state "flexibility," and recasting Medicaid in the light of the New Federalism, Reagan and his 97th Con-

the Senate Financing Committee. The eventual 1981 legislation did establish a commission to study the problem. Pub. L. No. 97-35, § 2165, Stat. 357, 806 (1981).

At an even more basic level, although far less likely given prevailing political attitudes, Congress could also distribute the burden of Medicaid cutbacks more equitably by attempting to rationalize some of the historic contours of the welfare patchwork. Medicaid funds could be targeted for low income children. Notwithstanding the states' flexibility with regard to other eligibility requirements, states could be mandated to maintain a medically needy program, or simply to abandon all categorical requirements that now serve as a prerequisite to eligibility and create distinctions between eligibles and ineligibles that do not seem to reflect relative need. Some of the "optional categorical needy" categories, *see supra* note 18, invite this kind of reform. *See* discussion in CBO MEDICAID ANALYSIS, *supra* note 14, at 37-43.

In more general terms, the Medicaid benefit structure that is now imposed on states could be reordered to favor the more essential services—assuming that such a delineation of medical services can really be made—or, a more intriguing possibility, to insure the survival of the most essential Medicaid providers. *See infra* note 295.

Whatever the political viability of these possibilities, rationalizing an often irrational program makes considerably good sense at a time when the distribution of benefits is being reduced.

A less optimistic possibility is that the Administration, or possibly even Congress on its own initiative, might opt to implement further Medicaid program cuts by rewriting Medicaid in the form of a block grant program, perhaps the ultimate conservative reform. States could be given unfettered flexibility at the cost of receiving only a fixed federal share beyond which each state would be fully responsible for the fiscal integrity and the administration of the program.

gress succeeded where their predecessors had failed: they managed to reform federal Medicaid policy in an effective and politically acceptable manner.

In the broader sense, of course, the dilemma was hardly resolved. At best, the political logjam shifted only temporarily, relieving the immediate pressure on the Administration and on Congress, but redirecting that pressure with increased focus to the state and local level.

The context of this redirected responsibility defines in large part both the underlying implications and the immediate future for the Medicaid program. Even taken alone, the federal program funding limits and program reductions portend a monumental task for state legislators and their program administrators. They are now faced with the sobering option of either replacing substantial budget reductions with state revenue or reforming their programs to meet the new financial restraints. Further, they must exercise their new found responsibilities to meet immediate budget limits while anticipating further funding limitations in the years to come. Marginal or short term program reforms, internal cost shifting, and the other strategies of the past decades will not be enough to meet the substantial, "real dollar" cuts already mandated, let alone those that may follow. State and local government, as the federal government has done, must find an immediately effective and politically acceptable resolution of the Medicaid dilemma. Unlike the federal government, however, state and local policymakers must directly address the difficult choices inherent in Medicaid reform, a task that is both technically and administratively complicated, as well as politically sensitive no matter how that reform is sought to be achieved.

Beyond the political and technical difficulty of taking such immediate cost containing steps, this responsibility falls on the states at a time and under circumstances where they may be least able to make responsible choices. The federal budget problems have been paralleled at the state level. Revenues in most states have been stagnated for at least a decade, and the impact of the contemporary economy and the Reagan-era federal policies has only worsened the state revenue picture.²⁶² Moreover, Medicaid is only one of many programs subjected to the fiscal restraints of the New Federalism. State legislators are now faced with similar choices with regard to education, social services, highway funds, various state and local activity telescoped into block grants, and the wide array of other domestic

262. See analysis in WASH. REP. ON MEDICINE AND HEALTH, June 29, 1981 ("Perspectives"). In addition to other political and economic factors, many states have income tax laws tracked to the federal tax laws and, therefore, may lose revenues as the 1981 federal tax cuts are implemented.

programs for which they have been given increased and virtually immediate responsibility. The promise of additional flexibility and the return to a more balanced federal order are of little consolation to beleaguered state legislators who find federal aid to states reduced by \$7 billion in 1982, and by 33% by 1986,²⁶³ who hear little else but pessimistic economic forecasts, and who are beseeched by a chorus of competing interest groups, of which Medicaid providers and beneficiaries may not be the loudest or the most powerful. In this political and economic context, states will have little choice and scant opportunity to evaluate options for Medicaid reform. Attempts at Medicaid cost containment only hinted at the likely response of most states to the pressing demand to effect immediate and substantial program cost controls while they adjust to their new responsibilities.

This is not to suggest that states have no choice but to cut their Medicaid programs. In theory, at least, states have a wide range of political options. Some states might consider offsetting the loss of federal Medicaid funds by increased state funding, although this option is hardly likely given the economic and political considerations outlined above. More realistically, states could pursue a variety of cost containing measures within the existing Medicaid structure which would continue services and eligibility at levels comparable to their current programs or, at least, which would rationalize the choices inherent in limited program growth. Indeed, some of the more recent federal amendments specifically invite innovative program reform, and provide states with significant discretion in general program design and administration. The scope of this article permits only a brief review of the nature and range of these options, and the relevant political and practical considerations which make affirmative Medicaid reform unlikely.²⁶⁴

263. Following the first round of federal budget cuts, states were estimating that they would receive \$7 billion less in federal funds in 1982 than they did in 1981, and that they faced a threatened 33% drop in federal aid by 1986, figures that must be read against annual double digit inflation rates. See discussion, *State, Local Officials Assess Void Left By Budget Cuts*, 39 CONG. Q. 2047 (1982).

264. The best discussion in the literature of possible cost containing strategies for state Medicaid programs can be found in five sources:

The Urban Institute published a series of reports: J. HOLAHAN, W. SCANLON & B. SPITZ, *RESTRUCTURING FEDERAL MEDICAID CONTROLS AND INCENTIVES* (1977) [hereinafter cited as *RESTRUCTURING MEDICAID*]; J. HOLAHAN, B. SPITZ, W. POLLAK, & J. FEDER, *ALTERING MEDICAID PROVIDER REIMBURSEMENT METHODS* (1977) [hereinafter cited as *MEDICAID REIMBURSEMENT METHODS*]; J. HOLAHAN & B. STUART, *CONTROLLING MEDICAID UTILIZATION PATTERNS* (1977) [hereinafter called *MEDICAID UTILIZATION*]; B. SPITZ & J. HOLAHAN, *MODIFYING MEDICAID ELIGIBILITY AND BENEFITS* (1977) [hereinafter cited as *MEDICAID ELIGIBILITY*].

More recently, the Center for Policy Research of the National Governors' Association has published a similar analysis: B. SPITZ, G. ENGQUIST-SEIDENBERG, F. TEITELBAUM & R.

States or the administrator of a federalized program could offset a substantial portion of shrinking program funds by developing more efficient and more effective management techniques. Many authorities have accused Medicaid state agencies both of wasting program funds,²⁶⁵ and allowing provider and beneficiary abuse.²⁶⁶ The 1981 amendments once again strengthened the state's hand in sanctioning both providers and beneficiaries.²⁶⁷ Given the estimates of program funds lost to fraud and abuse, states could make substantial savings if workable programs were established for recovering losses caused by overutilization of the program, unnecessary services, and outright fraudulent activity.²⁶⁸

CURTIS, STATE GUIDE TO MEDICAID COST CONTAINMENT (1981) [hereinafter called MEDICAID COST CONTAINMENT].

265. For example, many states have apparently failed to secure reimbursement from other public and private payors that might be "first payors" for Medicaid recipients. See discussion in MEDICAID COST CONTAINMENT, *supra* note 264, at 47-50. The National Governors' Association estimated that as much as \$800 million could be collected annually in unclaimed insurance benefits and other third party sources and used to offset Medicaid program costs. *Id.* at 47.

States have also been advised by authorities that more rigorous administration of eligibility determinations could result in considerable savings. See MEDICAID COST CONTAINMENT, *supra* note 264, at 41-46. The Department of Health and Human Services has estimated that if all errors in the eligibility determination process had been eliminated in 1978, nearly \$2 billion in state and federal funds would have been saved. *Id.* at 41. Other authorities have estimated that ineligibility among medically needy recipients may run as high as 20%. See MEDICAID UTILIZATION, *supra* note 264, at 25.

States have also been frequently criticized for simply being incapable of generating sufficient and timely data concerning utilization, eligibility, and provider participation to facilitate both long term and short term management decisions. See MEDICAID COST CONTAINMENT, *supra* note 264, at 3-4. See also discussion *infra* note 282.

266. Fraud, abuse, and mismanagement have long been cited as responsible for high Medicaid program costs, and have often been the target of legislative and administrative reform. See *supra* notes 64, 86; but see *infra* note 282. For a bibliography of federal legislative investigations, see SPECIAL COMM. ON AGING, U.S. SENATE, 97TH CONG., 1ST SESS., BACKGROUND MATERIALS RELATING TO OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES: EFFORTS TO COMBAT FRAUD, WASTE, AND ABUSE 49-64 (Comm. Print 1981).

267. See *supra* note 199. In particular, states now have the authority to "lock-in" beneficiaries and "lock-out" certain providers. See MEDICAID COST CONTAINMENT, *supra* note 264, at 27-31.

268. Some estimates of the amount of program funds lost to fraud and abuse are nearly unbelievable. For example, former Senator Frank Moss estimated in 1977 that 10% of the program funds were lost to provider fraud. *Comm. on Ways and Means, Comm. on Interstate and Foreign Commerce, Subcomm. on Health, and the Subcomm. on Health and the Environment, Joint Hearings on Medicare and Medicaid Anti-Fraud and Abuse Amendments*, 95th Cong., 1st Sess. 91 (1977). In its initial annual report, the Office of Inspector General, see *supra* note 86, estimated that 24-27% of Medicaid program costs were due to fraud, abuse, and waste. HEW ANNUAL REPORT 3 (1978). Note that while authorities agree that the problem is substantial, the exact magnitude of the problem, as well as its definition, has been a source of continuing controversy. The Office of the Inspector General has admitted that

States might also develop effective cost containing strategies without substantially cutting services or eligibility by altering current reimbursement practices, particularly under the modified reimbursement principles now allowed by federal law.²⁶⁹ Any shift away from fee-for-service, cost-based reimbursement and towards more prudent purchasing among available services, holds out some promise for program cost limitations without necessarily effecting the availability of services.²⁷⁰ Furthermore, assuming

the basis for its estimates cited above were "soft." See discussion HEW ANNUAL REPORT 159 (1980). And, in fact, the bases for these estimates are little more than educated conjecture. See *id.* For "harder," albeit anecdotal, data on provider fraud and abuse, see examples cited in NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, MEDICAID FRAUD REPORT CUMULATIVE INDEX 1-9 (1982).

269. See *supra* notes 189-200.

270. Hospital reimbursement is an obvious target of such strategies. Hospitals are major recipients of the Medicaid dollar and have long been accustomed to reimbursement by both private and public payors that establish little incentive for cost consciousness. They have thus contributed significantly to inflation in Medicaid program costs. See discussion in CBO MEDICAID ANALYSIS, *supra* note 14, at 48-49.

The new federal policies adopted during the 97th Congress break away from the inherently inflationary "reasonable cost" reimbursement. See *supra* note 42. The new standards still require a relationship between reimbursement and costs, but do so in a manner that clearly expands state discretion to limit costs and encourage cost containment, options that states are virtually required to employ.

Critics have suggested numerous options: prospectively determined rate setting; exclusions of certain costs associated with expensive or unnecessary utilization; use of imputed rather than actual occupancy rates in estimating the Medicaid share of a facility's costs; or use of flat rates or fixed ceilings on reimbursement. For an extended discussion of these and other options, see MEDICAID REIMBURSEMENT METHODS, *supra* note 264, at 39-99. See also MEDICAID COST CONTAINMENT, *supra* note 264, at 13-20.

Given the historical use of reasonable cost reimbursement by both public and private providers, any variation on the so-called "prudent-buyer" theme as applied to hospital reimbursement has particular appeal if reasonably pursued and under circumstances where alternative providers are a real option.

Given the significant portion of Medicaid program costs attributable to long term care, see *infra* note 299 and *supra* note 20, there are also a number of possible approaches to limitations on nursing home reimbursement that states should give particular attention. Indeed, given the reliance of many nursing homes on Medicaid-financed patients, it is possible that such cost containing reimbursement strategies could be reasonably expected to encourage economy or efficiency without necessarily curtailing provider participation or access to necessary services. See lengthy discussion of options in MEDICAID PROVIDER REIMBURSEMENT, *supra* note 264, at 103-39; see also related discussion of utilization review mechanisms, *infra* notes 278-81.

As with hospital reimbursement, states could set a flat per diem rate, offer rates for reimbursement based on the lowest actual cost of any certified nursing home, or set a ceiling at some average industry costs. Unlike the situation with hospitals, where such mechanisms remain largely untried, there has been considerable experience in some states with such methods, with apparent success. For example, Oklahoma has set reimbursement for each category of nursing home at the 60th percentile of the cost for each identifiable cost center within an institution. For an explanation, see MEDICAID COST CONTAINMENT, *supra* note 264, at 11. States could also exclude unnecessary or inappropriate costs from individual rate

available administrative technology, such limits could be targeted only to discourage expensive or unnecessary services or to encourage more efficient utilization.²⁷¹ Some critics of the existing Medicaid program have argued that substantial cost savings could be achieved simply by better management of the reimbursement process.²⁷²

States could also undertake more ambitious reforms within the existing Medicaid structure by providing more attractive incentives for the development of prepaid health plans which would provide care to Medicaid beneficiaries. The 1981 amendments added to the incentives for the states to do so.²⁷³ Many experts have argued, some enthusiastically, that prepaid health plans or other variations on the health maintenance organization concept could provide comparable medical services to an enrolled population on a more inexpensive basis than fee for service medicine, as well as encourage preventive care, noninstitutional services, and less overutilization.²⁷⁴

Another option available for Medicaid cost containment is to expand regulatory controls over medical care resource allocation or utilization.

determinations, or simply apply existing cost reimbursement principles with more rigor and efficiency. Again, the experience in some states has been impressive. *See id.* at 10-12.

As indicated above, the peculiar relationship of the nursing home industry to Medicaid funding creates the possibility that limitations in reimbursement may not result in reduced availability of long term or institutionalized care at least in the short run. Moreover, a longer track record with such strategies in some states indicates that these methods are both workable and, arguably, effective.

Some of these same strategies could be employed in determining reimbursement for physicians and other individually performed services, and such services as prescription drugs, eye glasses, prosthetic devices, and the like. *See MEDICAID COST CONTAINMENT, supra* note 264, at 20-21. Flat fee schedules and other options for reimbursement at rates lower than actual charges have been frequently employed by states attempting to control program costs in the past. *See supra* notes 45, 62.

Lastly, as indicated earlier, some authorities have suggested that improved management practices might result in savings without further modifications of existing reimbursement principles. For a discussion of prepaid health plans, *see infra* note 274.

271. In addition to those examples explained above, other examples of "prudent purchasing" hold out promise for at least moderate program savings. The 1981 amendments, *see supra* note 198, allow states unprecedented discretion to experiment with bulk purchasing or the use of competitive bidding for high cost or high volume supplies or services, e.g., prescription drugs. *See MEDICAID COST CONTAINMENT, supra* note 264, at 50. The Congressional Budget Office has estimated that \$600 million could be saved in five years if all states relied on bulk purchasing arrangement for certain common medical supplies. *See CBO MEDICAL ANALYSIS, supra* note 14, at 47.

272. *See, e.g.,* tape-to-tape billing, "gang billing," uniform cost accounting principles, and other management techniques. *See MEDICAID COST CONTAINMENT, supra* note 264, at 9, 20.

273. *See supra* note 200.

274. For a summary of recent literature and discussion, *see* Gelder, *Bringing It All Back Home*, 1 HEALTH AND MEDICINE 9, 14 (1982); *see also* Trieger, Galblum & Riley, *HMOs:*

There is a substantial literature,²⁷⁵ subject to considerable criticism,²⁷⁶ that argues that states could contain medical care cost inflation, and thereby control Medicaid cost, by expanding "command and control" type regulatory mechanisms such as hospital rate setting, certificate of need or health planning review of resource allocation, or various utilization review programs. Alternatively, state Medicaid program administrators could adopt regulatory-type restrictions applicable only to providers that participate in the Medicaid program by conditioning reimbursement on more rigorous audits of services rendered,²⁷⁷ preadmission or concurrent screening of services,²⁷⁸ prior authorization or second opinion requirements,²⁷⁹ or a variety of other utilization review mechanisms²⁸⁰ which attempt to isolate either unnecessary or expensive services.²⁸¹

These options for program reform and for the exercise of flexibility in program administration suggest that Medicaid could be managed more ef-

Issues and Alternatives for Medicare and Medicaid, HEALTH CARE FINANCING ISSUES 4-11 (1981).

One commentator has suggested that states authorize local governments to operate networks of local clinics and hospitals. *See* Gelder, at 9. Similar organizations could be devised relying on community health centers, area health education centers, local health departments, or public hospitals and related facilities that have traditionally provided services to Medicaid beneficiaries.

275. *See generally* G. ENGQUIST-SEIDENBERG, F. TEITELBAUM & D. LYTTLE, INNOVATIONS IN CONTROLLING STATEWIDE HEALTH COSTS (1981).

276. For a discussion of both the theoretical and practical limits on "command and control" health care regulation, see C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 25-48 (1982).

277. *See, e.g.*, MEDICAID COST CONTAINMENT, *supra* note 264, at 28-30.

278. *See* MEDICAID UTILIZATION, *supra* note 264, at 82-101 for discussion of various concurrent and retroactive utilization review mechanisms.

279. For data on experience with second opinion requirements, see *supra* note 264 at 28-29.

280. *See generally* MEDICAID UTILIZATION, *supra* note 264, at 29-114. *See also* MEDICAID COST CONTAINMENT, *supra* note 264, at 33.

Nursing homes are prime targets for utilization controls. Data indicate that a substantial portion of people in nursing homes are either inappropriately placed or could be cared for in a more inexpensive setting. *See* discussion of data and various remedial programs in Knowlton, Clauser & Fatula, *Nursing Home Pre-Admission Screening: A Review of State Programs*, 3 HEALTH CARE FIN. REV. 75 (1982). *But see id.* at 86.

281. States have several options, the range of which can only be suggested here. States can choose simply to disallow reimbursement for certain unnecessary or expensive services. Alternatively, states could effectively require—by withholding reimbursement—the rendering of more efficient or economical services. For example, they could disallow reimbursements for out-patient services in emergency rooms, or require or allow community-based alternatives for people in nursing homes who can be cared for in less expensive settings.

This latter example is one of the more interesting of the options created by the 1981 amendments. Considerable discretion is now allowed to states in financing supportive and other services for people placed in the community. *See supra* notes 205-08.

ficiently, allowing a continuation of a program for medical services to the poor, even in the face of the federally imposed budget restrictions, and that these restrictions do not necessitate substantial reduction in either available services or eligibility. But whether these options offer realistic alternatives for most states, or for a federally administered program, should be viewed with a skeptical eye.

The pressure of immediate federal reductions in Medicaid funding is an unprecedented incentive for program cost containment; nonetheless, states have had political and financial incentives to reduce program costs virtually from the inception of the program; yet Medicaid costs have been almost impervious to even the most rigorously pursued cost containing strategies.²⁸²

In some measure this lack of success can be explained simply by the fact that the state of the art of Medicaid administration is unimpressive. Selective reimbursement strategies, utilization controls, health planning programs, and the like, all assume an ability to distinguish the necessary from the unnecessary, to assess the fairness or necessity of various costs, or to make various judgments about the behavior of providers and beneficiaries. Improved or more efficient management assumes what many state programs have demonstrated that they lack: sophisticated data on such elements as costs, the efficacy of services, beneficiary needs, and utilization, as well as the capability to analyze this data and implement remedial programs.

Thus while experts have argued that program savings could be achieved if the Medicaid programs were administered more efficiently and that a variety of administrative controls could achieve additional savings without reducing the program, those arguments only highlight the fact that the the

282. States have been under pressure to increase management and administrative efficiency throughout the history of the program and particularly in recent years, with little impact on program inflation. See CBO MEDICAID ANALYSIS, *supra* note 14, at 53. Many of the regulatory-type controls and administrative limits have been tried before, even under the threat of financial penalties, yet they have not been particularly rewarding. MEDICAID COST CONTAINMENT, *supra* note 264, at 24.

Highly visible items such as fraud and abuse have proven to be elusive targets. States have been encouraged (sometimes coerced) to counteract fraud for years; yet the Congressional Budget Office estimates that few fraud and abuse programs have even been self-supporting. See CBO MEDICAL ANALYSIS at 53.

"Command and control" strategies have fared little better. The PSRO programs have failed to prove cost effective. See CBO, THE IMPACT OF PSROs ON HEALTH-CARE COSTS: UPDATE OF CBO'S 1979 EVALUATION (1981).

Perhaps the general point should be added that even where examples of successful cost containment measures can be found, it is not clear that they will be successful if adopted at other times or other places.

organizational and management techniques for doing so have not been developed in many states either within the Medicaid program or in other public and private financing schemes.

Without the ability to target precisely cost containing strategies, or even to assess their impact, such strategies will be ineffective at best and may even fail to provide the proper incentives for actual program savings, or may do so by sacrificing either the quality of the services rendered, or the availability of such services to Medicaid beneficiaries.²⁸³ Fraud and abuse enforcement, however politically attractive, may prove to be a futile exercise, costing more to administer than actual program savings.²⁸⁴ Many apparently cost saving limits on Medicaid programs may prove in practice to be more expensive, either for the Medicaid program or for other state programs.²⁸⁵ Less expensive alternative services may be absorbed by unmet demand rather than reduce utilization of expensive services. Again, targeting Medicaid reform measures may exceed existing administrative capabilities.

It is universally conceded that the costs of medical care are inflated, that many services are unnecessary or inefficiently delivered, and that medical

283. Tightened reimbursement or anything comparable to prudent purchasing schemes, even assuming they can be implemented or pursued in the face of provider resistance, may be effective only in the crude sense of either eliminating the availability of existing services where prudent alternatives are not available, or causing providers to withdraw from participation for lack of incentive. Even in theoretically over-bedded areas, the Medicaid beneficiary's actual "choice" may be limited in fact to a few providers or even a single provider who may not be the most prudent alternative. Prudent purchasing also assumes that providers will be willing to compete for the Medicaid beneficiary's business, an assumption that hardly comports with the likely behavior of most individual or institutional providers. Providers offered less reimbursement may simply refuse to accept Medicaid; just as critically, less expensive providers may be reluctant to take Medicaid in the first place and may restrict additional Medicaid utilization even at the same level of reimbursement they have been receiving, rather than accept an increased Medicaid caseload.

Perhaps most critically, the "prudent buyer" of hospital services must be cognizant that the higher priced hospital may well be the facility that has been the primary source of access for hospital care for Medicaid beneficiaries, as well as the primary source for other medical services. Notwithstanding their higher costs, public hospitals have long been the mainstay of many Medicaid programs. Poorly devised prudent buyer schemes may starve already financially-troubled institutions, or force them to adopt restrictive admission practices, cutting off access to physicians, long term care, and the like.

In general terms, the basic problem of excluding unnecessary costs or expensive providers is that such schemes may be inequitable in their design, making overly simplistic comparisons between only partially comparable providers or ignoring legitimate cost differentials. Not all hospitals have the same costs. Even disaggregated by size of facility, levels of care or geographic region, substantial inequities can be created which either force institutions out of the program or create financial hardships which will eventually have the same effect.

284. See *supra* note 282.

285. See discussion of "secondary demand," *infra* note 292.

care delivery could be reformed in a variety of ways. But there seems to be little authoritative agreement on whether these excess costs can actually be isolated, or on how to devise workable programs to reduce or eliminate them, particularly in the context of existing Medicaid programs. It must also be conceded that potentially innovative programs, whatever long term advantages they may offer, are unlikely to be developed in the current political context of most state administrations where their success is measured only in terms of immediate impact.²⁸⁶

Beyond these practical and administrative constraints lies the even more intractable problem of provider participation. Any change in the terms or conditions of Medicaid reimbursement or any attempt to regulate the setting or delivery of Medicaid services to contain costs will almost certainly cause at least some providers to withdraw from the program. So long as Medicaid participation remains voluntary, which as a political matter appears to be a permanent feature of the program, the threat of provider withdrawal puts a weak link in the design of any cost containing strategy, potentially sacrificing access or freedom of choice for the elusive promise of reduced program cost, or simply forcing program administrators to tacitly avoid implementing cost containment in a rigorous manner. Particularly with regard to physicians, reluctance to participate can be easily documented, and since physicians control access to virtually every other medical service, particularly institutional services, the withdrawal of physician participation has a kind of multiplied effect on overall availability of services.

Yet the threat of withdrawal from the program is only one element of the certain resistance of providers to cost containing strategies. Providers have traditionally demonstrated substantial political clout when faced with the prospects of structural or regulatory changes in Medicaid that interfere with business as usual. Even symbolic threats to the cost-based, fee-for-service reimbursement, "freedom-of-choice," or traditional patterns of de-

286. The prospects for innovative use of prepaid group practice and other limits on provider choice are good examples.

Even in the best of times, it was not clear whether many states could foster further growth of HMOs or PHPs. Despite several years of effort, by 1981 only 55 prepaid health plan Medicaid contracts had been let in 17 states. Trieger, Galblum & Riley, *supra* note 274, at 1. And administration of these contracts had a long and controversial history. See MEDICAID REIMBURSEMENT METHODS, *supra* note 264, at 170. Particularly in the context of the existing pressures on state agencies and legislators, only a foolhardy gambler would assume that short term program savings could be achieved where there had not been prior groundwork or experience for such efforts, or that such contracts could be administered properly, however attractive such arrangements might be as a long term option.

livery will evoke the political wrath that has forestalled many state and federal efforts to reform Medicaid in the past.

Viewed realistically, most state program policymakers will find that the only solution to the immediate dilemma posed by Medicaid that is acceptable to providers, feasible from a political and pragmatic point of view, and certain to meet federal financial constraints is a reduction in the overall size of their program by limiting program coverage, cutting eligibility, or adopting restrictive reimbursement policies which will effectively curtail the scope of their programs and, consequently, the availability of medical services to the poor. The lessons of the last two decades dictate that the same political and programmatic constraints that have forestalled reform of the program and stymied aggressive attempts at improved administration of Medicaid will once again make it difficult to affirmatively reform or control the program as a means of reducing its growing cost. Particularly given the magnitude of the cost savings that have now been mandated and those that must be anticipated, and the almost monumental competing demands for state legislative and administrative attention, few states can be predicted to rely on affirmative program reforms to achieve the immediate, "big dollar" savings now required.

These Medicaid program reductions may be fashioned in several ways. Given the recent federal changes, the states have considerable flexibility in limiting program eligibility.²⁸⁷ Such options, holding aside the impact on program beneficiaries, have several advantages that many states either cannot or will not overlook. Unlike other affirmative techniques for controlling program costs, which may be both complicated in their design and uncertain in their result, eligibility reductions have the potential for immediate and administratively workable "big dollar" savings. Eligibility reductions may also meet with less provider resistance since providers, or at least those that are free to choose whom they serve,²⁸⁸ will focus most of their concern on avoiding cuts in reimbursement levels for covered eligibles and administrative controls over their utilization. Even aside

287. Federal law now allows states to limit or modify medically needy eligibility in many ways, including the option exercised by many states in the past of not maintaining a program for the medically needy at all. Similar discretion is allowed for other categories. *See supra* notes 18, 184-86.

States also have considerable discretion, although it is somewhat constrained by federal law, with regard to mandatory eligibles. By raising income or resources standards for AFDC, or imposing other allowable eligibility requirements on AFDC or Medicaid, states can significantly limit or reduce the number of categorically needy recipients.

For a broader discussion of possible eligibility restrictions that states can impose, see MEDICAID ELIGIBILITY, *supra* note 264, at 5-23.

288. *See infra* notes 294-95.

from their actual impact, eligibility reductions also have a certain amount of political appeal at a time when "welfare fraud" and "malingerers" seem to be popular scapegoats for our economic troubles.

Almost equally appealing, when viewed apart from the actual impact on program beneficiaries, are the various options for limiting or eliminating coverage of services,²⁸⁹ or imposing cost-sharing requirements²⁹⁰ which are also strategies encouraged by the federal program changes that accompanied recent funding limitations. As noted below, while the long term impact of eligibility or service reductions may not actually result in program savings, simply lining out certain items in the Medicaid budget must be a tempting short-term cost-saving option for program administrators and their legislative counterparts under their present, harried circumstances.

But while service and eligibility reductions may be the policy of choice for the most pragmatic or hard pressed state when expressed in budgetary terms, if stated in terms of the effects on its citizenry, a state can hardly afford such measures. In most states, further reduction in Medicaid services or eligibility would belie any claim to the maintenance of a program for the medical needs of the poor, the ostensible intent of Medicaid. Despite the rhetorical implications of "optional" services and "optional" eligibility, there are few people who can be cut from existing Medicaid programs and few currently covered services that program recipients can go without, except at a cost of considerable human suffering.²⁹¹ Moreover, whatever the human implications of such policies, the economics may not

289. See generally MEDICAID ELIGIBILITY, *supra* note 264, at 41-83 for discussion of various options now available to states.

290. States are now authorized to rely more heavily on cost-sharing as a means to contain the costs of Medicaid. See *supra* note 243. And cost-sharing has a certain amount of appeal, both from a conservative political perspective, as well as from an aggregate statistical view. Available evidence indicates that it does reduce cost, principally by reducing utilization. See MEDICAID UTILIZATION, *supra* note 264, at 1-27.

The CBO has even gone so far as to estimate that \$4.6 billion savings on the federal share of Medicaid could be achieved by imposing an across-the-board 5% copayment on physician services and making Medicaid recipients responsible for one half of the cost of the first day of hospitalization. See CBO MEDICAID ANALYSIS, *supra* note 14, at 44.

Conservatives would argue, of course, that cost sharing cuts utilization, but does so selectively, causing the beneficiary to exercise restraint in utilizing services. It must be noted that the permissible forms of cost-sharing do effect only "first dollar" and not "last dollar" liability—spreading the inequity of its impact, even if it does not necessarily select out unneeded services. On the other hand, cost-sharing limits on "first dollar" coverage have a greater impact on initial access to services, a key issue in gauging Medicaid's overall effectiveness.

291. Some of the most disabling reductions in services are tossed out almost euphemistically in public debates (e.g., elimination of prescription drugs, prosthetic devices, dental care), but such "optional services" are rarely discussed in terms reflecting or even predicting actual human impact. Except with regard to a very narrowly defined range or marginally

be much better. The irony of such reductions is that the necessity of the services eliminated will often stimulate immediate secondary demand for other services, or eventually produce demand for other and most likely more expensive, services as the untreated condition grows worse in the long run, thus defeating the cost saving purpose of some reductions.²⁹² Eligibility reductions can have the same result. As medically needy recipients or recipients from other "optional" categories are denied eligibility, they may choose, or be forced, to give up jobs or other sources of income and regain eligibility as mandatory eligibles. Only the most draconian service or eligibility cuts can be sure to achieve lasting program savings, because only such measures can be certain to produce the continuing disability, endured suffering, or the loss of life that would reflect both an immediate and lasting reduction in utilization of Medicaid and thereby reduce Medicaid costs by significant amounts.

Perhaps further articulation of this human impact would only belabor

necessary services, it is hard to imagine anyone needing the services covered by Medicaid "opting" to forego them. See analysis in MEDICAID ELIGIBILITY, *supra* note 264, at 59.

292. There is virtually no hard data on such phenomena as "secondary demand," reflecting again the difficulty of devising Medicaid cost containment strategies within current administrative technology. Intuitively, however, strong arguments can be made that elimination of necessary services will result only in increased utilization of other covered services. Thus, for example, where physician services are not covered or are unavailable, high cost emergency room services will be demanded. Or when long term care or home health care are eliminated, beneficiaries may eventually demand higher level institutional care—eventually costing more Medicaid dollars. Or, more simply, Medicaid beneficiaries denied access to medical care on a periodic basis or at initial stages of medical need will develop more severe problems involving more and more costly medical care as the condition progresses. The crucial point simply may be that the actual effect on utilization of reimbursement decreases (or increases) or service limitations is difficult to predict and confounded by many variables.

The ironic and sobering implication of this analysis would be that in order for service cuts to be effective, they must be substantial enough to eliminate any treatment of a particular type of condition or medical need. Reductions that only eliminate unnecessary or more expensive services, as discussed earlier, or other fine-tuned limits on Medicaid utilization are attractive options, but they cannot always reasonably be expected to have immediate and substantial budgetary impact.

The same analysis can be made of some eligibility reductions. Many of the so-called optional beneficiaries once eliminated from Medicaid eligibility will rather quickly reappear on Medicaid rolls or, at least, become eligible for other state programs. Eliminated "medically needy" recipients may prefer to give up low paying jobs and return to welfare eligibility to become "categorically needy," particularly those with great medical needs. The same would be true of people eliminated from the mandatory eligible population by changes in the income or resource standards for Medicaid or AFDC. People who rely on Medicaid to survive will forego jobs or other sources of income to drop back into Medicaid eligibility or spend off resources. Also, many residents of nursing homes or recipients of home services if denied eligibility would eventually be forced into public rest homes or mental health institutions, at full state expense.

what should be obvious, but at least several additional points deserve attention if the real price of implementing federal Medicaid budget reductions is to be fully appreciated.

First of all, as this article is designed to emphasize, this human price must be viewed as only one part of the cumulative impact of the Reagan-era domestic budget reductions.²⁹³ The impact of Medicaid cost containment strategies implemented as they likely will be, will fall on the shoulders of a population which is being asked to bear a disproportionate burden of our national belt-tightening by also absorbing reductions in the funding for income maintenance, food stamps, public housing, social services, and the variety of other programs no longer viewed as the necessary fabric of our social safety net. Even isolating only the effects of the budget cuts on programs effecting the availability of medical care, the cumulative

293. As some indication of this impact, about 70% of the \$35-40 billion budget cuts mandated in the first session of the 97th Congress were from programs directly or indirectly benefiting low income people. *Millions of Poor Face Losses Oct. 1 As Reconciliation Bill Spending Cuts Go Into Effect*, 39 CONG. Q. 1833 (1982). Over 700,000 families were estimated to lose AFDC eligibility in the first year alone and over one million lost food stamps. *Id.* To this must be added the cumulative burden of cuts in unemployment benefits, education assistance, job training, low income housing support, and nutrition programs.

The reductions in outlays for fiscal year 1983 for various programs affecting the poor as a result of 1981 budget cuts were estimated by the CBO to be:

Social Security retirement	\$2.7 billion
Social Security disability	250 million
Railroad retirement	100 million
Civil Service retirement	400 million
Military retirement	270 million
Trade adjustment benefits	360 million
Low income energy assistance	300 million
Student Loans	1.02 billion
Low income housing	330 million
Medicare	1.02 billion
Medicaid	1.02 billion
Unemployment	4.6 billion
AFDC	860 million
Food Stamps	2.08 billion
Child Nutrition	2.6 billion
Veterans benefits	100 million
Pell Grants	490 million

Telephone Interview with Patricia Ruggles, Congressional Budget Office (June 11, 1982) (documenting data used in CBO, EFFECTS OF TAX AND BENEFIT REDUCTIONS ENACTED IN 1981 FOR HOUSEHOLDS IN DIFFERENT INCOME CATEGORIES (1982)).

By way of comparison, the same study estimated that the personal income tax reductions enacted in 1981 would reduce revenues by over \$82 billion and would be distributed in such a way as to have the greatest impact on middle and upper income people.

To these figures must be added the results of the 1982 domestic spending reductions and those which will follow.

effect can only be described in degrees of inequity. The New Federalism with comparable dispatch has undermined the financial support of community clinics, rural and migrant centers, public clinics and hospitals, and other providers who are the major components of the fragile infrastructure of the Medicaid provider network, without which the program, even if it were to receive continued funding, would likely fail.²⁹⁴

More crucially, eligibility and particularly service reductions, explicit or *de facto*, fall not just on a population of the poor, but selectively on certain people within that population who may well be least able, in the most literal sense, to fend for themselves without assistance. Notwithstanding our preference for aggregate statistics and for expressing Medicaid cuts in terms of dollars saved, it must be acknowledged that these reductions can also be defined by the few who are or would be recipients of the services no longer available—the elderly or mentally retarded person in an intermediate care facility, the child in need of continued rehabilitation, the adult with needs for hospitalization beyond durational limits. These are people who might well be called the truly needy had not the term been given a different political meaning. These are the people who will pay the price for the federally-mandated program reductions and for cost containment strategies that simply reduce the program's coverage.

At this time, more specific predictions of the states' Medicaid cost containment strategies would be speculative.²⁹⁵ As indicated earlier, some states will opt to fashion affirmative Medicaid reforms which may mitigate the impact of funding reductions. Moreover, the full impact will be felt only when the annual percentage reductions already enacted are implemented and Congress, in response to whatever economic and political influences lie ahead, either modifies or stays the course of current federal policy. But while specific predictions are impossible, the likely thrust of

294. Medicaid cuts fall hardest on providers such as public hospitals, clinics, and specialty programs that serve a high proportion of Medicaid patients. Reductions or limitations in levels or reimbursement affect these providers more than other providers since they typically have higher institutional costs than other facilities and serve more public beneficiaries. Thus, while they constitute a crucial part of the Medicaid provider infrastructure, many states, under pressure from federal budget reductions, will adopt reimbursement policies that starve them financially. And while Medicaid limits reimbursement, the stagnating tax basis of state and local government will restrict the ability of state or local governments to offset Medicaid losses with other funds. Indeed, the survival of public hospitals and clinics under the economic and political pressures created by New Federalism will be one of the crucial determinants of the future of the Medicaid program.

295. For the best available summary of various state cost containment strategies currently being implemented, see GEORGE WASHINGTON UNIVERSITY, NATIONAL GOVERNORS' ASSOCIATION, RECENT AND PROPOSED CHANGES IN STATE MEDICAID PROGRAMS: A FIFTY STATE SURVEY (1982).

federal policy, and therefore, the states' reactions to it, are rather clear. The delayed effect of implementing cuts and of phasing in reductions, the immediate opportunity of short term marginal savings, and the year or so of delay before program deficits become all too clear, may create a political complacency suggesting that the cost of the current federal policies is not as bad as once predicted; but is unlikely to be felt as such by those who will really pay.

IV. CONCLUSION

The Medicaid program can be easily criticized. It has never been an adequate program of medical care for the poor, by design or by administration. Even for the fraction of the poor who are covered beneficiaries, Medicaid eligibility assures neither access to available medical service nor treatment of all their medical needs. Medicaid is lacking in any cognizable underlying philosophy, frustrating even for those providers willing to participate, and increasingly costly, from anyone's perspective, but particularly from the perspective of the state or federal legislator.

Medicaid's deficiencies can be traced directly to its political origins. It was originally formed and has been sustained as much by the political support of state and local governments and by the economic interests of providers as by any genuine interest in providing for the medical needs of the poor. Therein lies the fundamental dilemma of the Medicaid program or, for that matter, any program which will bear a political resemblance to welfare medicine. The true basis for its political support also insures severe political constraints on both its improvement and its reform. Particularly when reform measures are directed at controlling costs, available solutions are quickly pared away, leaving only program reductions inflicted on the largely disenfranchised Medicaid population as the only politically acceptable solutions.

The Reagan Administration, even at the height of its political strength, opted to follow this more acceptable course rather than to tackle directly either Medicaid's growing cost or other deficiencies. In doing so, however, the Administration merely shifted the responsibility for resolving Medicaid's problems to state and local officials. And by doing so at a time when states will have little opportunity to exercise their newly granted flexibility and shrinking resources with which to administer all of their new domestic burdens, the Administration virtually mandated that the states follow the course of least political resistance and not address the real issues inherent in Medicaid reform.

The principal cause of Medicaid cost inflation, at least in the last decade,

has been inflation in the cost of medical care services in general.²⁹⁶ Medicaid inflation has not been caused by an expanding Medicaid population; the Medicaid population has remained relatively stable for the last several years and may even have declined.²⁹⁷ It has not been a result of a marked increase in utilization of Medicaid covered services,²⁹⁸ with the notable exception of the expansion of the use of institutionally-based long term care services.²⁹⁹ The Medicaid budget has expanded and continues to expand primarily because the price of medical care has inflated unchecked and, under current public policy, will continue to do so. There are also continued allegations of a certain amount of fraud in the program, some evidence of over-utilization and inefficiency, and rather obvious structural and administrative deficiencies. These factors also contribute to Medicaid's cost, as well as to its inadequacy and lack of effectiveness. All of these problems cry out for reform; yet none can serve as justification for the kind of program eligibility or service reductions that seem to be the inevitable result of the federal and state policy choices now being made.

From a policy point of view, we would be better served, both in the short and the long term, to direct both federal and state attention to the identified causes of Medicaid's shortcomings. In particular, the cost of medical care is not only a problem for Medicaid policymakers, it looms as a major policy issue for the Reagan Administration and for state governments on a variety of fronts, ranging from the overall impact of medical care inflation on the economy in general to the impact of that inflation on Medicare, government employee health benefit programs, and the range of health-related programs effected by medical care prices. A federal policy which was realistically designed to mitigate the impact of medical care price inflation would be far more sensible, just as a federal Medicaid policy targeted with a reasonable expectation of success in isolating and eliminating the other causes of Medicaid costs outlined above would be far more realistic and, at the same time, more sensitive to real human needs. If the cost of medical care inflation had been addressed concurrently with or,

296. Medicaid has not even been an inflating part of our collective efforts, remaining relatively constant at 3% of both state and federal budgets during the last decade. See Davis and Schoen, *supra* note 10, at 57.

297. See *supra* note 17.

298. See CBO MEDICAID ANALYSIS, *supra* note 14, at 24. In fact, Medicaid costs per recipient seem to be inflating less rapidly than per capita health care expenditures.

299. *Id.* Special attention should be given to the increased utilization of nursing home services by the Medicaid population. Finding a better or cheaper way to provide long term care to the aging or disabled could have a major impact on Medicaid costs. However, as this article has indicated, resolution of the broader social problems, of which Medicaid long term care policy is only one part, is unlikely in the present political climate.

preferably, prior to the Reagan reforms of Medicaid, many of the difficulties with administering effective Medicaid cost containment strategies could be more manageable. More importantly, many of the less attractive service and eligibility reductions might not be necessary at all. At the least, a conservative federal Medicaid policy implemented under circumstances which gave states a more realistic opportunity to exercise their newly created discretion would be easier to accept as reasonable and coherent public policy.

It should be noted that the rhetoric of the President's original call to the nation for a program of economic recovery and his continuous reaffirmation of that commitment have always promised us just that: sensible but sensitive national policy. We have been told that a period of national belt-tightening would be required, but that programs for the truly needy would not be sacrificed. We have been told that federal spending limitations would be paired with an increase in state and local discretion, but that the resulting budget reductions could be largely absorbed through more efficient and flexible program administration and not by reductions in necessary benefits.

Yet the realities of the President's proposals as applied to Medicaid by Congress, and as likely to be implemented by state legislatures, deny the veracity of such a predicted scenario. Despite the fact that most federal and state policy makers have rather steadfastly refused either to predict or to monitor the real impact of Medicaid program reductions, that impact can no longer be denied or obscured by euphemistic rhetoric. The emerging truth is that the Medicaid program and its beneficiaries are being largely neglected. Perhaps this kind of impact is exactly what is intended, though not articulated; perhaps the formulators of domestic social policy have tacitly agreed that the new conservative America has no necessary role for such programs as Medicaid. The next few years will give us ample opportunity to clarify such political assessments.

Whatever the real intent of Medicaid policy, it must at least be admitted that such policy has not been and will not be compelled by our economic circumstances. We could tolerate and afford an adequate program providing medical benefits to the nation's poor. Medicaid, no doubt, has been expensive; but the nation's Medicaid cost problem is a self-imposed crisis. At a time when taxes are reduced and expenditures for some programs raised, the pretense that a continued Medicaid program is unaffordable is a sad commentary on prevailing political ideology. The direction of our future public policy will be a political choice, not an economic necessity. If our current conservative leanings cannot tolerate a program that does little

more than provide a last resort for only some of the nation's medically needy, it is difficult to believe that such a political philosophy really reflects the character of a majority of the nation's electorate.

