THE POLICY PAGE

An update on state and federal action from

The Center for Public Policy Priorities

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MORE KEY MEDICAID AND HEALTH ISSUES IN SENATE & HOUSE BUDGET BILLS

This Policy Page provides additional updated information on House and Senate budget proposals to add to the information included in PP #52 of 7/9/97. Negotiations are underway, and a compromise bill is sought before the August 2 break. Readers wishing to comment on these provisions should do so promptly!

Child Health Proposals

(see PP #52, 7/9/97 for additional detail)

- Senate would spend $24 billion over 5 years ($8 billion of this from cigarette tax hike); House would spend $16 billion over 5 years.

- Senate bill requires states to spend this money on actual health coverage for children (i.e., either Medicaid or Blue Cross-style health insurance); House bill allows states to use funds for direct services, making it possible for states to use substantial portions of the block grant to replace Medicaid Disproportionate Share Hospital payment cuts that were used in the state budget to fund state mental hospitals, teaching hospitals, etc. This type of "supplantation" is a very real possibility in Texas given current state budget pressures and the recent choice to give away $1 billion in property tax relief. **The Center estimates that less than one-third of the "surplus" of the new TANF (welfare) Block Grant was dedicated by the Texas Legislature to creation of new welfare-to work programs in the 1998-1999 state budget.** The rest was used to "re-finance" existing state health and human service activities or fill other budget gaps. If the House version of these federal Child Health provisions is adopted, the new Child Health Block Grant is likely to get similar treatment. The Texas Legislature is likely to once again feel pressured to use a substantial portion of the funds to fill in gaps in the state budget, rather than for direct insurance or Medicaid coverage of uninsured Texas children.

New Details Not Included in PP #52:

- Senate bill would allow states to provide coverage of Legal Immigrant children with these funds; House bill would require 5-year "freeze-out" for children arriving in U.S. after 8/22/96.

- Senate bill caps administrative costs at 10% in first year, dropping to 5% by fourth year; House bill allows up to 15% spending on administration and "general initiatives to improve children's health."

- House bill would allow states expanding children's Medicaid coverage to cap the number of children added to the rolls and use waiting lists, i.e., the expanded coverage would not be an entitlement.

Key Conferees:

House: Archer (R-TX); Armey (R-TX); Bilirakis (R-FL); Bliley (R-VA); **DeLay (R-TX);** Hastert (R-IL); Hobson (R-OH); Kasich (R-OH); Rangel (D-NY); Thomas (R-CA)

Senate: Domenici (R-NM); **Gramm (R-TX);** Lott (R-MS); Moynihan (D-NY); Roth (R-DE)

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SSI for Legal Immigrants

- Senate bill continues eligibility for old age and disability poverty benefits for those immigrants enrolled as of 8/22/96 AND for those present in the U.S. on that date, but who become disabled after that date. House bill covers only those immigrants enrolled as of 8/22/96.

Major Medicaid Policy Changes

(see PP#52 for discussion of Medicaid DSH cut proposals)

General:

- Neither bill would restore Medicaid eligibility for children being terminated from SSI coverage due to more restrictive disability standards imposed under the 1996 Federal Welfare Act.

- Both bills **repeal** the "Boren amendment," which in current law requires state Medicaid programs to pay nursing homes and hospitals rates "reasonable and adequate" to meet the cost of "efficiently and economically operated" facilities.

- Both bills would allow privatization of the Medicaid eligibility function, to allow Texas to pursue an integrated eligibility and enrollment privatization project like TIES.

- Both bills call for a USDHHS **study** of the EPSDT benefits package (called Texas Health Steps in Texas) for children.

- Both bills would create criminal penalties for attorneys who assist persons in sheltering their assets and still becoming eligible for Medicaid (e.g., to get Medicaid-home care).

- Both bills would increase assistance to low-income persons with Medicare out-of-pocket expenses. **House** version would raise the income limit for "Qualified Medicare Beneficiaries" (QMBs), for whom Medicaid pays the Medicare Part B premium, from the current 120% FPL to 135% FPL. It would also have Medicaid pick up the cost of the new **increase** in Medicare Part B premiums (increase is due to "moving" home health from Part A to Part B) for persons up to 175% FPL. The Senate bill would give states a temporary 5-year block grant to pay Part B premiums for persons up to 150% FPL.

- Both bills allow states to offer 12 months continuous eligibility to children through age 19, even if their family income changes during that period.

- The Senate bill would allow persons with disabilities whose income is under 250% FPL (who meet SSI disability standards) to "buy in" to Medicaid.

- The Senate bill would create new guidelines allowing states to impose cost-sharing requirements for Medicaid enrollees with incomes above 100% of the federal poverty level (FPL). Cost-sharing would be capped at 3% of gross monthly income (minus workers' child care costs) for persons between 100-150% FPL, and at 5% of gross monthly income for those from 150-200% FPL. Children with family income under 150% FPL would be exempt from cost-sharing.

Medicaid Managed Care

- Both versions **repeal** the "75/25" rule that now requires that HMOs serving Medicaid clients must have at least 25% non-Medicaid enrollment.

- Both bills allow states to mandate Medicaid managed care participation *for certain populations* (see next bullet) without requesting a federal waiver.

- However, both bills **continue** to require federal waiver approval before states may mandate Medicaid Managed Care enrollment for (1) children on SSI, in Foster care, or in other out-of-home placements; (2) persons dually-eligible for Medicaid and Medicare; or (3) American Indians.

- Both bills would continue to require that persons mandated into Medicaid Managed Care be offered a choice between plans, except in rural areas.

- Both bills require that Medicaid Managed Care enrollment brokers who contract with states be completely independent of any health care provider or health plan.

- Both bills allow states to "lock" enrollees into a health plan for a period of time (6 months House, 12 months Senate), unless the enrollee has good cause (not fully defined) to change plans.

- The Senate bill would require states to allow and assist enrollees in changing plans for up to 90 days after a default assignment to a managed care plan.

- Though both bills include significant requirements for marketing to Medicaid enrollees; the Senate version contains a substantially more comprehensive package of consumer protections, including provisions for children with special health care needs, access to specialty treatment, and mandatory ombudsman programs that would also monitor the performance of managed care plans. The Senate bill also includes a far more comprehensive set of requirements for state quality assurance operations in Medicaid Managed Care.

- The House bill includes provisions guaranteeing the right to self-refer for OB-Gyn care, and a prohibition on "gag rules" that prevent health care providers from informing enrollees about all treatment options.

- **Both bills include a provision that would automatically deem any managed care plan that meets Medicare standards, or has National Council for Quality Assurance (NCQA) or other (undefined) non-profit private accreditation to be in compliance with all quality assurance standards. National health advocacy groups object to this provision on the grounds that such accreditation is not an adequate substitute for federal and state oversight.**

Note: *Families USA has posted a detailed side-by side analysis of Medicaid Managed Care provisions in the budget bills at:*

http://epn.org/families/managesb.html

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