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An update on federal action from

The Center for Public Policy Priorities

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Senate and House Bills Abolish Medicaid as We Know It

Timetable

Senate Finance and House Commerce committee proposals to repeal Title XIX, the Medicaid Program, and replace it with the "Medigrant" block grant program are expected to be voted on **this week** (probably Thursday, Oct. 25th) in both houses of Congress. Unlike Medicare and Welfare proposals, the Medicaid repeal will **not** be voted on separately. Instead, the committee Medicaid proposals will be rolled into **single votes in each house** on the massive Omnibus Budget Reconciliation Act (OBRA). In the Senate, Democrats are expected to offer a floor amendment to reduce the Medicaid cuts from the $182-185 billion in Republican proposals to $62 million. The Democratic plan would preserve Medicaid eligibility under current law, but would cap the growth in spending per recipient. This amendment is not expected to pass. After both houses have voted, a conference committee will hammer out a House-Senate compromise bill to send to the President. Most observers are predicting that the President will veto the bill, and that there will not be enough votes for a Republican override of the veto. Congress will then draft a revised OBRA with enough changes to win a Presidential signature.

Medicaid Impact: The Big Picture.

Though the Senate proposal preserves more protections for the poor, **the repeal of Medicaid would eliminate entitlement (guaranteed eligibility) to Medicaid for tens of millions of poor Americans under either bill**. The House version eliminates entitlement for **all 37 million recipients**, while the Senate bill would preserve coverage for about half of those enrolled. State governments would be given a fixed amount of money which would not necessarily increase at the same rate as demand for indigent health care. **Texas government would make sweeping decisions regarding who is eligible for Medicaid, and what benefits they can get.** The table below compares **major** provisions of the two bills.

Comparison of House Commerce and Senate Finance Medicaid Proposals

Note: changes in these provisions may have occurred since press time, as the bills are modified for floor votes in each house.

Provision	House Bill	Senate Bill
Guaranteed Eligibility (entitlement)	• No group guaranteed Medicaid coverage, regardless of income or disability. • Each state would set its own eligibility standards. • Maximum allowable income eligibility cap: 300% federal poverty level (FPL). • States may not limit eligibility or coverage in any way based on a pre-existing condition, nor may they allow their contractors (e.g., HMOs, etc.) to do so.	Eligibility Guaranteed for: • Children under 100% of federal poverty level (FPL) up to age 12; • Pregnant women under 100% FPL. • Some coverage of disabled persons required, but each state gets to decide what constitutes disability and set income cap. • Any additional eligibility groups to be set by each state. • Maximum allowable income eligibility cap: 250% FPL.
Benefits	• Children's immunizations (as set by state health dept.) are the only required benefit. • Bill includes list of benefits for which Medigrant funds may (at state option) be used; this includes several which currently require waiver (see Waivers, below). • Each state would define benefits.	Same as House, **except** includes 2 required services**:** • Children's immunizations (as set by state health dept.), and • Pre-pregnancy family planning services.

Provision	House Bill	Senate Bill
Spending Rules (Including Maintenance of Effort, or "Set-Aside" provisions)	States must (at minimum) allocate shares of their "Medigrant" spending according to a formula linked to 85% of each state's average spending from 1992-1994 on each of 4 groups: • low-income families (must include child or pregnant woman) • low-income elderly • low-income disabled • elderly receiving assistance with Medicare premiums only. This formula **doesn't count any spending on clients whose eligibility was optional under current federal Medicaid law**, or on benefits that were optional under federal law. The sole exception is a major one; **all** elderly in nursing homes are counted, even if their coverage was optional. This is **not** an actual floor on spending. Only the **relative shares** of spending, and **not the total amount** is mandated. States are also given the option to discontinue Medicaid completely, with 90 days public notice.	Similar to House Formula, but: • Uses 1995 spending as base year • Unlike House version, Senate bill sets actual minimum spending floors, not just percentages of spending, for each group. • States may NOT use Medigrant funds to replace current state public health spending. • 1% of funds must be set aside for payments to Federal Community, Migrant, and Homeless Health centers, and Rural Health Clinics.
Nursing Home Standards	• Repeals all Current Standards; • Allows each state to set own standards, requires that state standards cover specific topics, but no minimum standards. • retains spousal impoverishment standards in current federal law (protections that allow spouse of Medicaid client in nursing home to retain some income and assets).	Same as House.
Children	• the EPSDT program of check-ups and comprehensive care for children is abolished, including guarantees of medically necessary coverage. • Only special service required for children is immunization coverage.	Same as House
Out-of-Pocket Costs	• "Nominal" (term is not defined in bill) co-payments, co-insurance, and deductibles (no premiums) may be applied to families under 100% FPL. • Premiums, co-insurance, co-payments, and deductibles would ALL be allowable for the elderly and the disabled, for ALL services. • Higher co-pays for inappropriate ER use, sliding scale cost-sharing, and "incentive" cost-sharing allowed.	Same as House
Provider Reimbursement	• "Boren Amendment" (requiring payments related to reasonable cost for hospitals and nursing homes) repealed. • Cost-based reimbursement for Federal Community, Migrant, and Homeless Health Centers and Rural Health Clinics repealed. • Disproportionate Share Hospital (DSH) payments no longer required. • State plan must describe how patients of DSH hospitals and Federal Health Centers will be served. • Some level of urban-rural payment parity required.	• "Boren Amendment" (requiring state payments related to reasonable cost for hospitals and nursing homes) repealed • Retroactive "Boren" lawsuits prohibited. • Cost-based reimbursement for Federal Community, Migrant, and Homeless Health Centers and Rural Health Clinics repealed. • Current DSH replaced by smaller program using federal funds only and targeted to only those hospitals with the highest percentage of Medicaid and uninsured patients

Provision	House Bill	Senate Bill
Basic Medicaid Principles	• States are no longer required to ensure equal access to the program statewide. • States may provide different levels of benefits to different groups. • States may limit client choice of provider in any way.	Same as House.
Legal Rights of Clients	• No federal suits allowed based on state's failure to comply with this law or the state's Medigrant state plan. • Past judicial and administrative decisions under Medicaid do not apply to Medigrant.	• No federal suits allowed based on state's failure to comply with the state's Medigrant state plan.
Managed Care	• Because states may limit client choice of provider in any way, no waiver needed for Managed Care. No choice among HMOs required, as under current federal Medicaid law. Also eliminates current prohibition against HMOs that serve only Medicaid. • States that contract for Managed Care must document methods for setting capitation rates, and projecting spending and utilization. Must also describe required qualifications for HMOs and other Managed Care Organizations.	Same as House.
Waivers	• Because Title XIX is repealed, states no longer need federal permission to do the things that currently require waivers. • Bill specifically authorizes states to use funds for a number of services which can only be covered under waiver in current law. Examples: home and community-based services (including personal care, assistance with daily living, chore services, day care services, respite care, training for family members), community supported living arrangements, residential mental health services for children, substance abuse treatment.	• Current statewide 1115 waivers may continue operation, but are not entitled to any funds above the level of the block grant allotment.
Paternity Establishment	• States must require unmarried Medigrant recipients to cooperate in establishing paternity and obtaining support of their children; exceptions for pregnant women found by state to have good cause for refusing to cooperate.	presumed same as House; details not yet available.
Undocumented Aliens	• Allows states to use federal Medigrant funds for emergency services to undocumented persons who otherwise meet state criteria for eligibility (same as current law, except that new state-option eligibility rules would apply). • Does not require state to match these costs.	Same as House, **except requires usual state match.**
Legal Aliens	***These provisions, included in Welfare Reform bills, rather than Medicaid bills, are included FYI.*** • Legal Immigrants would be ineligible for Medicaid, • with exceptions for: refugee status, veterans, over age 75 after 5 years residence, and persons with disabilities so severe that they are judged incapable of achieving naturalization. • Immigrants could be eligible upon naturalization. • Income of immigrant's sponsor would be counted as immigrant income ("deeming") until naturalization. • Currently-eligible resident aliens would remain	***These provisions, included in Welfare Reform bills, rather than Medicaid bills, are included FYI.*** • All Legal Immigrants would be ineligible for Medicaid for at least 5 years • with exceptions for: refugee status, veterans, and persons with 40 quarters (10 years) work history (20 quarters for those qualifying based on disability). • Income of future immigrants' sponsors would be counted as immigrant income

Provision	House Bill	Senate Bill
	eligible for benefits for one year.	("deeming") until earlier of naturalization or 10 years work history. • Current immigrants would be subject to "deeming" for 5 years.

Who Loses?

Senate Bill:

- **Elderly poor**: No entitlement if they are not disabled.
- **Children in poverty over age 12**: No entitlement.
- **Pregnant Women from 100-185% poverty -- and their babies**: No entitlement.

People with disabilities with incomes over 100% FPL (under current law some low-income persons with disabilities are covered for home and community care, nursing home, or residential care): No entitlement.

House Bill:

- **All current Medicaid clients lose guarantee of continued eligibility.**
- **"Set-asides"** based on recent state Medicaid spending on families, elderly, and disabled **do not include** spending on some major services:
- **Residential care for mentally retarded** (including state schools and group homes).
- **Long-term care (community or institutional) for non-elderly disabled recipients** with incomes above the SSI level.
- **Prescription drug spending.**

Both Bills:

- **Children** are unlikely to retain current entitlement to all medically necessary care.
- **Nursing home residents** lose protections of Federal Quality Standards established in 1987.
- **Public Hospitals:** many patients now paid for by Medicaid become uninsured, increasing uncompensated care in public hospitals.
- **Public Clinics:** federal health clinics and rural health clinics lose guarantee of cost-based reimbursement that has allowed them to grow and serve more people and communities in recent years.
- **Health Care Providers:** 100% of the reduction in Medicaid spending is lost income to the health care industry -- unless federal cuts are replaced with state or local dollars!
- **LOCAL TAXPAYERS: since Federal cuts do not eliminate ANY of the DEMAND for health care, Texas communities will have to choose between turning the uninsured poor away, or raising new taxes. Some tax increases are virtually certain.**

How Much Federal Funding Will Texas Lose?

Understanding the serious impact of Federal Medicaid cuts on health care for low-income Texans, and on Texas' health care industry in general, is made more difficult by the fact that several completely different sets of estimates are being publicized by different groups. Projections of Texas' Federal funds loss under these bills vary enormously, depending on the assumptions used by the entity doing the projecting.

- The assumptions chosen are driven to some extent by the position on the block-granting of Medicaid held by the group generating the numbers; block grant supporters might choose assumptions which result in lower projected "losses," while groups advocating for client access to care may choose assumptions resulting in higher projected loss estimates.
- Some differences in the estimates are less politically motivated, and are an unavoidable consequence when different groups attempt to make educated guesses about how much an entitlement program would have cost over the next seven years, under **current** federal laws.
- Politically motivated or not, there **are** rationales for the different assumptions. Below, the Center attempts to shed some light on the different assumptions being used in Texas.

Federal Medicaid Funds Loss, Texas 1996-2002	Assumptions
Source: Center on Budget and Policy Priorities, Washington, D.C.	
House: $6.6 billion **Senate: $11.8 billion**	**Assumes annual growth rates ranging from 9% to 11.7%.** Uses state-by-state growth rates developed by Urban Institute, adjusted to be consistent with the Congressional Budget Office (CBO) projection of national Medicaid costs from 1996-2002.
Source: Urban Institute; also used by U.S. Dept. of Health and Human Services	
House: $7 billion **Senate: $12.2 billion**	**Assumes annual growth rates ranging from 8.3% to 11.3%.** Urban Institute analyzed state Medicaid spending over last 5 years, and adjusted downward to project a national growth

Federal Medicaid Funds Loss, Texas 1996-2002	Assumptions
	rate of less than 10%.
Source: Texas Comptroller of Public Accounts	
House: $4.9 billion **Senate: $7.7 billion**	1) Rather than projecting actual growth in **demand** for Medicaid in **1996 and 1997**, uses the increase in Medicaid **funding** in the 1996-1997 state budget. Because Medicaid was budgeted significantly less than the expected demand for funding, this budget rate is much lower (less than 1% in 1996 and just 5% in 1997) than Texas Medicaid spending history would suggest. 2) **For 1998-2002, assumes 10.2% annual growth**, based on Comptroller's analysis of Texas Medicaid spending over the last decade, projected growth in low-income households, and projected medical inflation. 3) The Comptroller does not assume that Texas can take advantage of all the funds available under the House bill in the 1996-1997 biennium, because the state General Revenues appropriated for the program are insufficient.
Source: Texas Health and Human Services Commission	
House: $2.8 billion GAIN **Senate: $2.8 billion loss**	**Assumes growth rates ranging from 5% to 7.6%.** 1) Like the Comptroller, THHSC used increases in Texas Medicaid budget appropriations for the "growth" in Medicaid in 1996 and 1997; **however,** THHSC and Comptroller's assumptions of total federal dollars appropriated for Medicaid in 1996 and 1997 **differ by more than $500 million.** 2) However, THHSC uses a **much** lower growth assumption for 1998-2002 than the Comptroller, and one that is substantially lower than longer-view historical trends in Texas Medicaid spending would suggest. The rationale or assumption behind this rate is that, even under current law, the legislature would have "down-sized" the program due to budget pressures. Assuming that the **state** would have made significant program reductions under current federal law, the **net additional loss** to Texas resulting from the proposed Federal Medicaid changes naturally appears to be lower. **3) THHSC assumes that Texas will "draw down" the maximum allowable federal funds under the House bill in the 1996-1997 biennium, despite the low state General Revenue appropriation for Medicaid.**

What Does It Really Mean?

It is easy to understand how a 4% or 5% difference in the assumed Medicaid program growth rate could result in **drastically** different estimates of the future cost of Medicaid. Just think about your home mortgage, or your credit card bill, and what a difference 4% or 5 % would make to you. What's not so simple is deciding which set of estimates to believe.

The Center offers this interpretation. **The assumption that demand for program growth under current law would be in area of 10%** (consistent with all but the THHSC estimates) **is reasonable.** Significant program down-sizing would have to occur to hold the growth rate down to the growth rate assumed by THHSC. The THHSC numbers **assume that the Texas Legislature would have "down-sized" the Medicaid program even without a change in federal laws.** This assumption is based, in part, on the reality that the Legislature did appropriate less money than was required to meet the projected need for Medicaid for 1996-1997. In essence, this scenario identifies **two "pots" of Medicaid cuts;** voluntary state reductions (like Texas' 1996-1997 Medicaid budget) in Medicaid under current law, plus a second pot of cuts that would be imposed by the Federal capping of Medicaid. THHSC estimates assume that the pot of state-initiated cuts is fairly large, and since those cuts are not counted as part of the impact of federal cuts, the THHSC estimate of the size of the "federal pot" of Medicaid cuts that would result from these bills is much lower.

The important thing to realize is that "a cut is a cut." The **outcome** of reducing Medicaid funding below the level of projected need is the same, regardless of whether the reductions are initiated by the state or the federal government. A Medigrant program operated at either of the House or Senate funding caps would require massive down-sizing of the Texas Medicaid program from its current level of coverage. **To achieve those "savings," some combination of the following must occur:**

- **Reduced eligibility = more uninsured Texans,**
- **Fewer benefits = unmet health care needs,**
- **Lost income to health care providers, and/or**
- **Higher State or Local taxes.**

Message

1. Call Texas' Congressmen and Senators today and tell them you support the Daschle Medicaid Amendment to reduce Medicaid cuts and preserve Medicaid entitlement.

2. Let President Clinton know you support his veto of OBRA based on these Medicaid cuts.

What About Medicare?

This is a brief summary of some major Medicare provisions. Many other significant technical changes are involved in these proposals. Both the House and Senate plans would reduce Medicare spending by about $270 Billion over 7 years (1996-2002).

Senate Plan

Spending Reductions

According to the Congressional Budget Office (CBO), the Senate Medicare plan would "save":

- $71.0 Billion by increasing premiums and deductibles for Medicare enrollees
- $42.6 Billion by reducing current levels of payments to HMOs
- $7.1 Billion from optional conversion of more Medicare enrollees to HMOs
- $152 billion by capping increases in payments to doctors, hospitals, and other health care providers
- The plan would COST $2.3 billion MORE due to the use of Medical Savings Accounts.

The Senate bill has provisions to automatically make **additional cuts** if savings targets are not being reached every year. These cuts would be made across the board, for both fee-for-service Medicare and Managed Care.

Other Provisions

- Raises age of eligibility from 65 to 67
- Repeals current law provisions requiring state Medicaid programs to pay premiums, deductibles, and coinsurance for Medicare beneficiaries under 100% FPL, and premiums only for those between 100-120% of FPL.
- Would allow states to regulate physician and hospital-based Managed Care plans **only if state can certify plan within 90 days,** otherwise plans could operate under temporary (3 year) federal oversight.

House Plan

Spending Reductions

According to the CBO, the House Medicare plan would "save":

- $147.5 billion by capping increases in payments to doctors, hospitals, and other health care providers
- $55.0 Billion by increasing premiums for Medicare enrollees.
- $34.6 Billion from optional conversion of more Medicare enrollees to HMOs, and by reducing current levels of payments to HMOs
- $1.3 billion from "other" methods.

$31.8 billion represents the gap between the reductions listed above and the $270 billion target. These **additional** reductions would be triggered unless the above-listed methods achieve the $270 billion savings target.

Other Provisions

- **Modifies** current law provisions requiring state Medicaid programs to pay premiums, deductibles, and coinsurance for Medicare beneficiaries under 100% FPL; program would pay for premiums only. Payment of premiums only for those between 100-120% of FPL under current law would be reduced.

House Republicans were able to win support of the American Medical Association by adopting the following provisions:

- Would repeal Federal law which currently prohibits "self-referral", and would allow Doctors to refer their own patients to facilities (such as labs, diagnostic centers, day surgery centers, etc.) in which they have a financial interest.
- Would allow Doctors and Hospitals to form HMO-like managed care plans to serve Medicare beneficiaries, but would **exempt** them from state standards for solvency, quality assurance, adequacy of provider network, and consumer protections which HMOs must meet.
- Would cap damage awards in some medical malpractice cases.
- No upper limits would be imposed on doctor's charges to patients who have Medical Savings Accounts.

Major Concerns About Both Medicare Proposals

- Medicare beneficiaries are subject to considerable out-of-pocket costs. Under current law, the poorest elderly (with incomes below about $458 per month) are eligible for Medicaid, which picks up all their out-of-pocket costs, as well as providing prescription drug coverage which Medicare does not cover at all. As described above, other poor and low-income elders have their out-of-pocket costs or premiums paid for by Medicare. **Reductions in assistance with the Medicare costs of low-income elders, coupled with the loss of entitlement to Medicaid for the poorest elders proposed under both House and Senate Medicaid bills, threatens to destroy the safety net for older Americans which, until now, has successfully reduced poverty among seniors.**
- **Unregulated Managed Care Organizations represent a financial and health threat to America's elders.**
- **These cuts represent a loss of about $18 billion to Texas over 7 years.** These losses will take the form of higher out-of-pocket costs for seniors, and reduced income to the health care industry. When combined with massive Medicaid cuts, these losses will have a devastating impact on health care providers, especially public hospitals.
- Both bills include both direct and indirect reductions of unknown magnitude in payments to health care providers. The combined effect of these cuts could seriously jeopardize access to health care for seniors by reducing providers' willingness to accept Medicare patients.

Reminder on Istook Amendment

The vote on the Simpson-Istook compromise amendment is likely to take place Wednesday, October 25th. the compromise is not considered acceptable because, like the original Istook Amendment, it would limit public policy debate and raise serious free speech concerns. please contact Senators Hatfield and Jeffords and tell them to continue to oppose the compromise. **Use the toll-free number 1-800-336-0047**

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