PROPOSED

MEDICAID TRANSFORMATION ACT OF 1995
(called MEDIGRANT)

HOUSE VERSION

BACKGROUND: On September 19, 1995, the House Commerce Committee released the "Committee Print" of the Medicaid Transformation Act of 1995. The Print will be incorporated in the Reconciliation bill to accomplish whatever programmatic changes are necessary to meet budgetary limitations adopted by Congress. The final Appropriations bills will contain the programmatic changes to correspond with the funding reductions. Mark-up began on September 2 0; the House Committee measure was approved on September 22, 1995.

HIGHLIGHTS

* Medicaid entitlement eliminated;

* Each state must determine which services will be covered, type of provider, and payment levels;

  No requirement of "statewideness" or comparability of services;

  No requirement of freedom of choice of providers;

  No limitation on the state's ability to contract with managed care plans;

  Medical assistance is defined as a list of services similar to those services specified under current law;

  Most federal standards for nursing homes would be repealed. States must develop their own standards for protection and enforcement of resident rights (notice of rights and services, privacy /confidentiality, freedom from abuse) ; and follow some guidelines in developing standards regarding quality assurance, resident assessment procedures, staff qualifications, and operational policies and procedures;

  States are given almost total flexibility in all aspects of the program;

Based on information from 10/03/95

States are required to fund a set-aside for people with disabilities under age 65. Set-aside funding is set at 85% of the average percentage of the state's Medicaid spending in earlier years for mandatory services for this population. No required services are specified.

Long term care services (ICF/MR and waiver); speech, occupational, physical, and other therapies; prescription drugs; case management; clinic and rehabilitation services are not mandatory services. Consequently, Medicaid spending for these services in previous years could not be used to establish the 85% set-aside funding level. Mandatory services include physician costs, hospitalization, and EPSDT;

States are allowed to establish a set-aside percentage below the 85% minimum if the state determines and certifies that the health care needs of that population are lower;

States are permitted to impose premiums, co-payments, co-insurance or deductibles based on a fee schedule. Each state would develop its own fee schedule;

States are permitted to decide the types and amounts of assets that can be kept by the spouse of a nursing home resident;

A "Medigrant" Task Force is established; members will be appointed by the National Governor's Association. An Advisory Group of eleven individuals will assist the Task Force with one individual representing each of the following:

National Committee for Quality Assurance Joint Commission for the Accreditation of Health Care Organizations Group Health Association of America American Managed Care and Review Association Association of State and Territorial Health . Officers American Medical Association

Based on information from 10/03/95

American Hospital Association
American College of Gerontology
American Health Care Association
"an association representing the interest of disabled individuals and an organization representing the interests of children;"

Federal funding for FFY 1996 would be based on expenditures for FFY 1994 with an increase for inflation that is limited to 2%-4% until the year 2002. Allocations will not be decided until November or December.

SENATE VERSION

BACKGROUND: The Senate Finance Committee began mark-up of its Medicaid proposal on September 26, 1995. The Committee plans to end Medicaid's federal guarantee of basic health insurance for the poor. Program expenditures would be reduced by $182 billion over the next seven years.

The Senate Finance Committee seems more willing to impose restrictions on the states. The House Commerce Committee would give the states greater discretion and almost total flexibility in all aspects of the program.

HIGHLIGHTS:

Each state would receive a block grant for health care costs. Block grants would total $773 billion over seven years, 19% less than Federal Medicaid spending under current law;

States are permitted to spend less of their own money than is now required in order to receive a given amount of Federal Medicaid funds;

Slightly higher growth rates proposed than under the House plan. However, all states would still fall below spending levels projected under current law; 2 7 states would get more money under the proposed Senate plan than under the proposed House plan;

Current federal restrictions to prevent spouses of nursing home residents from becoming impoverished by nursing home costs are retained;

Based on information from 10/03/95

Most federal standards for nursing homes would be repealed;

One percent of the federal grant must be used for local health centers. The House plan rejected a similar set-aside provision.

Based on information from 10/03/95

Possible Federal MA Budget Cuts for Minnesota

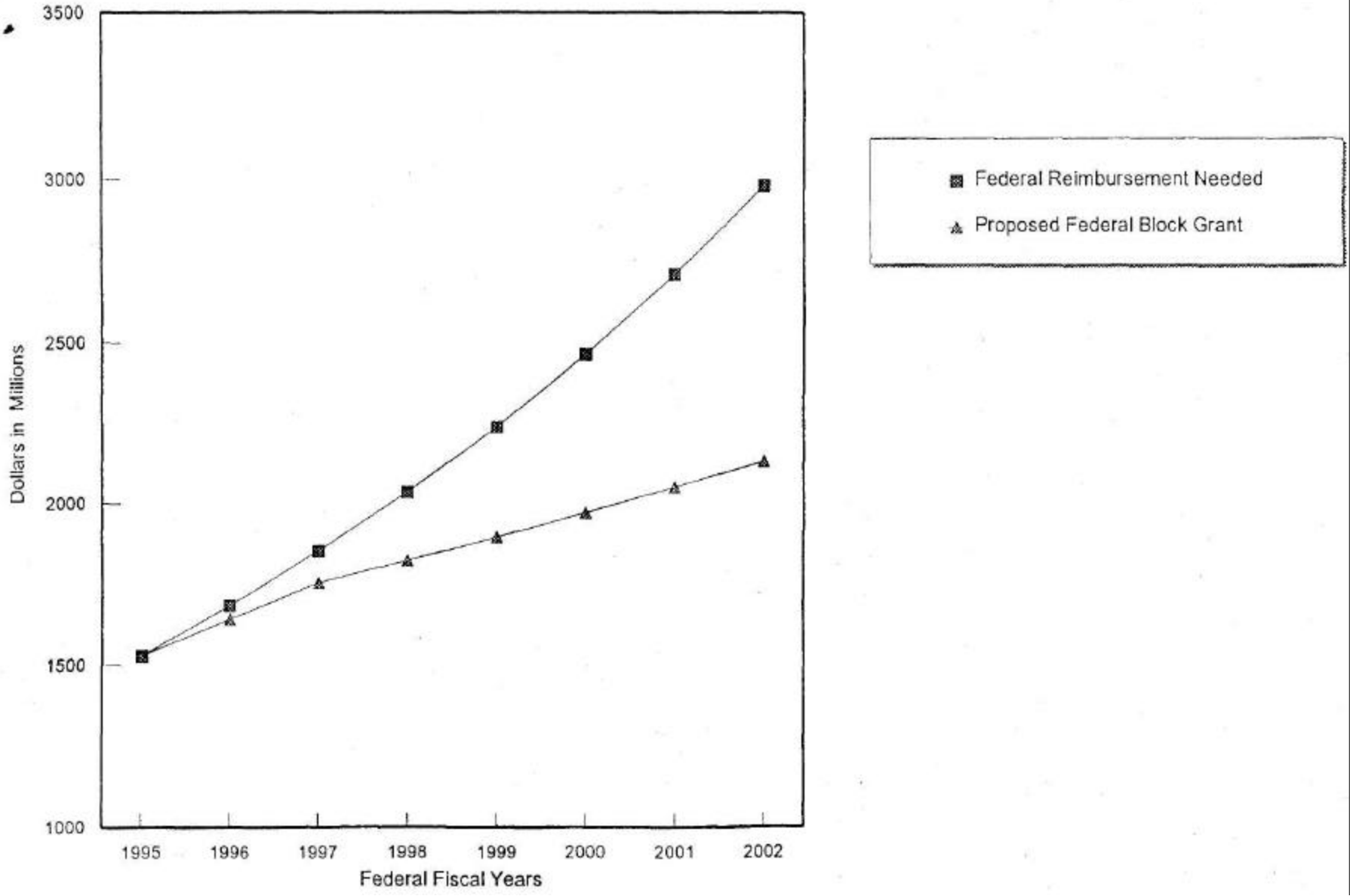
From the latest Congressional Budget resolution

(Dollars in Thousands)

	% Growth Allowed	Federal Cuts $$	% MA Cut
FFY 1995			
FFY 199k	7.2	(66,110)	-3.88%
FFY 1997	**6.8**	**(82,419)**	-4.50%
FFY199B	4.0	(221,447)	-10.85%
FFY 1999?	4.0	(361,069)	-16.02%
FFY 2000	4.0	(509,937)	-20.57%
FFY200I	4.0	(668,555)	-24.62%
FFY 2002	4.0	(824,024)	-27.90%
Seven Year Total		(2,733,560)	-17.10%

Minnesota's Health Care Federal Share

Cost Increases vs Proposed Block Grant



Minnesota House of Representatives
Mini-Session - Park Rapids September 20, 1995

PROPOSED CHANGES IN MEDICARE

HOUSE VERSION

Reduce spending by $270 billion, or 14%, over the next seven years. According to the Congressional Budget Office, only $30.8 billion in savings would come from greater use of HMOs and other types of managed care. The balance of savings would come from increased premiums, and limited payments to doctors and hospitals;

SENATE VERSION

* Greater use of H.M.O.'s and other forms of managed care would result in a savings of $47.5 billion over the next seven years;

* Eligibility age gradually raised from the current age of 65 to age 67 by 2027. This change corresponds with the proposed increased eligibility age for Social Security;

* The premium for Part B Medicare (optional coverage for doctor bills) would hold at 31.5% of the program cost; the balance of program costs would be paid by general tax revenues. The monthly premium for FFY 1995 was $46.10; increases are projected at $54/month for FFY 1996 and would reach $92/month in 2002. A premium subsidy would be phased out for wealthier individuals;

* The annual deductible would increase to $150 in FFY 1996, and then increase by $10 annually through 2002;

* Money raised by increased premiums and deductibles would be deposited in Medicare's Hospital Insurance Trust Fund which pays hospital bills for Medicare beneficiaries;

* Beneficiaries could remain in the fee-for-service Medicare program or choose other options including HMOs, medical savings accounts with a high-deductible catastrophic policy, health insurance policies offered by organizations or unions, or go outside of their selected network and pay higher costs;

* "Medicare Choice" option plans would be available to beneficiaries; insurers would have to meet federal requirements:

Based on information from 10/03/95

- Cover anyone eligible for Medicare Part A and enrolled in Medicare Part B;

- Cover same items and same services as traditional Medicare;

- Cover anyone who wanted to enroll for as long as they wanted to remain enrolled as long as bills were paid;

- Annual open enrollment period;

- Provide clear explanations about all plan options, including prices, services, co-payments, deductibles, and other restrictions;

- Outline quality assurance strategies;

- Provide limited coverage for a Medicare beneficiary who has a pre-existing condition and chooses another plan;

Demonstrate that insurers have the capacity to adequately serve the number of beneficiaries they expect to enroll;

- Develop procedures for beneficiaries to use regarding dissatisfaction with coverage or health care plan decisions;

Medicare provider changes include reductions in inpatient and outpatient hospital payments, reductions in hospital and nursing home capital costs, and payment formula recalculations;

The freeze on annual inflation updates for routine nursing home service costs would continue for FFY 1996.

Based on information from 10/03/95