Don't WAIVER on Health Care

Secretary Braddock's Plan for Medicaid puts low-income families, people with disabilities, and the elderly at risk

Northwest Federation of Community Organizations

Taking Action
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Washington Citizen Action

September 2001

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Overview

Health care costs are increasing across the country, affecting private employers providing health insurance and public health insurance programs alike. Between 1999 and 2000, the cost of employer-based coverage premiums increased by 8.3 percent in the U.S. Medicaid spending per beneficiary increased by four percent during the same time period.[1] The high cost of prescription drugs and their increasingly significant role in health care is a driving force behind the overall increase in health care costs.

Washington's public health insurance programs like Medicaid and the Children's Health Insurance Program (CHIP), serve thousands of low-income families, the elderly, and people with disabilities. Medicaid's comprehensive package of benefits, including a full range of medically necessary care for children with special needs, can be critical for children with complicated health problems. Medicaid provides preventive and primary care for people who would not otherwise be able to afford health insurance, and would therefore be forced to go without care until conditions become emergencies.

As in all health care plans, costs are rising in Medicaid. The Washington Department of Social and Health Services (DSHS) Secretary Dennis Braddock has responded by internally drafting a proposal that could significantly reduce health care services and increase costs for participants in Medicaid and CHIP. DSHS Secretary Braddock is proposing to ask the federal government to waive key Medicaid requirements for Washington. Specifically, Secretary Braddock aims to cap enrollment, reduce services, and increase cost-sharing in the state's Medicaid program. Cost-savings achieved by these strategies would be accomplished largely by limiting access to services.

Limiting health care benefits and making health care programs more difficult to access will harm the health of Washington's low-income families, people with disabilities, and elderly. Secretary Braddock's proposals will increase the number of uninsured by capping program enrollment and imposing premiums. He also proposes to impose point-of-service co-payments, even on people living below the federal poverty line. When people don't have access to health insurance, they often end up in a hospital emergency room seeking service for a costly health problem that could have been prevented with an earlier visit to the doctor.

While Washington equally shares the cost of Medicaid with the federal government, sharp increases in program costs should concern us. However, Secretary Braddock's proposal does not address the root causes of the increased cost of Medicaid, most notably the rapidly rising costs of prescription drugs. Instead of addressing the prescription drug cost crisis by using one of the many state strategies available, Secretary Braddock wants to require program participants to pay more and receive fewer health care services. These requirements may lead to more uninsured families and higher health care costs in the future.

Section I: Secretary Braddock's Waiver Proposal

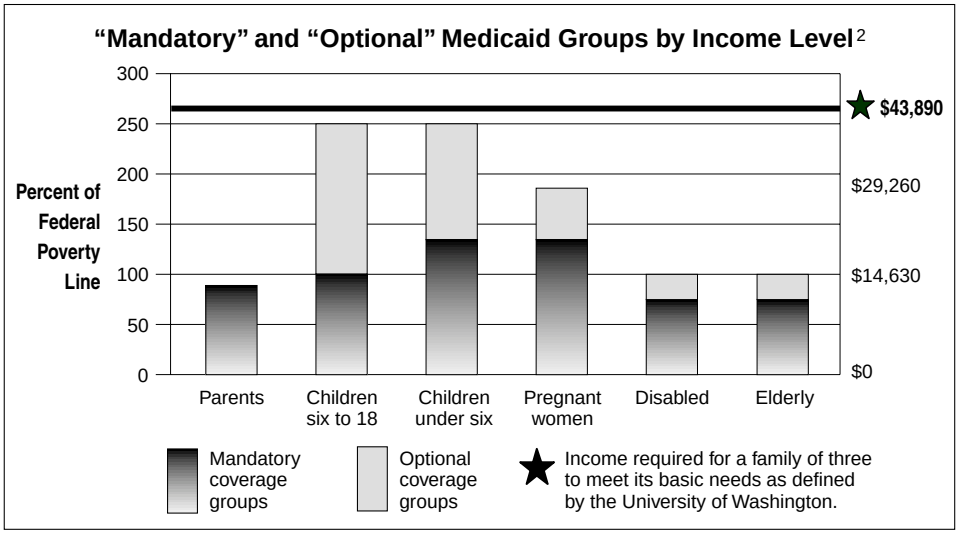
According to an August 16 memo from Secretary Braddock (see Appendix B), Washington state intends to request blanket exemption from a large number of federal laws that govern how states design their Medicaid programs. Specifically, Secretary Braddock wants to disregard federal laws that limit cost-sharing, establish a strong benefit package, and allow all those eligible to participate in the Medicaid program.

A. Secretary Braddock Requests "Benefit Flexibility"

Benefit "Flexibility" Means People Lose Benefits

Currently, states participating in the Medicaid program must offer a comprehensive package of benefits to all Medicaid enrollees. This means that all eligible people have access to a benefits package designed to avert serious health care problems and ensure that those with disabilities and serious health care problems can get the care they need to maintain their quality of life. Secretary Braddock's proposal would change this by providing different groups of people with different benefits depending on their income and other factors. Medicaid-eligible people would be segregated into two different groups — "mandatory" and "optional" groups — and only those in the mandatory group would continue to be guaranteed the federally mandated Medicaid benefits package.

As family income fluctuates due to increased hours, layoffs, or other reasons, family members will move between the mandatory and optional groups. When family income increases, some members will move into the optional coverage group and lose benefits. When family income decreases, some family members will move into the mandatory coverage group and receive a richer benefit package. Because the mandatory and optional group eligibility is based also on age, children in the same family may be eligible for different benefit packages. Tracking this change in benefit package will not only be difficult for families, it will require the state to keep careful record of families' incomes to ensure that children are receiving the right benefit package.



Secretary Braddock's memo describing the waiver reports that DSHS would be able to cut the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for those in the optional group.[3] EPSDT is one of the most important benefits in Medicaid and CHIP because it provides children with scheduled preventive care that helps them avoid painful and costly future health problems. Under EPSDT, states are responsible for informing parents about EPSDT services and ensuring that children receive all the medical items and services they need. A July 2001 study by the American Academy of Pediatrics found that a series of well-child visits improves health. It recommends focusing on compliance with periodic preventative care for children to boost immunization levels and reduce avoidable hospitalizations.[4] Removing the EPSDT benefit for children could lead to long-term health problems that could have been prevented with inexpensive early screening and preventive care.

Instead of providing members in the optional group with the existing benefit package, Secretary Braddock proposes to base the new benefit package on the significantly weaker benefit package offered by the Washington's Basic Health Plan (BHP). The BHP package does not provide home care service, eyeglasses or routine eye examinations, dental services, some durable medical equipment, speech, occupational, or physical therapy, and other services. These services are critical for people to remain healthy and maintain a decent quality of life. The removal of these benefits will particularly impact people with disabilities.

Benefits that People in the Mandatory Group May Lose	**Benefits that People in the Optional Group May Lose**
The following services are considered optional by the federal government but are currently provided by Washington's Medicaid program.	The people in the optional group could lose all of the benefits that a member of the mandatory group can lose as well as the following benefits:
• Prescription drugs • Dental services • Physical therapy and related services • Dentures • Prosthetic devices • Eyeglasses • Hospice care • Nurse midwife services • Case management services • Respiratory care services	• EPSDT, a comprehensive prevention and treatment benefit for children that ensures they receive the medical items and services they need. • Care that does not require the regular services of trained medical or allied health care professional and that is designed primarily to assist in activities of daily living or "homecare." • Medical equipment like wheelchairs, walk aids, respiratory equipment, and oxygen.

B. Secretary Braddock Requests Enrollment Caps

Currently, states are required to provide Medicaid benefits to all people who meet the eligibility criteria. This is to ensure that those in need have access to health care benefits. Secretary Braddock proposes to limit enrollment for certain people. The groups of people at risk of being shut out of health care coverage include those in the optional group: children in families earning more than the federal poverty line, medically needy elderly and disabled people, working disabled people, women with breast and cervical cancer, and others. If an enrollment cap was put into place, anyone applying

for the program after it was closed would be put on a waiting list until an enrollment slot became available. Those who were placed on waiting lists would likely join the ranks of the uninsured because they are low-income and likely do not have funds to purchase health insurance on the private market.

Secretary Braddock's memo describing the waiver does not specify how the groups selected for the enrollment caps would be chosen, but suggests that the decision would be based on cost. Since people with disabilities and the elderly typically require more health care services than parents and children, these groups could be targeted first. In addition, the waiver would allow DSHS to stop enrollment in Medicaid at any time, without input from the public or the legislature. There is no required public process to determine which groups would be subject to these enrollment caps.

C. Secretary Braddock Requests Premiums and Co-payments

Secretary Braddock's waiver proposes to institute premiums costing up to five percent of a family's income for anyone in a family earning more than the federal poverty line ($14,630 for a family of three). Families living above the poverty line but still eligible for Medicaid are typically low-income working families who are struggling to meet their current needs. The fact that their income has pulled them above the official poverty line — which is a measure of a family's *inability* to meet its basic needs, not its ability to meet those needs — does not mean that the family is doing well and can afford to pay five percent of its income on premiums. A recent study from the University of Washington pegged the wage necessary for a family of three to meet its basic needs in Washington state at $38,500 a year — more than two and half times the federal poverty line.[5]

Judy Kaufmann
Kent, Washington

I am 50-year-old disabled mother of two girls, Andi and Marjory. Andi is 16 and still lives with me. Marjory is 18 and lives on her own.

When I was 13 years old, I was thrown from a motorcycle. I was thrown 90 feet through the air, and the impact crushed my pelvis, fractured my leg, and put me in a coma that lasted for three months.

I have to use a wheelchair to get around now. I have had health care problems for years, but nobody was really sure why until I finally got a CAT scan in 1993. The CAT scan showed that the balance center of my brain had been damaged, and was shrinking.

Medicaid has been really good in helping me get the anti-inflammatory drugs and other medicine that I need. I also wouldn't have the wheelchair I use without Medicaid. I can't afford to pay for my prescriptions, and I sure can't afford to buy myself a wheelchair. I understand that things like wheelchairs would become optional if the waiver goes through. It's not optional for me. I need to have it.

I had always understood that the government would take care of the people that needed help, especially disabled people. But with the cuts that they talked about to vision and dental care, and now with the waiver that's been proposed, I'm starting to have my doubts.

In addition, the proposed waiver would allow DSHS to impose co-payments on prescription drugs and any other non-mandatory Medicaid benefits for all Medicaid beneficiaries. This means that people living in poverty could be subject to co-payments equal to five percent of their income. By definition, people living in poverty have no income to spare. Asking them to pay co-payments for health care services will push them deeper into poverty.

Another problem with cost-sharing is that DSHS will need to track both the amount that families pay in premiums and the amount that they spend on point-of-service co-payments to ensure that families are not charged more than the five percent cap. However, the memo describing the waiver does not specify how DSHS will do this. Will families be required to save and submit their co-payment receipts? Will physicians be required to inform that state when their Medicaid or CHIP patients pay co-payments? Will physicians be responsible for paying a co-payment from their reimbursement if a patient cannot afford it? Administering the cap and ensuring that no family pays more than five percent could be a costly, complicated process for the state.

Moving from Welfare to Work

Yolanda Hernandez
Kent, Washington

I am 26 years old and a single mother of my son, Kerrigan. I work at an assisted living home and I bring home about $900 a month. We get food stamps, but it's only $12 a month. You can use that up in two days on groceries. We're getting Medicaid right now. I'm not eligible for insurance from my job, so that's the only health care option I have.

I see a doctor once a week for my allergies. It will be quite a hit if I had to pay weekly co-pays for those doctor's visits. My son's pretty healthy, but he needs the Medicaid in case something happens.

If I had to pay a premium, or pay co-pays for doctor visits, that's going to put a dent in my budget. I might have to drop Medicaid, and that really worries me. More costs for my medical insurance means that there's less food for Kerrigan and me. That's the bottom line.

* * *

Under Secretary Braddock's proposal, Yolanda could pay up to $45 a month, or $540 a year, in health care cost-sharing.

Yolanda's family budget

Yolanda's hours change each month, so her income is not consistent. Except, for her rent, utilities, and childcare, Yolanda's costs also fluctuate each month.

Rent:	$185	**Emergencies, household clothing, personal, other:**	$200 to $500 depending on month
Utilities:	$100		
Food:	$250 (Yolanda receives $12 a month for food from the Food Stamp Program)	**Health Care:**	Currently provided by Medicaid, "nominal" cost-sharing only
Transportation (car):	$80 to $300 depending on month	**Savings:**	none
Childcare:	$78 (co-payments for subsidized state child care program when she works)		

Yolanda's family cannot afford to pay additional costs for health care.

Section II: Major Changes Without a Public Process

DSHS Secretary Dennis Braddock is requesting a federal waiver to set enrollment caps, reduce services, and implement cost-sharing for Medicaid beneficiaries without consulting families affected by these new policies.

Secretary Braddock's proposal to cap enrollment, reduce services, and increase cost-sharing in the Medicaid programs undermines federal legal rights for program beneficiaries. Because his proposals conflict with federal protections, the changes must be approved by the U.S. Department of Health and Human Services (HHS) by submitting what is called a Section 1115 waiver. Under Section 1115 of the Social Security Act, states are permitted to establish comprehensive demonstration projects that waive key Medicaid and CHIP requirements. Section 1115 gives the HHS Secretary broad power to approve demonstration projects without prior Congressional review or any public involvement.[6]

The former presidential administration published non-binding guidelines that explicitly recognized that "people who may be affected by a demonstration project have a legitimate interest in learning about proposed projects and having input into the decision-making process prior to the time a proposal is submitted" to HHS.[7] The Bush Administration has made no such commitment to ensure that states involve the public in the development of a Section 1115 waiver. Historically, "public access to information on demonstration approval and monitoring is limited."[8] Once DSHS Secretary Braddock submits the waiver to HHS, there will be little, if any, possibility of input from those impacted by the cuts in services.

Thus far, Secretary Braddock has engaged in very little dialogue with Washingtonians about his plans for the Medicaid program. Under the former administration, HHS encouraged states to hold one or more public hearings on the proposed waiver and provide copies of the most recent working proposal to the public.[9] Except for ongoing DSHS "Community Conversations" that involve asking participants "to free their imaginations and describe health care in a perfect world," and then talk about "how their perfect world would change if there wasn't enough money to cover the all the needs and costs of the real world,"[10] there is no plan to engage the public and affected people specifically about the proposed waiver. Public meetings held to discuss public health programs in general terms are not adequate if the state does not provide information about the proposals for the public to consider as part of the discussion.

Despite the fact that little public input has been sought or obtained, an August 16 memo from Secretary Braddock indicated that the state intended to move on an "aggressive timeline" and aimed to submit the waiver at the end of September. Although the memo said that the DSHS would seek

input for legislators, state agencies, the tribes, the official Medicaid advisory committee, and other "stakeholders," it did not describe how it would do so. In addition, there was no mention of public input from Medicaid beneficiaries themselves. Several days later, after a request from health care advocates, Secretary Braddock told the Seattle Times that he would not submit the waiver until the end of October.[11] However, this is still a very short timeline to effectively organize a statewide public review process, especially considering that the waiver itself has not been released to the public.

DSHS's view is that the public process will occur until after the federal government approves the waiver. Secretary Braddock says that once the state receives approval, there will be a state legislative process to consider the proposed enrollment caps, reductions in benefits, and imposition of premiums and co-payments. However, Secretary Braddock has yet to describe how those impacted by the changes proposed in the waiver will be heard. As for the legislative process, the legislature would be able to make these policy changes at any time through the budget process by using budget provisos. This process typically occurs in private, back-room budget negotiations, with only a few legislators present and no opportunity for public comment.

Capping enrollment, reducing benefits, and increasing cost-sharing as proposed by Secretary Braddock will radically alter the Medicaid and CHIP programs. Currently, these health insurance programs provide the same affordable package of adequate health care benefits to all beneficiaries. Secretary Braddock's proposal could change that, yet no attempt has been made to hear the voices of those who will be impacted the most by these proposed changes. There is no opportunity for impacted people to participate once the waiver goes to the federal government and little opportunity once it comes back to the state legislature. Now is the time to listen to the voices of those who will be impacted by the changes proposed in the waiver.

Section III: Proposal Won't Halt Rising Costs

The proposed waiver doesn't address the rising costs of prescription drugs, the driving force behind higher Medicaid costs.

While the Secretary of DSHS has made it clear that saving money is the driving force behind the waiver,[12] nothing proposed in the waiver addresses the rising cost of prescription drugs. Since 1989, Washington spending on prescription drugs has increased by eight times, from $121 million to a projected $1 billion in 2003.[13] According to a recent report from DSHS, the cost of prescription drugs is growing faster than all other health care services provided by Medicaid.[14] This is likely due to the fact that the growth rate of prescription drug prices is an astonishing 18 percent a year.[15]

A recent ranking by Forbes magazine found that pharmaceutical companies are the most profitable in the world,[16] which is not surprising considering that the average retail price of a prescription drug in the U.S. grew by almost 60 percent between 1991 and 1998.[17] The pharmaceutical companies justify their exorbitant prices by claiming that they must invest in research and development. However, taxpayers fund much of the early critical research through the National Institutes of Health[18] and the top ten drug companies spend nearly three times more on marketing, public relations, and administration than they spend on research and development.[19]

This spring, the state Title XIX Medical Assistance Advisory Committee, a group of health providers, advocates, clients, and health plans, approved a motion stating that "The Title XIX Advisory Committee is concerned over the disproportionate increases in the cost of prescription drugs and requests the Executive and Legislative branches of Washington State to actively pursue legislation to reverse this trend, without compromising access to needed medications."

In addition, the Northwest Health Law Advocates, a consumer health advocacy group based in Washington state, has recommended that "No programs or benefit cuts pursuant to a waiver should be sought until Washington has brought spending on prescription drugs under control…Until a substantial effort to reduce these costs is made, no waiver should be granted that allows the state to drop beneficiaries or services. These cuts would only alleviate the pressure to deal with the main cost driver."[20]

Containing costs in health care is a challenge for both private and public health plans and must be addressed if health insurance plans are to remain solvent. However, Secretary Braddock's proposal does nothing to address the rapidly increasing costs of prescription drugs, the main cost-driver in Washington's Medicaid and CHIP programs.

The proposed waiver will discourage people from getting the care they need and increase the number of uninsured in Washington — leading to higher costs in the future.

Imposing premiums in the Medicaid program will likely lead to people dropping coverage. Failing to pay a premium can shut a family out of insurance coverage entirely, not only for the time period for which the premium is unpaid, but for the time it takes to re-enroll in the program if non-payment results in exclusion from coverage. A study of Washington's Basic Health Program found that just a $10 premium increase cut enrollment by 13 percent.[21] In a different survey of Washington state residents who called inquiring about the Basic Health Program but did not join, 78 percent stated that they did not enroll because "the monthly premium is too expensive."[22] Because DSHS has not specified in its waiver memo who will be charged premiums and how much they will be charged, it is not possible to estimate how many families will drop off the program. However, the experience with the Basic Health Program indicates that even small premiums result in lower enrollment.

In addition, research has found that cost-sharing discourages people from seeking needed care, and that an absence of cost-sharing is especially beneficial to low-income participants of a health care program.[23] A recent survey of 106 low-income Washington families found that a third of families reported that co-payments had discouraged them from accessing needed health care services.[24] If people with health care needs forego early doctor visits to address the health care problem, they may end up in emergency rooms later. Emergency room care is extremely costly and treating a condition that has been allowed to become an emergency is much more expensive than providing preventive care or early intervention.

Missing out on critical preventive cares takes its toll on families. Children who do not receive preventive care and immunizations are more likely to be sick more often and to miss significant amounts school as a result. Unmet health care needs reduce a child's ability to grow into a healthy and productive adult. For example, ear infections that are left untreated can result in hearing loss as well as speech and language difficulties. Providing preventative health care for children and early treatment of illnesses prevents children from missing school and parents from missing work to care for sick children. Short-term savings on health insurance for kids and families now can cost Washington state more in the long run when lack of access to treatment creates lifelong, preventable, health problems.[25]

A higher number of uninsured and those who have delayed seeking medical care puts pressure on Washington state hospitals.

When the uninsured need medical attention, they have few affordable options to access care. Children who are uninsured are less likely to access regular health care, are less likely to maintain a schedule of recommended immunizations, and are less likely to have developmental delays diagnosed and monitored than their insured counterparts. Compared to the insured, the uninsured are more likely to be hospitalized for illnesses that could be avoided or treated with less expensive interventions.[26] A recent survey of 106 low-income Washington families found that more than half of the uninsured go to an emergency room when they need care.[27]

Emergency room care is quite expensive compared to other types of services. A study in Michigan found that an emergency room visit costs $124 on average while a visit to a doctor's office was $53.[28] Most public or private non-profit hospitals missions' require them to treat those without funds, although hospitals are not compensated when they treat the uninsured. Hospitals must finance the cost of uncompensated care at the same time health care costs are increasing and "public and private payers are ratcheting down the rates they pay for hospital services."[29]

Treating the uninsured in emergency rooms strains the resources of public hospitals and is not a good option for those who need non-emergency services or follow-up care. The emergency room is not designed to provide follow-up treatment for long-term health problems or preventive care. These kinds of treatments are the most cost-effective and most likely to avert serious health problems. Providing health care coverage to the uninsured helps by ensuring that people can access the preventive care. One study found that the increases in Medicaid eligibility from 1983 to 1996 led to a 22 percent decline in avoidable hospitalization.[30]

Secretary Braddock's proposals do little to address the real problem facing public and private health insurance programs — the rising cost of health care services, particularly prescription drugs. Instead, his proposal to cap enrollment and implement premiums will contribute to the number of uninsured by making health care coverage more difficult to access. Hospitals inevitably become the health care provider of last resort for the uninsured, one of the most expensive avenues to access health care. Secretary Braddock should investigate ways to control the high costs of prescription drugs rather than cutting services to those in need.

Tifanny Owens
Kent, Washington

I'm the mother of a two-year-old son, Marcelas. I work for a fast food restaurant and my schedule changes week to week. I'm lucky if I take home $300 a month from my job. I'm not eligible for insurance there until I've worked for a year.

I was told by DSHS that I had to work 40 hours a week, while going to school, to qualify for medical benefits, TANF, or food stamps. My caseworker told me that if I couldn't work 40 hours, at least work 30. I can't do all that and still take care of my son, and he takes priority. So, I don't get a lot of help from the state. Marcelas gets Medicaid, and he would have no insurance otherwise. He'd have to go to the emergency room if he became sick.

If I had to pay premiums for Medicaid, I wouldn't get it. I can't afford any new bills right now. I had to make a choice a few weeks ago between paying for my bills, like cable and power, or paying for food. So that was the end for the cable. My power was off for over a week until I could get it turned back on. More costs in the Medicaid program are going to cost a lot of people their coverage. A lot of people are in my situation — they can't afford another nickel in their budget.

Section IV: A Better Solution

A. Washington Can Reduce Medicaid Costs by Controlling Spiraling Prescription Drugs Costs

Legislatures across the country are examining ways to reduce the costs of prescription drugs and ensure the solvency of public health care programs. In 2001, 27 states considered fair pricing bills modeled after Maine's Prescription Drug Fair Pricing Act. Maine's legislation directs the state government to use its bulk purchasing power to negotiate steep discounts and pass the savings on to consumers. While the pharmaceutical industry stalled this legislation by attacking it in court, the First Circuit Court of Appeals upheld the act as constitutional in May of 2001. With this green light, more states are expected to implement this type of legislation in the upcoming 2002 sessions.

Florida recently adopted a similar measure focused specifically on controlling prescription drug costs in the Medicaid program. The Florida law, which took affect on July 1, establishes a list of drugs that can be prescribed to Medicaid patients. Of course, doctors can continue to prescribe any drug to their patients that they deem medically necessary, but the list allows the state to use its bulk buying power to negotiate better prices from drug companies. Florida hopes to save $214 million a year in its Medicaid budget. Not surprisingly, the pharmaceutical industry has taken Florida to court over its plan to control prescription drug costs. However, Governor Jeb Bush has vowed to fight the lawsuit and said, "We are more concerned about making sure our senior citizens have better access to affordable prescription drugs. Protecting the large profits margins for multi-billion dollar pharmaceutical companies is not a priority."[31]

Yet another strategy to reduce the cost of prescription drugs is to establish a regional buying pool to negotiate better prices for drugs. Connecticut, Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont have established the Northeast Interstate Commission on Prescription Drug Prices to discuss how to work together to contain the cost of prescription drugs.

Veronica Langley
Tacoma, Washington

In August of 1992, I fell 30 feet from a platform and sustained a severe head injury. Immediately after the fall, I began experiencing severe migraines and double vision. Within two years, I was also having seizures. In the nine years since the accident, I have not had one migraine-free day. I am currently on large doses of anti-seizure medication as well as a myriad of prophylactic medications for the migraines. But, in spite of the medication, I have headaches so severe that I lose my speech and vision several times a week.

My medication costs, paid by Medicaid, run approximately $1,200 a month. If a co-pay for Medicaid prescriptions were put into place, it would literally be a death sentence for me. It is depressing to contemplate the ramifications of this proposed waiver. It would be life-threatening for me and an enormous number of people in the same situation.

Three of these states, New Hampshire, Maine, and Vermont have already established a regional buying pool and expect to be able to obtain drugs at 23 to 35 percent lower than retail.[32] During the 2001 session, the Washington legislature passed legislation urging joint action with its Northwest neighbors to establish a cooperative prescription drug strategy. Idaho passed similar legislation.

Controlling the exorbitant cost of prescription drugs should be first on Secretary Braddock's list if he is concerned with the increased cost of the Medicaid and CHIP program. There is clear interest from the legislature in exploring options and proven strategies from around the country. Cutting back on benefits and services and capping enrollment will simply increase the number of the uninsured in our state and further strap hospital resources. Secretary Braddock should instead focus on long-term solutions like controlling prescription drug costs.

B. Washington Can Access More Federal Funds to Help Pay for Its Health Care Programs

Secretary Braddock's waiver represents a shift in direction from Washington state's history of seeking ways to expand health care access to the uninsured. Washington has long been a leader in the nation in providing coverage to the uninsured and was covering children up to 200 percent of the federal poverty line before Congress adopted the Children's Health Insurance Program (CHIP) in 1997. Since this was the group that CHIP was created to serve, Washington was unable to use all of its allotted CHIP funds. Currently, Washington has available about $180 million dollars in unspent CHIP funds.

Recently, the state of Minnesota renegotiated its state-funded MinnesotaCare program to obtain more federal funds. Washington could do the same with its Basic Health Program and receive federal funds to cover parents, children from the ages of 19 to 21, and possibly other groups as well. Or, Washington state could use CHIP dollars to cover parents in its existing CHIP program as New York state recently received permission to do. These actions will bring additional federal money into the state without having to reduce services or increase the cost burden on beneficiaries.

Section V: Conclusion

Secretary Braddock's proposed waiver fails to solve the problem of increased costs in the Medicaid program because it does not address the main cost-driver in Medicaid: prescription drugs. Instead, Secretary Braddock proposes to balance the Medicaid budget on the backs of our low-income families, people with disabilities, and elderly by reducing services, increasing cost-sharing, and capping enrollment in the Medicaid program. This approach threatens the health of a group of people who need access to Medicaid to maintain their quality of life, while letting prescription drug profiteers off the hook.

A better approach that would protect the health security of low-income families, people with disabilities, and elderly, is to control the spiraling cost of prescription drugs before making any cuts in services. The state can use its bulk purchasing power to negotiate affordable prices for prescription drugs in the Medicaid program as Florida has done. In addition, Secretary Braddock can draw down more federal funds to pay for the cost of providing health care to the uninsured in Washington.

If adopted, Secretary Braddock's approach to the Medicaid program will lead to higher numbers of uninsured and more people foregoing needed health care. This is not the kind of health care reform Washington needs.

Appendix A

[Drafted 8-16-01]

TO: Interested Parties

FROM: Dennis Braddock, Secretary
Department of Social and Health Services

SUBJECT: MEDICAID & SCHIP REFORM WAIVER PROVISIONS

The purpose of this memorandum is to outline the principle provisions that the Department of Social and Health Services (DSHS) would propose to include in its Medicaid & SCHIP Reform Waiver proposal.

The objective of this Reform Waiver is to provide the Governor and Legislature with flexibility to design and administer Washington's optional Medicaid programs to help sustain health coverage for our low-income residents. The waiver also would allow Washington to use its unspent State Children's Health Insurance Program (SCHIP) allotment to expand coverage for parents of Medicaid and SCHIP children.

The Reform Waiver would be a unique demonstration waiver. Instead of requesting specific changes that would be implemented at the start of the demonstration, Washington's waiver would request flexibility in certain programmatic areas. Washington would have the ability to implement these changes as needed in order to sustain its Medicaid and SCHIP programs, and to make additional coverage available to parents within available funds. As described below, any cost-sharing or benefit changes would require legislative approval.

Following are the programmatic and funding changes that are being considered for the waiver. Other provisions may be incorporated as our agency seeks input from the Legislature, state agencies, Title XIX Advisory Committee, Washington's tribes and other stakeholders.

- **Copayments:**

Washington's Reform Waiver would comport with the cost-sharing principles set forth in the National Governors' Association (NGA) HR-32 Health Care Reform Policy. Specifically, no point-of-service cost-sharing (copayment, deductible, co-insurance) would be imposed on mandatory services for Medicaid mandatory populations, as defined in the federal Medicaid statute, except for non-emergent use of hospital emergency rooms.[1] Affordable point-of-service cost-sharing could be adopted for optional services for mandatory populations, and

1 The Medicaid CN mandatory services include: inpatient hospital services; outpatient hospital services; other laboratory and x-ray services; physician services and medical and surgical services of a dentist; nursing practitioners' services; nurse-midwife services; rural health clinic (including federally qualified health care center) services; nursing facility (NF) services and home health services for individuals age 21 and older; early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21; and family planning services and supplies.

for non-preventive services for Medicaid optional populations, as defined in the federal Medicaid statute.

- **Premiums:**

The Reform Waiver would allow Washington to adopt reasonable premiums for medical coverage for all Medicaid clients with income above 100% of poverty. However, total cost-sharing (premiums plus point-of-services cost-sharing) for health related care could not exceed 5% of the family's income. In accordance with Washington's tribal accord and federal Medicaid and SCHIP policy, cost-sharing requirements would not be imposed on American Indians. Cost-sharing would require legislative approval.

- **Benefit Flexibility:**

Consistent with HR-32, Washington's waiver would retain existing mandatory benefits for mandatory eligibility groups, as defined in federal Medicaid statute. Comparability of service requirements for Medicaid mandatory and optional groups, and among optional groups would be waived. The wavier also would waive mandatory service requirements, including EPSDT, for Medicaid optional groups.[2] This would allow Washington to have different benefit designs for its various eligibility groups.

The Reform Waiver would establish a "benefit floor," which would be the state's Basic Health (BH) Program design, without preexisting condition limitations, and with coverage of outpatient rehabilitation therapies. The floor could be adjusted for changes in the scope of BH program benefit design. Washington would retain flexibility under current federal law to change optional services not covered by BH for mandatory populations. Any changes in benefit design would require legislative approval.

- **Enrollment Limits:**

To comport with federal intent of the Medicaid program and ensure coverage to its most vulnerable residents, the waiver would continue to guarantee coverage for mandatory Categorically Needy eligibility groups.

The waiver would allow Washington to offer coverage to other "categorical" populations within available state matching funds authorized by the legislature. The state would be able to impose waiting lists for coverage if state funds were not sufficient to cover optional groups. The waiver would allow Washington to prioritize categorical populations that would be first subject to enrollment limits. As permitted under existing federal law, Washington also would be able to eliminate coverage for optional groups.

- **Program Eligibility Simplification:**

To reduce administrative burden on clients, health plans and state agencies, MAA may con-

2 EPSDT coverage would be retained for mandatory coverage of children, which includes: children up to age one in households up to 185% of poverty; children age one through five to 133% of poverty; children age six through 18 in households up to 100% of poverty; and, children in state placed foster care. DSHS also would retain its exception to rule policy for both mandatory and optional coverage.

sider obtaining waivers to: (1) remove the signature requirement on the application; (2) implement a gross income test with a child care disregard; and (3) allow RHCs, FQHC's, disproportionate share hospitals, local health departments and the Health Care Authority to conduct eligibility determinations for children, pregnant women, and families.

- **Unspent SCHIP Allotment:**

In order to support the state's efforts to provide subsidized health coverage to low-income residents, the Reform Waiver would include a SCHIP demonstration component. This would allow Washington to use its unspent SCHIP funding to cover parents of Medicaid and SCHIP eligible children. Coverage would be offered through the BH program. It would include all existing BH program cost-sharing and preexisting condition requirements. Coverage under the demonstration would be limited to available SCHIP allotments and state matching funds authorized by the legislature.

DSHS and the Governor would continue to work with the Congressional delegation staff and other states in efforts to amend federal law to be able to use our unspent SCHIP allotment to fund coverage for Medicaid eligible children.

- **Waiver Administration:**

In order to ensure legislative direction and stakeholder consultation, the Reform Waiver would adopt an administrative process as used for the BH program, plus a prospective state plan amendment type approach with HHS' Centers for Medicare & Medicaid Services (CMS).

Under this model, DSHS would not adopt cost-sharing or benefit changes without approval from the Legislature. DSHS also would submit a waiver plan amendment to CMS. DSHS could impose an enrollment freeze at any time that expenditures were projected to exceed the appropriated amount. DSHS would issue an emergency public notification and waiver notice to CMS.

The Reform Waiver will enhance our state's efforts to sustain our major commitments to provide health coverage to our most vulnerable residents and to support efforts to make health coverage available to low-income working families. The proposed flexibility represents a change in the Medicaid program. However, these changes are consistent with national and other states' efforts to develop strategies to sustain coverage to low-income individuals. The waiver also includes appropriate safeguards for our most vulnerable residents.

We are on an aggressive timeline to develop our waiver application, and anticipate its submittal at the end of September 2001. During the development stage, we will be seeking input from the Legislature, state agencies, Title XIX Advisory Committee, Washington's tribes and other stakeholders.

Endnotes

1 Leighton Ku and Jocelyn Guyer, *Medicaid Spending: Rising Again, Nut Not to Crisis Levels*, Center on Budget and Policy Priorities, April 20, 2001, p. 2.

2 There are other ways that people can obtain Medicaid coverage beyond meeting the income guidelines. For example, people with disabilities, the elderly, and some children and qualify for the Medically-Needy program. To qualify for the Medically-Needy program, your medical bills must be so large that your income meets the eligibility level. The income needed to support a family of three is from the Northwest Job Gap Study, University of Washington Northwest Policy Center and the Northwest Federation of Community Organizations, June 2001.

3 Secretary Braddock says in his memo that DSHS would retain EPSDT coverage for children up to age 1 in families earning up to 185% of the federal poverty line, for children between ages 1 to 5 in families earning up to 133% of the federal poverty line, children between ages 6 and 18 in families in families earning up to 100% of the federal poverty line and children in foster care.

4 Rosemarie B. Hakim and Barry V. Bye, *Effectiveness of Compliance with Pediatric Prevenative Care Guidelines Among Medicaid Beneficiaries*, American Academy of Pediatrics, July 2001, p. 1.

5 *Northwest Job Gap Study*, June 2001.

6 Jeanne Lambrew, *Section 115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview*, The Kaiser Commission on Medicaid and the Uninsured, July 2001, p. 2.

7 59 fr 49.249 Federal Register: September 27, 1994 Administration for Children and Families, [ORD-069-N] Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures.

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12 "There just isn't going to be the amount of money available to continue Medicaid, if we continue at our current levels," said Dennis Braddock, secretary of the state Department of Social and Health Services. 'You can't ignore the arithmetic that's going on in health." Carol M. Ostrom, "Families worry about state plan to change Medicaid benefits," Seattle Times, August 22, 2001.

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19 "State Action to Lower Prescription Drug Prices," Center for Policy Alternatives, July 2000.

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About the organizations releasing this report

Washington Citizen Action (WCA) is a social and economic justice organization with over 50,000 individual members statewide. In addition to its dynamic grassroots membership, WCA also includes permanent coalition partners from other community organizations, labor, senior, religious, and people of color organizations. WCA has both a legislative and non-legislative issue agenda that focuses on increasing access to health care and living wage jobs.

The Northwest Federation of Community Organizations (NWFCO) is a regional federation of five statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), Washington Citizen Action (WCA), and Coalition of Montanans Concerned with Disabilities (CMCD). Collectively, these organizations engage in community organizing and coalition building in 14 rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Idaho.

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