Don't Waiver on Medicaid

Governor Kempthorne's Proposal for Medicaid Puts Idaho at Risk

Idaho Community Action Network

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Overview

Health care costs are rising around the country, and Idaho is no exception. In the face of skyrocketing costs, the struggle to maintain adequate health coverage affects individuals, employers, and state governments alike.

Without public health coverage programs such as Medicaid and CHIP, more than 180,000 Idahoans would be left without health care. These include low-income families, children, people with disabilities, and the elderly. Medicaid provides a comprehensive package of benefits, including primary care, for people who would otherwise be unable to afford health insurance. Without Medicaid, these people would be forced to go without care until health conditions become emergencies.

As in all health plans, costs are rising in Medicaid, and Medicaid constitutes a growing share of the state budget. The rising costs of health care are exceeding the pace of inflation or economic growth. The Governor is proposing sweeping changes to Medicaid that attempt to address these rising costs to the state. Specifically, the Governor is applying for a federal 1115 waiver that will allow the state to fundamentally change the nature and structure of the Medicaid program.

Two of the most significant changes that the Governor proposes include cost-sharing and segmentation of the beneficiary population. The waiver will allow the state to restrict access to the Medicaid program by charging premiums and co-pays. It will also allow the state to segment Medicaid recipients and limit benefits to certain groups. 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 Idaho's low-income families, people with disabilities, and the elderly. When people don't have access to health insurance, they often end up in an emergency room seeking costly care for a problem that could have been easily prevented by an earlier visit to a doctor.

Medicaid is a state-federal matching program, and for every $10 that Idaho spends, the state receives $24.44 from the federal government. In exchange for the ability to alter the Medicaid program, as is offered by the 1115 waiver, the state will receive a capped amount of federal spending instead of a federal match that will rise to keep pace with Idaho's growing health care needs. As the costs of health care continue to rise, this cap will put Idaho's state budget at risk.

There are better ways for Idaho to address rising health care costs. For example, there are many state strategies for addressing the rising cost of prescription drugs, a root cause of rising Medicaid spending. However, Governor Kempthorne's proposal doesn't address the prescription drug crisis, instead focusing on requiring program participants to pay more and receive fewer health care services. These requirements will lead to more uninsured families and higher health care costs in the future.

Section I:

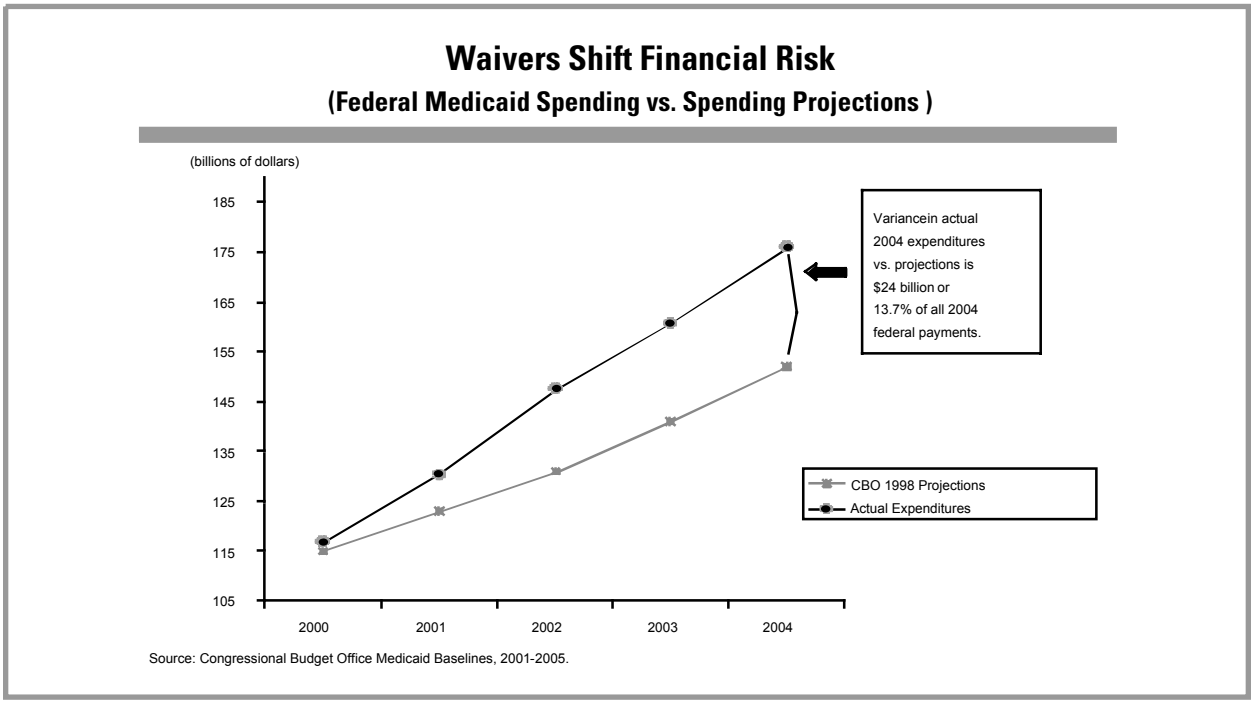
Governor Kempthorne's Waiver Proposal

Medicaid is the source of health coverage for 180,000 Idahoans, including people with disabilities, low-income children and their parents, and the elderly. The Governor and the Idaho Department of Health and Welfare are submitting a proposal to "modernize" Medicaid. Three key changes to the program include a cap on state Medicaid spending, increased premiums and copayments for Medicaid recipients, and segmentation of Medicaid beneficiaries into eligibility categories.

A. Caps on State Medicaid Spending

Rising health care costs are the primary driver behind the Governor's Medicaid reform proposal. The fact that the state's average Medicaid annual growth rate of 17.7 percent between 1987 and 2005 exceeded the average annual growth rate in general fund expenditures (7.1 percent) has led the Department of Health and Welfare and the Governor to conclude that "Medicaid is unsustainable in its current form." To control Medicaid spending, the Governor has proposed a cap on state financing. Yet a financing cap does not address the reasons why health care costs are increasing, and will have a ripple effect that will limit the state's ability to respond to the critical health needs of Idahoans.

The Governor's Medicaid budget recommendation would reduce the rate of growth in Medicaid from 12.7% to a fixed 12.3% in the State General Fund.[1] This targeted rate of growth is an arbitrary figure



1 David Rogers, Administrator for Medicaid, Department of Health and Welfare. From House Health and Welfare Committee Minutes, January 16, 2006

Rebecca Hales
Boise, ID

I am a home care provider, and all of my clients are on Medicaid. I am concerned about the Governor's proposal, which will put caps on this vital program and institute premiums and co-pays. Some of my clients simply couldn't afford these costs. My clients are on fixed incomes, usually about $500 a month. If they needed to pay a co-pay to see a doctor or go to the emergency room toward the end of the month, they couldn't do it.

Premiums will also make it hard for some people to get the care they need. It's the lowest-income people who are going to have trouble paying the premiums, and without Medicaid they wouldn't have anywhere to go. If my clients can't get their medications or see their doctors regularly, they'll be in the hospital or a nursing home, or worse. And we all know that emergency rooms and nursing homes cost a lot more than in-home care.

I know from my own family experience how cutting Medicaid or instituting premiums will affect people. The good thing is, with Medicaid my husband at least has health insurance. But if we had to pay for doctors' visits every time he went to the doctor, we couldn't afford it. I support us on $9.15 an hour, which not much money when you work out all the bills. If Medicaid spending is capped and we have to pay premiums and co-pays, the repercussions for my family and for my clients will be serious.

that does not reflect cost of health care or the growing need for Medicaid coverage. If Medicaid costs increase beyond this amount, whether due to health care inflation or increased enrollment due to a recession, the state will be forced to cut vital health services.

Currently Idaho receives federal matching funds to administer Medicaid, which helps subsidize the program when costs increase. A state cap on health care spending also caps federal matching funds, and as a result the loss of health care dollars will exceed the savings to the state. Currently, Idaho receives $24.44 in federal funds for every $10 it spends on Medicaid. Thus, for every $10 reduction in the state Medicaid budget, the state will lose $24.44 in federal matching funds. This loss will have ramifications for the state's economy as well as for its vital health care services.

Another possibility that arises with the Medicaid waiver proposal is a federal block grant, an annual federal Medicaid contribution that would be pegged to projected Medicaid costs.

Medicaid costs, however, are rising faster than federal projections. By accepting a block grant, Idaho would assume responsibility for costs above projected increases, without federal assistance. When costs rise faster than projections, either Idaho taxpayers will have to foot the bill or the state will have to cut services or reduce enrollment. Financing caps are likely to prevent Idaho families from getting the health care they desperately need, and push more people into the health gap.

B. Governor Kempthorne's Proposal to Increase Co-pays and Premiums

One of the fundamental changes to the Medicaid program as proposed by Governor Kempthorne is to impose premiums and co-pays for Medicaid recipients. This proposal has been submitted as draft legislation, which was presented to the Senate and House Health & Welfare Committees by David Rogers, Director of the Division of Medicaid.

According to the draft legislation, premiums would vary according to income. Premiums for families between 133 percent and 150 percent of the federal poverty level would be $10 per person per month, up to a maximum of $30 a month. For families between 150 percent and 185 percent of the federal poverty level, those premiums rise to $15 per person per month, to a maximum of $45 per month. In addition to premiums, the waiver would allow the state to increase Medicaid co-pays for medical services, such as doctor's visits, emergency room visits, and prescription drugs. Other states have that have implemented premiums and co-pays provide lessons about the anticipated outcomes of such policies.

The Effect of Premiums and Co-pays: Lessons from Other States

The Medicaid program limits premiums, co-pays, and other forms of cost-sharing because it serves low-income people who are sicker and poorer than most Idahoans. Many Medicaid recipients are below the poverty line, and even Medicaid recipients who

Ron Bergloff, Dental Clinic Director
Academy of Professional Careers
Dental Clinic

I'm the director of a dental clinic that serves adults and children on Medicaid. Every day I see the challenges that Medicaid recipients face.

The Governor is proposing to increase co-pays in his Medicaid proposal. I know that this will be a barrier to necessary care for many people. Already, once or twice a day people come into our clinic who can't come up with our $40 introductory exam cost. We'll take payments, and we try to work with people. But they simply don't have the money. Waiting around when you have a toothache or when you need to see the doctor because you can't put together $7 or $8 can have serious consequences.

In dentistry, problems for children and adults start with decay. When that decay gets to the root, it causes excruciating pain. People can't function with a toothache, so they have to go to the emergency room, and that's $1500 a visit. The ER will treat them and send them to get the tooth extracted. A missing a tooth, especially a front tooth, affects a person's ability to get a job and participate in society. But to replace that tooth costs another $2400.

Another tragedy is that some people don't go to the emergency room because they're afraid of the cost. That tooth infection is close to the brain, and without treatment it can kill you. All of this could be avoided for the $48 it costs for a filling.

The Governor spoke of focusing attention on prevention, but his proposal uses co-pays as a deterrent. Co-pays are no magic bullet and don't eliminate just "unnecessary" care. They only delay and deter people from seeking preventive measures, which leads to greater acute/emergency treatment costs.

are above the poverty line are members of low-income working families who are struggling to meet their current needs.

Over the past few years, several states have implemented cost-sharing programs that imposed premiums and co-pays on Medicaid recipients. From these experiments, there is substantial evidence that even slight increases in premiums and co-pays lead to a sharp decrease in access to primary and preventive health care and do not generate significant revenue for the state Medicaid budget. States that have implemented changes similar to Governor Kempthorne's proposal include Oregon, Vermont, Rhode Island, and Utah.[2]

Oregon: In 2003, under a Medicaid waiver, Oregon imposed premiums for poor adults ranging from $6 to $20, based on income. Following introduction of these premiums, enrollment dropped by nearly half or roughly 50,000 people. There were enrollment losses among all those subject to the increased premiums, but losses were steepest among those with the lowest incomes. Nearly a third (31%) of surveyed disenrollees reported premium costs as a primary reason they lost coverage. Over two thirds (67%) of poor adults who were disenrolled became uninsured. Those who left reported worse access to care, less primary care utilization, and greater financial hardships than those who remained enrolled. Many also reported a decline in health status. As one focus group participant remarked, "Being able to afford $2 is a lot of money when you have absolutely nothing."

Vermont: In January 2004, Vermont increased premiums in its Medicaid waiver and SCHIP programs. During the first month of increased premiums, enrollment declined by 11 percent or 4,500 people. Premiums disproportionately impacted those with the lowest incomes, but also led to disenrollment among those with incomes above 150 percent of poverty. Cost was reported as the reason for disenrollment by 70 percent of adults with incomes between 150 percent and 185 percent of poverty who lost coverage.

Rhode Island: In January 2002, under a Medicaid waiver, Rhode Island began charging families with incomes above 150 percent of poverty premiums ranging from $43-$58 per month. Nearly one in five families were disenrolled due to nonpayment over the next three months, and nearly half of surveyed disenrolled families reported inability to afford the premium as the reason for losing coverage. A survey of the slightly higher income disenrollees in Rhode Island showed that just over half (51 percent) became uninsured.

Utah: Analysis of utilization data in Utah has assessed the impact of new co-pays in its Medicaid program. In a survey of adults subject to the new co-pays, over four in ten agreed that co-pays "seem small, but are actually a huge problem" and nearly

2 State results summarized from "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Samantha Artiga and Molly O'Malley. Kaiser Commission Issue Paper, May 2005.

40 percent agreed they cause "serious financial difficulties."

Charging premiums and cost-sharing can have a significant and immediate impact on low-income individuals' coverage and access to care. Low-income and poor families live on slim margins and often are not able to afford even nominal out-of-pocket costs. While some are able to get financial help to make payments, others are not as fortunate. Loss of public coverage is often not replaced with private coverage; instead families become uninsured.

C. Governor Kempthorne Proposes to Segment the Medicaid Population

The Governor proposes to "achieve improved Medicaid quality by identifying and sorting Medicaid populations according to their identified health needs." In specific, the Governor's proposal will segment the Medicaid population into three groups: Low-income children and working-age adults; individuals with disabilities or special health needs; and people with disabilities. With this sorting of beneficiaries, Idaho Medicaid "proposes to restructure the program by creating Medicaid eligibility categories based on health needs."[3]

How will this change affect access to benefits?

The state has not released any proposals detailing benefits or benefit reductions for different eligibility groups. This is critical information for determining how this proposal will affect beneficiary groups. However, with the waiver the state will have the ability to restrict benefits and discriminate against certain population groups.

How will this affect the administration of the program?

Segmenting the Medicaid population poses the risk of decreased efficiency and increased administrative costs. Currently, states participating in the Medicaid program must offer a comprehensive package of benefits to all enrollees, without discrimination against particular groups. As a result of this comprehensive and consistent coverage, Medicaid is a relatively simple program to administer. In fact, administrative costs associated with Medicaid (6.9 percent of total costs) are about half as high as administrative costs under private insurance (13.6 percent of total costs, on average), even though Medicaid cares for the poorest and sickest patients with the most complex health needs.[4] By segmenting the Medicaid population, the Governor's proposal adds layers of bureaucracy that are likely to be costly to the state and may prevent people from accessing necessary care.

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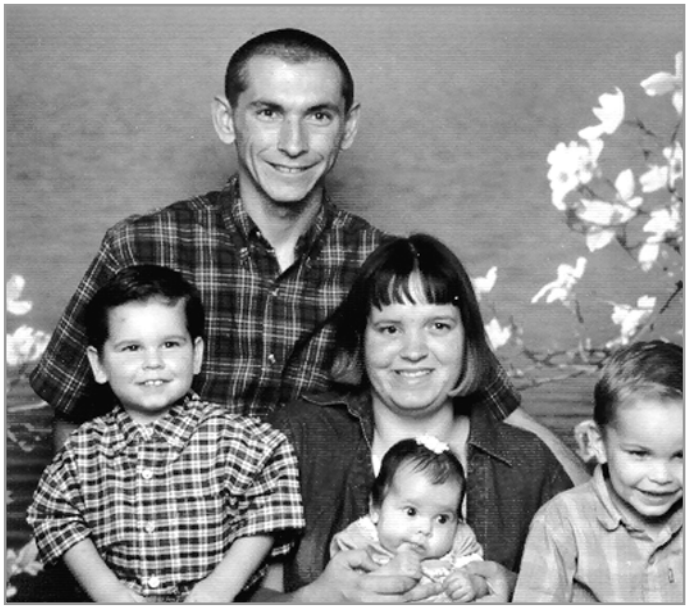
3 "Modernizing Idaho Medicaid: Value-Based Reform." Technical Proposal, December 31, 2005.

4 Cynthia Smith, et al. "Health Spending Growth Slows in 2003," Health Affairs, 24(1): 185-194, Jan./Feb. 2005. Medicaid administrative costs include both state administrative expenses and the administrative costs of Medicaid managed care organizations.



Nicole Cole
Boise, ID

My name is Nicole, and I'm a Medicaid recipient. I live with my husband, and our three children all rely on Medicaid. Recently, the Department of Health & Welfare posted a summary of the Medicaid "listening sessions". David Rogers, Administrator of the Medicaid Division, concludes the report by saying, "I'm pleased with the support the community has shown us in our Modernizing Medicaid effort."

I went to the listening session in Boise, and Mr. Rogers' comment makes me wonder, were they listening? Were we even at the same meeting?

In the summary, DHW did get one thing right: "the message was loud and clear from Idaho residents… – don't cut services…" That was certainly my message. Our family struggles on a tight budget; we can't afford to pay premiums or co-pays for my children's care.

Besides that, the Department's conclusions were far from what I experienced. At the meeting I attended, speaker after speaker stood up to express concern and ask for more details about the Governor's waiver proposal, only to be told that there would be no answers to questions. I gather from people who attended the meetings in Lewiston, Caldwell and Pocatello that the same was true there, too: lots of questions, no answers.

The few things we did hear weren't encouraging. They've said they are going to tell us when we can and can't take our kids to the emergency room. But I don't want to have to call 9-11 and then be told I can't bring my kid to the ER. They couldn't even tell us what would qualify as an emergency. If no one else is open, you've got to go. They also talked about co-pays in the ER. Even if we were told it was an emergency, we might not be able to afford it.

This waiver will affect families like mine, and we need to know the truth. Two of my babies were born premature. Without Medicaid, we couldn't care for either of them. People need to listen to us because they're not in our shoes. We speak from experience, not from the other side of the fence, looking in.

Section II:

Major Changes without a Public Process

Governor Kempthorne's Medicaid proposal to increase cost-sharing and segment beneficiary groups undermines current legal rights for program beneficiaries. Because this proposal conflicts with those protections, the changes must be approved by the U.S. Department of Health and Human Services through 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.[5]

Historically, "public access to information on demonstration approval and monitoring is limited."[6] Once the Idaho Department of Health and Welfare submits the waiver to HHS, there will be little, if any, possibility of input from those impacted by the cuts in services.

Thus far, the Idaho Department of Health and Welfare has engaged in very little dialogue with Idahoans about the plans for the Medicaid program. Between January 4th and 6th, the Department held "Listening Sessions" around the state. Notice for these sessions was posted on the Department of Health and Welfare website one week in advance, on December 28th. With the New Years Day holiday, this constituted less than five working days' notice. In addition, the sessions were held between 3 and 6 p.m. during the workday, when most working people would be unable to attend.

Recently, the Department posted a short summary of the "Listening Sessions". The Department reported a total attendance of 340 people. The Department estimates that only 120 people testified at those hearings, less than 0.01 percent of the state population. Moreover, when people expressed concerns and asked for details about the Governor's waiver proposal, they were often told that there would be no answers to questions.

The Department of Health and Welfare is implementing a second step in the hearing process through a series of pre-hearings at the state legislature. At these hearings, the public has not been allowed to testify.

Public meetings held to discuss public health programs are not adequate if the state does not provide information about the proposal at issue. Yet to date, no meaningful attempt has been made to hear the voices of those who will be affected the most by the Governor's proposed changes. Despite the fact that little public input has been sought or obtained, the Department has indicated that the state intends to move ahead based on what it deems, without evidence, as "cautious support" from the public. There

5 Jeane Lambrew, Section 1115 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.
6 Jeane Lambrew, Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview, The Kaiser Commission on Medicaid and the Uninsured, July 2001, p. 6.

will be no opportunity for the public to participate once the Department sends the waiver proposal to the federal government, and there will be little opportunity once the waiver comes back to the state legislature.

Section III:

The Governor's Proposal Shifts Costs to Counties and Health Care Providers

The Governor's Medicaid proposal is explicitly designed to address the cost of Medicaid to the state. Despite this directive, the proposal does not address the primary reasons why health care costs are rising in Idaho. One of the primary cost drivers in Medicaid is prescription drugs. In 1999, Idaho Medicaid spent $64 million on prescription medications, the third highest spending category in the state's Medicaid program. Two years later, the cost of prescription drugs increased by 58 percent, topping $101 million. By fiscal year 2004, this number climbed to $123 million. Despite the proven success of state strategies to curb prescription drug costs, however, the proposed waiver does not address the rising cost of prescription drugs.

There is reason to be concerned that the Governor's proposal will in fact lead to higher costs for the health care system. Reduced enrollment and a lack of access to health care that will result from increased premiums and co-pays will lead to increased pressures on providers and the health care safety-net. The experiences of other states demonstrate this outcome. For example:

• Following its Medicaid coverage losses, Oregon saw an increase in emergency room use by uninsured patients and increased pressure on clinics. In addition, some physicians diverted funds previously targeted to the uninsured to help Medicaid patients pay new prescription drug co-pays that they could not afford.

• Washington State attempted to transition a group of immigrant families from a state-funded Medicaid look-alike program to its state-funded Basic Health program, which charges premiums and co-pays. After this transition, the state experienced a marked increase (54%) in use of its Alien Emergency Medicaid Program, because many people were unable to afford the new premiums or needed services that weren't covered under the new plan.

Providers also reported a substantial increase in demand for charity care, emergency room use, and strains on clinic resources.

If the waiver proposal becomes reality, Idaho can anticipate increasing costs to the health care system, as former Medicaid recipients who are unable to afford premiums and co-pays or for whom needed services aren't covered end up receiving emergency care for which they cannot pay. The state is unlikely, however, to make up these costs through the increase in revenue from those premiums and co-pays. In Oregon, the state's premium revenues actually declined after it increased premium amounts and tightened payment policies because of the enrollment drop-off that occurred. As a result, Oregon reduced program spending due to lower enrollment, not higher premium collections.

When more people become uninsured, the cost for their health care is shifted to counties, who are legally obligated to pay for indigent care through the County Indigency Fund and through county hospitals. Many counties already struggle with medical indigency costs as the cost of health care is rising faster than county revenue. Because counties are limited to 3 percent growth in property tax revenue, increases in medical costs come at the expense of other services.

Other health care providers, particularly non-profit and for-profit hospitals, also bear the increased cost of emergency care and pass those costs on through higher prices for those who are insured. In sum, increasing financial obligations on low-income families may provide short-term savings in the state's budget, but those costs are passed on to counties and to all Idahoans. In terms of the state's fiscal and physical health, the cost-shifting imbedded within the Governor's Medicaid proposal comes at a high price.

Section IV:
A Better Solution

There are many ways that Idaho can improve Medicaid and achieve cost-savings without pushing more of Idaho's low-income families, the elderly, and people with disabilities into the ranks of the uninsured. They include finding savings for prescription drugs, simplifying eligibility guidelines, and improving care for people with disabilities.

Prescription drug costs are rising rapidly across the nation and the Northwest, in all types of health care programs. To deal with these costs, many states have started negotiating lower prescription drug prices from the extremely profitable pharmaceutical companies — and they are already saving money. Larger volume purchasers can negotiate larger savings, so

states are creating large purchasing pools. By using multi-agency and multi-state prescription drug purchasing pools and/or preferred drug lists, states have projected or realized savings of 5 to 15 percent of their total prescription drug costs.

By using these strategies, Idaho's state agencies would likely realize savings between 5 and 15 percent of their total prescription drug costs as well. The state of Idaho should change how it purchases prescription drugs by creating the largest purchasing pool possible. The pool should include state agencies, the underinsured and uninsured, private entities, local units of government, and labor organizations; and Idaho could join with other states to increase its savings.

Idaho can also improve Medicaid by removing eligibility barriers. The Governor's proposal would eliminate the asset test for children, which would make it easier to cover more Idaho kids. Idaho doesn't need a federal waiver to remove this asset test for children, however, nor does it need a waiver to make the asset test for adults less onerous. This can be authorized through a state plan amendment (under section 1932(a) of the Social Security Act). The state could do more to ensure that kids get all the screening they need, through the EPSDT (early and periodic screening, diagnosis, and treatment) program. The state could also expand eligibility for working people with disabilities by allowing them to buy in to the Medicaid program. The state could also eliminate the marriage penalty and allow people with disabilities to retain their access to health care regardless of who they marry.

Another way to save Medicaid costs is to make institutional care the last resort, instead of a first resort. This saves money for the system while treating people with disabilities and older people with dignity. This common-sense step also does not require a federal waiver or jeopardize federal matching funds for Idaho.

Conclusion

The Medicaid waiver that is being proposed by the Governor and the Department of Health and Welfare is likely to do more harm than good. For those who rely on Medicaid, the proposal will lead to increased costs, may restrict benefits, and is likely to cause many people to forego needed medical care. The waiver is also likely to shift health care costs onto counties, health care providers, and people who have health insurance, without generating revenue for the state or addressing the real cost drivers in Medicaid.

There are ways that Idaho can address rising health care costs without applying for a federal waiver or accepting federal spending caps. State strategies for addressing the rising cost of prescription drugs, simplifying eligibility requirements, and improving home care for people with disabilities are logical steps that will improve Medicaid without compromising the health coverage that 180,000 Idahoans depend on.

Don't Waiver on Medicaid

About the organization releasing this report

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The Idaho Community Action Network (ICAN) serves as a powerful, consolidated voice for low- and moderate-income Idahoans, with chapters and membership clusters in fourteen Idaho communities, including the state's three largest cities and numerous rural areas. Through ICAN, low-income Idaho families have a voice in the decisions that impact their lives. In addition to its direct action work, ICAN runs a statewide, volunteer-driven food program that helps low-income families supplement their monthly budgets.

ICAN's community organizing model integrates the provision of food with training, leadership development, and action on issues to win concrete changes in people's lives and advance the cause of social, racial and economic justice for all Idahoans.