Survival Coalition
of Wisconsin Disability Organizations

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To: Members, Joint Committee on Finance

From: Survival Coalition Co-Chairs
Lynn Breedlove, Disability Rights Wisconsin
Maureen Ryan, Wisconsin Coalition of Independent Living Centers, Inc.
Beth Swedeen, WI Board for People with Developmental Disabilities

Subject: Department of Health Services Medicaid Savings Plan – Under JFC Objection

The Survival Coalition of Wisconsin Disability Organizations has been monitoring the Department of Health Services' proposals to find efficiencies and savings in the state's Medicaid program since savings requirements were first introduced and passed in the state biennial budget. Over the last several months, disability advocates from across the state have participated in public hearings, issued position papers with questions and concerns, provided savings ideas and held meetings with Department officials, including Secretary Smith. We appreciate the Department's willingness to meet with and learn from stakeholders, particularly people with disabilities, who rely on the health of our state's Medicaid program.

That being said, the conclusion we share in this paper is that the Department's final proposal submitted to the Joint Finance Committee for review still contains too many unanswered questions and problematic assumptions. Although we recognize the fact that individuals with more significant disabilities accessing Elderly Blind Disabled (EBD) Medicaid are protected in the larger DHS proposal, it is important to note than many people with disabling conditions rely on BadgerCare programs to manage their illness, take care of their children and function. Without the current level of care and support they receive to afford co-pays for expensive medicines and reasonable premiums, we have reason to believe many of these individuals will see their conditions worsen. In addition, we believe that the Department has not included many of the savings ideas that were analyzed and submitted by numerous disability advocates and organizations and which could prevent the implementation of the concerning provisions we outline below.

In summary, we ask that you review each item in the proposal carefully and consider its unique implications for individuals with disabilities. We firmly believe Wisconsin can still achieve Medicaid savings without denying quality health care to tens of thousands of people.

ITEMS THAT WE OPPOSE OR WHICH REQUIRE MODIFICATION

1. **Alternative Benchmark Plan for BadgerCare Plus Standard Plan**

The Department has described this change as a shift of more than 200,000 people covered by the BadgerCare Plus Standard plan into a plan with lower costs for taxpayers (but fewer benefits for recipients) while also leveling the playing field with private insurance. This change will significantly impact people with disabilities who may not qualify for Medicaid through their disability but qualify through income and still have significant disability-related health concerns. This may be a family with a child with a seizure disorder or other special healthcare needs like diabetes, someone with mental illness who is not on SSI or SSDI, or a person with a physical disability who does not have long-term care needs. **This shift to Benchmark Plan coverage is significant for these individuals, particularly because increased co-pays will cause people to drop coverage and the less comprehensive service package will not meet people's needs. We are also concerned about the health care workforce crisis and members of the workforce who care for people with disabilities who may now not be able to afford insurance. Prior to BadgerCare Plus, it was estimated that approximately 20,000 home care and 4,700 nursing home workers in Wisconsin were uninsured.**[1]

Experiences in other states show that increasing the participant's cost-share led to unmet medical needs and financial stress, even when increases were nominal. In Oregon, a survey of poor adults subject to increased cost-sharing in the state's Medicaid waiver showed that, among those with unmet needs, over a third (35%) could not get needed care due to cost, 24% reported that they did not have the copayment, and 17% reported that they did not get care because they owed the physician money. Some individuals reported they were unable to obtain prescription drugs because they could not pay. [2] **Ultimately Oregon's copayment policies did not provide the expected cost savings because individuals skipped preventive care and used more costly hospital emergency care.**[3]

In addition, the proposed Benchmark Plan benefits may not be adequate to meet the needs of individuals and families affected by disabling conditions. It is unclear in the Department's proposal exactly which benefits will now change and we think this is a necessary clarification. When comparing to the current Benchmark Plan package, it appears that at a minimum dental and drug benefits will be limited. For people with conditions like Multiple Sclerosis, a drug benefit change could have severe consequences. It is also important to note that when other states have required cost-sharing for drug benefits, elderly Medicaid beneficiaries and beneficiaries with disabilities have shown lower rates of prescription drug use. This burden falls disproportionately on beneficiaries in poor health.[4] **We OPPOSE the mandatory shifting of people with disabling conditions to the new Alternative Benchmark Plan. At a minimum, the legislature should be provided with a complete comparison of benefit changes between these plans, including the brand-name drugs that will not be covered and how this could affect people with significant disabilities.**

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[1] Health Care for Health Care Workers Campaign. BadgerCare Plus Proposal Impact on the Direct-Care Workforce and their Families. Wisconsin Long Term Care Workforce Alliance. 2008.

[2] Artiga, S., O'Malley, M. Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. Kaiser Commission on Medicaid and the Uninsured. 2005.

[3] Neal T. Wallace *et al*., *How Effective Are Copayments in Reducing Expenditures for Low- Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*, 43 HEALTH SERV. RES. 515 (2008), *at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/.

[4] Stuart B, Zacker C., Who Bears the Burden of Medicaid Drug Co-payment Policies? 18 HEALTH AFF. (online ed., March/April 1999), http://content.healthaffairs.org/content/18/2/201.long.

2. **Increasing Premiums**

In May a study sponsored through Georgetown University ran scenarios estimating the impact of charging premiums from 3 to 4% of families' incomes on participation rates in Wisconsin's BadgerCare Plus. Their findings suggested that such changes would result in between 49,422 and 87,298 fewer children and their parents participating in BadgerCare Plus.[5] A similar action in Oregon increased premiums for poor adults between $6 and $20, based on income. Following these changes, enrollment dropped by nearly half, or roughly 50,000 people. In addition, survey results in Oregon showed that over two thirds (67%) of poor adults who were disenrolled following the premium increases and tightened premium payment policies became uninsured.[6]

During public hearings, DHS heard from many families and individuals who said they were willing to pay more for their coverage, but that the proposed premium hike was not affordable. **While DHS advises that an increase up to 5% of household income is fair, they have not been able to confirm how many people will drop off of coverage due to this change nor how much cost-shifting to hospitals will occur. We believe this calculation is essential and should be provided to the legislature by DHS before such a proposal is advanced. We OPPOSE this premium hike proposal which does not include a corresponding and comprehensive calculation of impact.**

3. **Restricting Eligibility for People with Access to Private Insurance**

DHS defines affordability based on one section of the federal Patient Protection and Affordable Care Act (PPACA) which says that individuals with access to employer-sponsored insurance would not be eligible for coverage if the lowest cost self-only premium is less than 9.5% of household income. **However, this section of the PPACA also includes a second piece of the affordability test which DHS did not include. In addition to consideration of a comparison to household income, the PPACA also recognizes allowances when the employer plan's payments cover less than 60% of total allowed costs.** (See p. 2 of the document linked below). **Wisconsin's affordability test for employer-sponsored insurance should include both important affordability measures.**[7]

Additionally, the section of the PPACA addressing premium credits appears to define affordability differently. Premium credits under the law are based on the "applicable percentage"—that is, the maximum percentage of income that individuals will be required to pay toward the second-lowest cost "silver" exchange plan in the area. While individuals with income above 300% of FPL will pay 9.5% people at lower income levels will pay a lower percentage of family income. For instance families at 150% of FPL will pay 4% of family income and families at 200% will pay 6.3% (see page 6).[8] **Wisconsin's proposal should provide for the more appropriate benchmarks to use for affordability.**

http://www.ncsl.org/documents/health/HlthInsPremCredits.pdf

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[5] Alker, J., Heberlein, M., Prater, W. The Impact of Premiums on Families in BadgerCare Plus, Georgetown Center for Children and Families, Georgetown University's Health Policy Institute, May 2011.

[6] Artiga, S., O'Malley, M. 2005.

[7] Congressional Research Service, Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA), April 2010.

[8] Congressional Research Service, 2010.

For people with disabilities, the scope of the benefit package is an equally important consideration to cost. **If Wisconsin adopts the same household affordability measure utilized in the PPACA, residents should also be allowed the same benefit safeguards guaranteeing a minimum level of coverage that is not currently available in most private plans. Essential benefits for people with disabilities include such elements as mental health coverage. <u>This proposal must be MODIFIED to address the above concerns.</u>**

4. **<u>Restricting Eligibility of Young Adults</u>**

DHS' proposal denies Medicaid eligibility to people between ages 19 and 25 who have a parent with employer health insurance that may cover the adult child. Although well-intentioned to ensure access to coverage, we believe that this proposal will have unintentional negative consequences for people with disabilities. For example, the parent's insurance may not cover the adult child's medical condition or disability, it may not cover medical providers in the community in which the adult-child lives, or it may be unaffordable. Moreover, because a parent is no longer legally responsible for a child after the child turns 18, a parent may refuse to allow his or her adult child to enroll in the parent's insurance plan for a variety of reasons: because it may be too expensive to add the child to the plan; the parent may be worried that he or she will lose his or her job if the adult child has significant medical needs that drive up the health insurance cost to the parent's employer; or the parent may have no relationship with the child. **In all of the circumstances, adult children under 26 would effectively have no access to health insurance. <u>This proposal must be MODIFIED to consider the above scenarios and necessary exceptions.</u>**

<u>CONCLUSION</u>

We would like to acknowledge the Department's attempts to ensure coverage for people while making changes in Medicaid, however, the options listed above are simply not affordable nor adequate for many people, including people with disabilities. More than three decades of research have shown that measures such as those listed above lead to poorer health and increased use of high-cost services like emergency rooms. These proposals create a false economy that results in significant cost-shifting – a cost-shifting for which DHS has not provided a calculation to the taxpayer or the employer.

Ultimately we ask that the above listed four items be eliminated from Wisconsin's proposal or significantly modified. We also ask at a minimum that the Legislature request more detail from DHS on how many people will a) experience loss of coverage because they cannot afford employer sponsored coverage b) not be able to afford new premiums or c) experience significantly reduced benefits due to the move from the standard plan to the Benchmark plan.

Thank you for considering our input. Please contact us with further questions on this matter.

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cc: DHS Secretary Dennis Smith,
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