

Health Access Legislative Briefing:

**How the Governor's Budget Impacts
Seniors and People with Disabilities**

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The House 1A proposal filed by Governor Romney would have dire consequences for many seniors and people with disabilities who depend on the Commonwealth for health care assistance. The budget underfunds a number of vital health care programs and continues a variety of policies that impede access to care.

Health Care For All calls on the legislature to reverse these cuts and provide adequate funding for health care needs. Seniors and people with disabilities are looking to the General Court to reject the Administration's inadequate funding and policies and provide for a high quality, affordable health support system for every Massachusetts resident.

Background: Rising Uninsurance and Declining State Coverage

A recent study by the Massachusetts Hospital Association estimates that the number of uninsured in the Bay State has grown to around 600,000. This figure is up significantly from the 418,000 found in a state survey in 2002. The growth in the number of uninsured reflects a decline in public and private coverage.

Significant cuts to public insurance programs have led to the loss of health coverage to approximately 70,000 people on MassHealth (our Medicaid program) and limited health coverage for hundreds of thousands of Massachusetts residents. The cuts come in the form of eliminated benefits, enrollment caps, increased premiums and co-pays, reduced reimbursement to providers and administrative obstacles. These policies are particularly devastating to seniors and disabled people with substantial health needs who rely on these programs for needed medical care.

The growth in the number of uninsured is reflected in the skyrocketing demand on the Uncompensated Care Pool. The Pool, which reimburses hospitals and community health centers for the cost of caring for the low-income uninsured, is funded by the Commonwealth, hospitals and insurers. Pool usage is up 35-40% in many hospitals, indicating a distressing increase in the number of people seeking hospital care as a last resort. Free care is a poor substitute for insurance. Hospital care, often delivered in costly emergency rooms, is much more expensive than primary and preventive care. These costs get passed on in the form of higher health care costs and premiums for those with coverage.

Despite the clear importance of Medicaid to the physical and economic wellbeing of Massachusetts, the Governor's budget reduces Medicaid spending by around \$152 million, compared to the amount required for maintenance of current services. As a result, Massachusetts will turn away approximately \$75 million in federal funding. These federal funds could support jobs and economic growth in the Commonwealth.

Economists have looked at the effect of Medicaid spending in Massachusetts and concluded that Medicaid spending is good for our economy. Health services are the largest employment sector in our economy. According to the Division of Employment and Training, health services accounted for over 440,000 jobs in 2002, with a total wage of \$16.6 billion. Every state dollar put into Medicaid returns \$2.21 in economic activity in the state. By cutting \$150 million from MassHealth, the Commonwealth stands to lose \$362 million in business activity, resulting in the loss of 3,164 jobs and \$129 million in lost wages.

Governor's FY05 Budget Continues Cuts to Coverage for Seniors and People with Disabilities

Programs providing health coverage to seniors and people with disabilities have been the target of many of these budget cuts. The cuts proposed by the Governor in House 1A would deny health insurance to even more of seniors and people with disabilities residing in Massachusetts. The impacted programs are described below with a brief explanation of the cuts proposed in the budget.

Prescription Advantage

Prescription Advantage is a prescription drug insurance plan that is available to Massachusetts residents age 65 and over and low-income people under 65 with disabilities. It began in April, 2001 to address a recognized need for a comprehensive drug program for this vulnerable population. Today it serves some 84,500 people, including 80,275 seniors and 4,225 people with disabilities.

It has an unlimited prescription drug benefit that includes most outpatient prescription drugs, as well as insulin and diabetic care supplies. Premiums currently range from \$0 to \$99 per month, depending on income. Like many insurance plans, Prescription Advantage encourages the use of lower cost drugs by utilizing a three tier formulary, with the cheapest drugs being generics and the most expensive prescriptions generally being those brand names with generic alternatives. There are also quarterly deductibles. Unlike traditional insurance plans, Prescription Advantage lowers the cost-sharing for individuals who have lower incomes.

The importance of Prescription Advantage cannot be overstated. Today, there are very few options for comprehensive prescription drug coverage. Aside from Prescription Advantage, there is only one other comprehensive prescription drug coverage program available to most Medicare enrollees, the Medicare " Supplement 2 " option in the Medigap market. The current price for the most common of these plans, Blue Cross' Medex Gold, is \$476 per month; this does include additional benefits.¹ This premium is clearly out of reach for the Massachusetts seniors and people with disabilities living on a fixed income and the state needs to ensure that other options remain available.

Underfunding, Cost-Sharing and Lack of Access

Last year, Governor Romney cut funding to Prescription Advantage partway through the FY03 budget cycle. As a result, the Administration closed the program to new enrollees and increased cost-sharing to those already on the program. In his FY04 budget proposal, the Governor eliminated all funding for the program. Thankfully, the Legislature re-funded the program and re-opened enrollment in the final budget.

In his budget proposal for FY05, the Governor level-funded Prescription Advantage at \$96 million, even though estimates for maintaining the current program as it is, including an open enrollment period, range from \$110 - \$122 million. Under his proposal, the Governor would have to postpone or eliminate an open enrollment period, increase premiums and cost-sharing again and/or reduce benefits to enrollees. Any of these changes would have a detrimental effect to the enrollees as well as the plan itself.

As with all insurance plans, the key is to attract new enrollees into the plan while they are still healthy, before the cost of their care is high. If new, healthier people are unable to enroll in the plan, the pool of participants will get older and sicker. Obviously, this will cause the program costs per person to increase.

The Governor has also made it clear that he believes Prescription Advantage will no longer be necessary when the new Medicare Part D plans begin in 2006. Unfortunately, there will still be a great need for this program. Even with the new Medicare Part D plans, there will still be significant gaps in coverage, the drugs covered by such plans may be limited and the new Medicare law does nothing to lower overall drug costs, so we can expect prices to continue to escalate. The full impact of this law is unclear, however we know that there will still be many people who will remain underinsured, despite the new plan. Prescription Advantage will still be very much in need.

MassHealth

MassHealth, the state's Medicaid program, currently provides health coverage to approximately 930,000 people, including 115,000 seniors, and 200,000 people with disabilities. The budget cuts in the FY2003

¹ Even this high-cost option is slated to end as the new Medicare law will prohibit Supplement 2 plans from enrolling new members in 2006.

and 2004 budgets have seriously eroded this program and with it, the access that people have to adequate medical treatment.

The Governor's proposal makes no restorations to ameliorate the cuts that have occurred over the past two years. Instead, it proposed additional cuts, particularly to providers.

MassHealth: Elimination of Coverage to Legal Immigrants

In August 2003, approximately 10,000 legally residing, special status immigrants were eliminated from the MassHealth program. This population includes 2,750 low-income seniors and people with disabilities. In January, the legislature overrode the Governor's veto of a supplemental budget provision to restore coverage to these seniors and disabled immigrants. This restoration has yet to be implemented, however. In the Governor's 2005 proposal, an additional 1,800 legal immigrants receiving EAEDC would lose access to health coverage, including approximately 1,650 seniors.

MassHealth: Enrollment Caps on the Disabled

The FY04 budget included a provision authorizing DMA to cap enrollment in certain MassHealth programs, including CommonHealth, the program that serves people with disabilities, and Family Assistance, the program that serves people with HIV as well as adults in the Insurance Partnership program. These enrollment caps were approved by the federal government but have not yet been implemented.

House 1A includes a renewed authorization to implement these caps. Capping these programs for people with known health needs and no other source of coverage is bad for public health, increases costs to the Uncompensated Care Pool, and forces people with complex health needs to rely on emergency departments which are often not equipped to provide comprehensive care to these patients.

MassHealth: Elimination of Benefits

Beginning in March 2002, access to a number of MassHealth benefits was eliminated for adults. This includes nearly all dental coverage, eyeglasses, dentures, some braces and chiropractic care. These benefits are particularly critical to seniors and people with disabilities who are disproportionately high users of these medical services.

MassHealth: Asset Tests

Last year's budget authorized the imposition of an asset test to people applying for MassHealth. Otherwise eligible disabled people would be denied care if their bank accounts and other liquid assets exceed the regulatory limit. EOHHS plans to implement the asset requirement during FY05. Massachusetts abandoned this lengthy process years ago to better streamline the application process. Studies have found that the administration of this test often costs more money than it saves.

An asset test would be particularly damaging to the CommonHealth population. Working CommonHealth recipients already pay a premium based on ability to pay. The asset test would prevent a disabled person who is earning well above the poverty rate to choose to set aside savings for a time when they are no longer able to work, or to accumulate savings for the purchase of assets like a car with appropriate, and oftentimes expensive, modifications or a home that can help maintain independence. CommonHealth was created to liberate disabled people from the unacceptable choice between enforced joblessness, which provided a guarantee of quality health care, or financial independence through work with all medical support stripped away.

MassHealth: Nursing Facility Care

When a patient leaves a nursing facility, bedhold payments are made to reserve the bed for the patient. It is common for people to leave a nursing facility for medical reasons, such as a hospital stay, and non-medical reasons, like a trip home to spend Christmas with family members. In August of 2003, bedhold payments for non-medical leaves of absence were eliminated. Therefore, people with disabilities and seniors risk losing their beds in their nursing facilities if they leave for any non-medical reason.

MassHealth: Definition of Disability

In August 2003, Massachusetts' Office of Medicaid applied to the federal Centers for Medicare & Medicaid Services (CMS) for a waiver to decouple Massachusetts from the federal disability standards. This initiative is seen as a very serious threat to people with disabilities. The Office of Medicaid has estimated that as many as a third of currently eligible people would no longer qualify as disabled under the new criteria. The new criteria would be particularly harsh on older, unskilled people. As such, it has been vehemently opposed by health access, legal and disability advocates. It is still being reviewed by CMS.

MassHealth: Personal Care Attendants

The Governor's budget proposal includes an outside section that impacts access to PCA services. These services, such as bathing, dressing and shopping, often enable people with disabilities to live in the community, as opposed to a nursing facility.² The proposed section will permit DMA to implement any change they seek to make in the PCA program without regard to language that has been in line items for the past years. DMA would like to make it much more difficult for disabled people to access services. The language is completely open-ended and would evade the normal review process.

Uncompensated Care Pool: Limited Eligibility and Coverage

As more disabled people lose health coverage, they will be forced to turn to the one remaining option, the Uncompensated Care Pool (UCP). Free care is expensive for the institutions that provide and fund it, including hospitals, insurers and state government.

The increase in the number of uninsured – through a loss of public or private insurance coverage – has resulted in a 20-30% increase in UCP use. This number will continue to rise if people are left with access to affordable health coverage.

“Free care” is provided by hospitals and community health centers. A person may be covered by the UCP, depending on both family income and on what free care is available at local institutions.³ People with incomes up to 200% of the federal poverty level (fpl) are eligible for free care at hospitals and health centers for medically necessary services. The services covered vary from institution to institution, and rarely include prescription drugs, doctors' fees for hospital care, or specialist care. In the Pool fiscal year 2003, 389,909 people received free or partial free care.⁴

Despite increased need, the Governor's budget substantially reduces amounts available to hospitals and health centers from the UCP. The proposed funding is some \$320 million less than the cost of providing care. This greatly exceeds the 2004 shortfall, which should reach \$222 million. This substantial underfunding will lead to increased strain as hospitals struggle to meet rapidly growing numbers of uninsured with fewer resources.

In addition, the budget proposes to limit services available from the UCP in hospitals. Many fear that this proposal will hurt low-income seniors and disabled people who have no choice but to use hospitals for their care.

² Department of Medical Assistance website, updated April 9, 2002.

³ The Uncompensated Care Pool is not a system of care but a partial reimbursement mechanism for free care provided by hospitals and community health centers. The “Pool” is funded by the state, hospitals and health insurers and is currently running a deficit, meaning that health centers and hospitals that care for uninsured people are not being fully reimbursed for this care. The Pool is significantly underfunded, and its future after FY05 is unclear.

⁴ Calculated from: Madden S. “Data on the Uncompensated Care Pool,” (presentation to the UCP Working Group). Massachusetts Division of Health Care Finance and Policy, December 2003.