



Budget Tidbits... just the facts

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The Costs of Federal Healthcare Reform: Making a Bad State Budget Situation Even Worse

The federal healthcare legislation passed earlier this year will have a dramatic, adverse impact on the state budget as legislators address a \$4.5 billion deficit, driving up state costs and limiting state legislative choices.

A. Up to Age 26 ‘Dependent’ Coverage -- \$86 million new cost to State-Funded Health Plans

Federal healthcare reform requires public and private insurers to allow young adults up to age 26 to enroll on their parents’ health plans. This is allowed even if the young adult is married or no longer listed as a dependent on their parents’ tax returns.¹

The financial problem is that federal law requires these young adults, despite being more expensive to cover than children, to be treated as children for insurance purposes. Neither they nor their parents pay the full share of the added actuarial cost, thus shifting part of the burden to employers and other enrollees.

Beginning January 1, 2011, the state’s public employee benefit plans must conform to this new requirement. The Health Care Authority recently released the estimated additional costs of this provision: \$43 million a year (\$40 million health care and \$3 million dental), or \$86 million over a full biennium.²

Simply put, at a time when virtually every area of the state budget will be undergoing reductions, the new federal health care law requires the state and taxpayers to incur millions in additional costs to cover the adult children of state employees.

B. Federal Language Unduly Ties State’s Hands

Beyond imposing new costs on the state, the federal legislation inflicts harm by preventing lawmakers from pursuing well-founded savings options.

1. “Eligibility Standards, Methodologies, or Procedures” may not be changed

The bill contains no provision more harmful to state governments than:

(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.— Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.³

In plain language, this provision says a state that tightens any of its Medicaid eligibility standards, procedures, or methodologies between now and 2014 will lose all federal funding for Medicaid.⁴

2. Examples of savings options ‘off the table’ due to new federal law

In response to a [request from Sen. Margarita Prentice and me for savings ideas](#), employees of the Department of Social and Health Services raised many examples of how to save money by tightening eligibility practices and standards. Several responses targeted lax or wrongheaded DSHS practices and policies.

One example concerned the ability to shelter income in a “corporation” to qualify for taxpayer-supported health care. The worker reported to us that a client who had a million-dollar home and earned over \$500,000 a year still qualified for public health care because his business was a corporation and DSHS does not treat that as income, even if the person was the sole shareholder. DSHS confirmed the essence of the report, stating that it would take an RCW change to permit a look at the income.⁵ Yet, unbelievably, closing that loophole would violate federal law as it would be considered tightening an eligibility standard.

Another recommendation suggested the agency’s procedures were too loose in qualifying people for assistance, namely, by permitting self-reporting of income and qualifying people entirely over the phone. Again, changing these practices would be considered tightening eligibility methodologies or procedures and disallowed by federal law.

Other examples of potential policy changes blocked by this provision of federal law include:

- a. Eliminating Retroactive Medical Payments – In many instances, DSHS not only pays medical bills from the time a person is enrolled in Medicaid but also the bills incurred during months prior to being enrolled.
- b. Eliminating Continuous Eligibility – If a child’s family income exceeds permissible eligibility levels during a year, DSHS continues to cover the child for a full 12 months. That means, if a child is deemed eligible in month one the state will continue to pay for the child’s health care for the next 12 months, even if the parent gets a job in month two that puts them over Medicaid standards. Conceivably, taxpayers could be paying expenses for a child whose family is making hundreds of thousands of dollars.
- c. More Frequent Eligibility Verification – Especially given the concerns reported by state employees, one would think the state should strongly consider more frequent eligibility

verification. Right now, eligibility is verified once a year for most enrollees. In the past, the state has verified income every six months.

- d. Imposing Asset Tests on All Programs – For children and pregnancy medical programs there is no asset test. DSHS does not look at a family's vehicles, bank accounts or other assets in determining eligibility.

C. State Medicaid Director Questions Whether to Opt-Out of Medicaid

Due to restrictions placed on state government, there are choices being considered that have previously been unthinkable in Olympia.

At a Transforming Washington's Budget subcommittee meeting, state Medicaid director Doug Porter brought up the possibility of the state opting entirely out of Medicaid.⁶ He expressed frustration at the tying of the state's hands, limited options available, and the inability to run a program that best serves the needs of Washington's citizens, due to federal restrictions. If the state were to go down this road, it would be walking away from billions of federal dollars supporting the provision of health care in our state, making such a choice highly unlikely. But the mere fact that it's being raised by the person in charge of the program signals the deep dissatisfaction with federal law.

And why shouldn't there be deep dissatisfaction? While common-sense options such as those outlined above are precluded by the "eligibility standards, methodologies, and procedures" language, the state is left with only the wholesale elimination of optional Medicaid services if it wishes to still participate in Medicaid.

One optional service proposed by DSHS to be eliminated is adult prescription drug coverage, impacting 277,000 individuals a year in our state.⁷ The projected savings is \$93 million in state funds (\$179 million total).⁸ The actual savings is likely to be less, considering the probable increase in hospitalization costs. DSHS acknowledged in its 2011-13 budget reduction submittal, "There will be a decline in health status and an increase in costs associated with more intensive services required to treat the more severely ill."⁹

Yet, why is this being proposed? DSHS says elimination of optional medical services "is the only viable option if the state chooses to maintain a Medicaid program."¹⁰

D. Federal Government is Forcing Irrational Decisions on States

This is unacceptable. The federal government, via its health care legislation, is forcing states to make irrational decisions. No state would choose to eliminate prescription drug coverage while maintaining policies that shelter corporate income, permit self-reporting of income, pay for bills incurred prior to being on Medicaid, pay for bills for persons with incomes too high for Medicaid, and allow eligibility regardless of an individual's other available assets. But that's precisely the outcome demanded.

To put the icing on the cake, the state does not see any increase in federal financial assistance for Medicaid until 2014. This means the federal government is hindering state options and authority while providing no tangible offsetting benefit.

Federal law needs to be changed, either permitting states a waiver from these requirements or through an outright repeal of the "eligibility standards, methodologies, or procedures" language.

Bottom Line

Is federal health care reform legislation
making an already difficult state budget situation much worse?

1. National Conference of State Legislatures, “Covering Young Adults through their parents’ or guardians’ health policy” <http://www.ncsl.org/default.aspx?tabid=14497>
2. Health Care Authority Memo – Sept. 14, 2010, authored by Kim Grindrod.
3. H.R. 3590 “The Patient Protection and Affordable Care Act”, Sec. 2001 (2010).
4. Fact Sheet from Families USA – Maintenance of Effort Requirements Under Health Reform (March 2010) -- <http://www.familiesusa.org/assets/pdfs/health-reform/maintenance-of-effort.pdf>
5. September 24, 2010 DSHS email.
6. August 31, 2010, Health and Human Services Subcommittee Meeting #1.
7. 2011-13 DSHS Budget Reduction Submittal, <http://ofm.wa.gov/reductions/2011-13/300-080.pdf> pp. 2-3.
8. Id.
9. Id., p. 6
10. Id., p. 5