

Mr. Chairman and Members of the Committee,

Thank you for the opportunity to speak to you about the important challenges we all face today in addressing the needs of the uninsured and under-insured. I would like begin my comments by applauding my colleagues who have appeared over the last two days for the exceptional job they have done in drawing a portrait of the uninsured -- both who they are and why they are uninsured -- and in outlining the strategies we could all use to reach and provide them with health coverage. I appear before you today as a representative of a state that has, by some accounts, the lowest rate of uninsurance in the nation (6.9%) and, by all accounts, even those like the GAO who rank RI second or third lowest, has achieved the greatest reduction in the rate of uninsured (4.6%) over the last five years.

RI's success in this arena has been attributed to many factors: (1) innovative use of Medicaid expansions; (2) SCHIP funds -- even if too late and in not nearly the amount justified; (3) equal measures of strong and dogged leadership in the governor and members of the legislature; (4) widespread public and political support; (5) careful targeting and persistent outreach to uninsured populations; (6) businesses and industries committed to providing employees with health coverage; and (7) an unusually robust state economy. Rather than explaining the contributions that anyone or even all of these factors made to the decline in the state's uninsurance rate, my goal here is to introduce, instead, a broader framework for thinking about, and ultimately, for addressing the needs of the nation's uninsured.

Among the issues before this Committee is the question of whether the states are afforded sufficient flexibility in both the Medicaid and SCHIP programs to develop health care programs that can reach the uninsured and under-insured. This latter group -- the under-insured -- is no less at risk, because the coverage they do have is too limited or too expensive to yield positive, long-term health care outcomes. Since 1994, RI has taken full advantage of every opportunity that availed itself to expand Medicaid coverage to low-income families and children, many of whom were among the state's uninsured.

Today, through RIte Care, the state's Medicaid managed care plan, RI covers children in families with incomes up to 250% of the federal poverty level and parents with income up to 185% of FPL. This group represents 74% of the Medicaid caseload. Although this is a remarkable achievement in and of itself, what is even more interesting are the health care outcomes that have resulted --- for example, longer inter-birth intervals, lower infant mortality, cessation in smoking, early lead poisoning detection and intervention. The cost of services to this, the largest Medicaid population, accounts for less 40% of all expenditures. The opposite is true for the elderly and those with disabilities who receive care through the traditional fee-for-service program, accounting for 26% of the total caseload but 60% of all expenditures.

When we look at RI's recent Medicaid expansions in this context, the most startling fact is the success of the approach: in the role of purchaser, the state was able use the considerable leverage afforded by the population's size to negotiate with commercial health plans to provide more and better health coverage, to a wider group of Rhode Islanders in need.

What we in RI have learned from this experience is twofold: (1) how health care is purchased is critical to maximizing dollars and optimizing outcomes; and (2) doing both, (maximizing dollars and optimizing outcomes) requires that the health coverage needs of all populations, both insured and uninsured, are addressed together and in the context of all available resources, both public and private. In short, the flexibility that the states need is the flexibility to coordinate, and co-mingle existing resources and benefits to extend and finance high quality coverage for the uninsured and the under-insured. In the last year, RI has used this framework to explore new, more cost-efficient mechanisms for providing current recipients with high quality care and, in the process, to make coverage more accessible to those in need.

To better handle the growth in the RItE Care program and assure that low income workers are able to remain in their employer-based health insurance, the state has established the RItE Share premium assistance program. The state will pay a Medicaid eligible employee's share of the cost for employer-sponsored insurance thus reducing the burden on the state, preserving the Employer-Sponsored Insurance, and ensuring private dollars on the table stay there. The states have had the flexibility to establish these programs under both Medicaid and SCHIP for some time, though within limits that are sometimes unreasonable. (Some of the more onerous of these requirements have been lifted, but not all.) The next step, and we are not there yet in RI, would be to allow small employers and adults without children (ages 19 to 64) who cannot afford or are not eligible for employer-sponsored insurance coverage to purchase or buy into RItE Care or some other alternative. In addition, RI is one of the states that has been awarded a HCFA grant to develop a buy-in for working disabled.

In this way, the state would be able to extend coverage to those among the uninsured now outside Medicaid's eligibility criteria. In other words, we have the foundation on which to build capacity if the financing is available, whether through tax credits or grants.

There are other mechanisms that could be used to finance expansions in health coverage if the states had greater flexibility to reallocate and coordinate existing resources. For example, RI currently has a plan on the drawing board to create service centers that use case management techniques to improve the efficacy and efficiency of services delivered to the elderly and adult Medicaid population. The states' ability to fully realize the potential of these centers is limited, however, by a system of arcane federal rules and regulations that prevent state Medicaid agencies from fully coordinating services and benefits paid for by Medicare. Moreover, these same rules deter rather than facilitate state efforts to provide cost-effective and seamless coverage for dual eligible beneficiaries across health care settings. The flexibility to waive these rules would not only promote the use of alternative approaches for providing care to this high cost population, but encourage the development of innovative new ones as well. In addition, eliminating some of the regulatory barriers that separate Medicare and Medicaid funds and services, could greatly enhance the leverage of the state Medicaid agency when purchasing prescription drug benefits and home-based services for recipients of both programs. Any savings that accrue to the state could be reinvested to finance expansions in eligibility and/or services.

RI was one of the first states to finance expansions in eligibility for Medicaid, to both children and families, using the flexibility and the cost-savings derived from a Section 1115a

demonstration project – RIte Care Medicaid Managed Care. As a consequence, the state did not have the flexibility to access its full allotment of SCHIP funds. Nonetheless, the state proceeded, without the benefit of SCHIP funds, to be among the first, once again, to extend eligibility to parents, but this time using the flexibility afforded under section 1931. Since then, the state has taken advantage of the flexibility it has been afforded to reach-out to and enroll eligible uninsured children, and to make it easier to apply for and retain benefits. As RI fiscal year 2000 drew to a close, it was the unexpected cost for Medicaid services provided to the adult and elderly population, in addition to the expected enrollment increases for children and families, that caused state policymakers to pause and nearly resulted in a roll back of eligibility for families. Thus, as the state entered the new millennium, it found itself but yet again in the position of front-runner. This time, RI was among the first states to experience the consequences of an unexpected sharp rise in health costs due to prescription drugs, technology, insurance pricing and a labor shortage at the same time it was making these important expansions and simplifications. Let me be clear, we predicted and expected the increases in families; we did not accurately predict and therefore did not expect the magnitude of growth in both the numbers of adults and children with disabilities who would become eligible and the increase in cost of the services, particularly prescription drugs, behavioral health and overall utilization levels.

In the months that followed, the state has requested several waivers of Title XIX requirements, in each case asking for the flexibility to reallocate existing resources to preserve the Medicaid expansions and reduce costs. In the case of SCHIP, the state requested access to funds to help offset the costs for providing services to the target-population the program was

established to serve. In some of these endeavors, the state has been successful -- SCHIP 1115 waiver for adults, but in others less so. For example, charging co-payments and income-related premium share as well as crowd-out provisions.

We also explored and submitted a waiver request for Adults with Developmental Disabilities which languished at HCFA for 6 or 7 years before we decided to move in a different direction.

Governors and state legislators frequently remind you that they must balance their budget at the end of the fiscal year. A 1 or 2 percent variation in an estimate of a program that accounts for 30% of the state budget creates a huge problem for state legislators and governors. While there is generally limited appetite for outright cuts, because the state loses \$1.00 for every 50¢ it saves, there is a tremendous focus on limiting unpredictability and avoiding large rates of increase in any one fiscal year.

Therefore, if we as a state are interested in getting to universal and comprehensive coverage, including prescription coverage for the elderly, we have to manage the resources we do have effectively.

The stark reality is we cannot do that alone. We need the enthusiastic partnership of the federal branch through Medicare, the tax code and ERISA flexibility.

I am hopeful that the new Administration will approach these issues with an eye toward real change and will see the tremendous opportunity before us. Let states develop solutions and work with us to figure out how to implement them, measure our progress and hold us to desired outcomes. I know that the members of this Committee understand the potential opportunity and will help us ensure we do not let it slip through our fingers.

Thank you again for having me testify. I would be happy to answer any questions.

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TESTIMONY OF CHRISTINE C. FERGUSON
DIRECTOR OF THE RHODE ISLAND DEPARTMENT
OF HUMAN SERVICES

Before the
UNITED STATES SENATE FINANCE COMMITTEE

Hearing on:

“Living Without Health Insurance: Solutions to the Problem”

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