April 13, 2011 | 82nd Legislature | House Public Health Committee

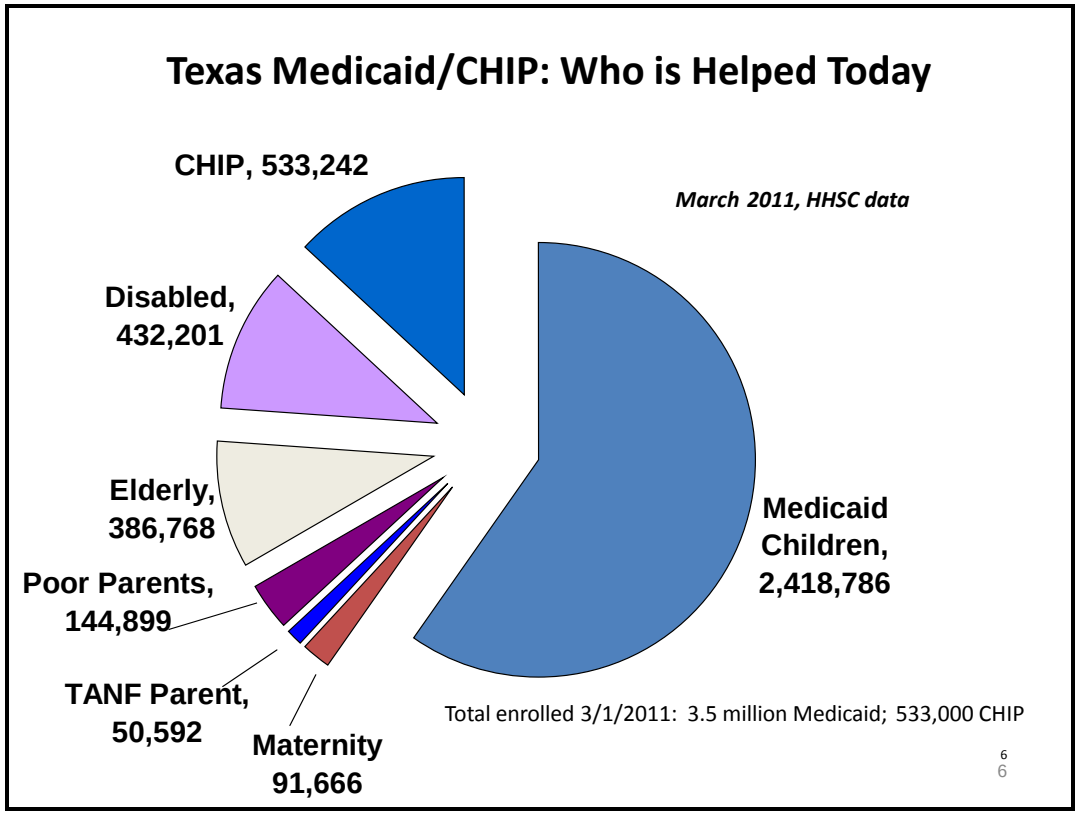
TESTIMONY:

CSHB 13 by Kolkhorst

The Center for Public Policies (CPPP) is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding. The Center for Public Policy Priorities wishes to register in opposition to HB 13.

HB 13 raises a number of concerns regarding adequate guarantees of protections for current beneficiaries, covered populations and services.

In Section 1, subsection 536.002(b)(1) the bill seeks "flexibility" to change eligibility categories and income thresholds. Given that our state already has authority to in raise income levels (i.e., without a waiver) in Medicaid, we interpret this request as reflecting an intent to reduce income thresholds or deny coverage to some current populations.



At subsection 536.002(b)(2), flexibility is sought to change Texas Medicaid benefits to vary according to local or regional differences in "demographic, public health, clinical and cultural needs." As with (1), this language suggests an intention to reduce covered benefits, particularly for children, given that numerous limits to adult

benefits are already allowed and in place in Texas Medicaid for adults. Without more detailed understanding of the kids of changes to benefits sought—presumably changes not allowed under current federal law—we are unable to support this language.

At subsection 536.002(b)(3), it is indicated that the replacement waiver for Medicaid should "encourage use of the private health benefits coverage market rather than public benefit systems." We believe that the current systems of Texas Medicaid Managed Care developed over the last 18 years in our program already pursue this goal in the most effective and practical way possible given the extraordinarily low incomes of our Texas Medicaid population, and the near absence of rate regulation in our Texas health insurance marketplace.

- Under Medicaid Managed Care, the great majority of Texas Medicaid enrollees are already enrolled in HMO coverage.
- Most Texas Medicaid children have incomes at or below 133% FPL, or less than $25,000 for a family of 3; and the average price of a family group plan in Texas is $14,000.
- Though the great majority of these kids are in working families, the parents are obviously working at low-wage jobs that rarely offer access to benefits. Nationally, only 1/3 of Americans with family incomes under $30,000 have employer-sponsored insurance (ESI) coverage, and only 26% of those with incomes below 150% of FPL have ESI.
- The population below poverty—where all of our Texas Medicaid acute care adults are drawn (seniors and adults with disabilities just below 75% FPL; and parents below 20% FPL)—only 12.6% of Americans have coverage from ESI.
- Texans on Medicaid cannot be re-directed to the private market unless it is significantly reformed.
    - Individuals and families seeking coverage in the Texas non-group market can be denied coverage or charged any amount of premium, because we have chosen not to regulate that market.
    - Unless Texas law is change to require guaranteed issue and community rating for the individual coverage market, Texas Medicaid recipients would be unable to reliably access or afford the market.

At subsection 536.002(b)(4), the bill calls for encouraging ESI take-up by Medicaid enrollees. Texas Medicaid already actively pursues access to ESI for the small portion of clients with access to that coverage option, but does so in a manner that ensures that the standard co-payments and coinsurance in typical ESI groups plans do not create a barrier for those below- and near-poverty families.

At subsection 536.002(b)(5), the bill calls for encouraging greater cost sharing, use of Medical Savings Accounts, and use of vouchers.

- CPPP supports the current federal restrictions on cost sharing in Medicaid, which limit applicability to children and pregnant women, and prevent the denial of care to persons below poverty. We would be willing to support pursuit of a limited pilot <u>testing</u> cost-sharing for children, but our understanding of the law is that that is not a "waiveable" provision under section 1115 of the Social Security Act.
- We have no objection to testing Medical Savings Accounts, as long as the program funds the savings account, participation is optional, and enrollees may opt back into traditional Medicaid if they encounter barriers to care.
- Vouchers are subject to the same challenges of the unregulated Texas individual health insurance marketplace:
    - There is no current market for coverage for wrap-around services for seniors in poverty on Medicare;
    - There is no current market for coverage for adults with substantial disabilities (SSI beneficiaries);

- Parents and children on Medicaid who seek private can be denied coverage or charged any amount.
- In addition, vouchers which are not of adequate value to ensure access to purchase a comprehensive plan are not acceptable.
- Vouchers are well-suited to targeted programs such as the consumer-directed hiring and purchase of non-medical community care and support services.

At subsection 536.002(b)(6) and (7), the bill calls for consolidation of UPL and DSH funds into the waiver, and the expanded use of intergovernmental transfers and certified public expenditures. CPPP supports the notion of redirecting local dollars to support maximum federal matching dollars. According to HHSC reporting, Texas received approximately $2.8 billion in federal dollars from DSH and UPL streams in FY 2010. But, nearly all the non-federal share of these programs came from local taxing authorities, and there are legitimate fiduciary responsibilities of those hospital districts that will have to be recognized if we intend to restructure those funding streams.

At subsection 536.002(b)(8), the bill calls for creating what seems to be a non-insurance alternative for the uninsured. CPPP does not oppose this concept, however, we feel that solutions for the 6.4 million uninsured Texans, or even the 1.5 million or more uninsured U.S. citizens below poverty in Texas, must include a guarantee of a basic standard of comprehensive care. We are concerned that this language might suggest a failure to ensure that major medical care or chronic care may not be fully covered.

At subsection 536.002(b)(10), the bill calls for an internet-based health insurance marketplace. While CPPP support the creation of a Texas connector, exchange, or portal, we must emphasize that the only existing connector that has made a significant difference in coverage, the Massachusetts Connector, owes its success to two critical components: (1) sliding-scale premium assistance for low-income residents above the Medicaid income cap; and (2) substantial regulation of the small group and individual markets which limit wild price variations and denials that characterize the current Texas marketplace. Without thes features, a portal is little more than "E-health insurance.com", which already exists.

Section 2 at (b) and (c) calls on the state to pursue an FMAP formula change that takes into account t relative poverty rates. CPPP would support that notion. However, the formula should continue to also take into account relative per capita personal income, because without that measure wealthy states with high poverty will be treated the same as poor states with high poverty. States with greater wealth and average incomes can and should pay more, even if an adjustment that also reflects their poverty rates is warranted.

Section 2 at(d) calls on the state to pursue more favorable federal funding for care to undocumented residents. CPPP supports this provision.

- Texas Medicaid cost per enrollee data from HHSC and the LBB show that our inflation-adjusted cost-per-enrollee today is actually lower than it was a decade ago (see table). Enrollment growth, not "runaway spending" is driving Texas Medicaid costs.

- Texas Medicaid provides health care and life-saving supports for 70% of Texans in Nursing Facilities, virtually 100% of Texans with Intellectual Disabilities and other serious lifelong or childhood-acquired disabilities, 55% of Texas babies, 2.5 million kids (3 million with CHIP), and community help to keep 100s of thousands of seniors and Texans with disabilities out of institutions.

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Texas Medicaid spending Trend per Client			
	Cost per Client	**$/Client Adjusted for Inflation**	
1996	$3,730	$6,027	5.6%
1997	4018	6,372	5.7%
1998	4474	6,993	9.7%
1999	4846	7,314	4.6%
2000	5155	7,455	1.9%
2001	5535	7,766	4.2%
2002	5729	7,872	1.4%
2003	5600	7,388	-6.2%
2004	5165	6,549	-11.3%
2005	5351	6,383	-2.5%
2006	5595	6,339	-0.7%
2007	5712	6,132	-3.3%
2008	6201	6,303	2.8%
2009	6404	6,535	3.7%
2010	6522	6,522	-0.2%
2011	$6,767	$6,767	

Source: HHSC and LBB data