CPPP Center for Public Policy Priorities

Testimony

May 10, 2011 | 82nd Legislature | Senate Health and Human Services Committee

TESTIMONY:
HB 5 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 5.

Bill Overview

Section 1: Proposal that states be given authority over health care (apparently including Medicare; see definition of "Health Care" and "Member State Base Funding Level"). States would enter into a compact for mutual support and information sharing as they took on that new authority.

(*At this point, the remainder of Section 1 includes a new set of section numbers for the contents of the compact*:

Sec.1: Definitions

"Health Care" notably only excludes military, veteran, and Native American health systems.

"Member State Base Funding Level" does not exclude Medicare, and is listed as $60.4 billion for 2010.

Sec. 2: Pledge to seek and secure approval of Congress along with other potential Member States.

Sec. 3: Legislatures of the Member States will regulate Health Care in that state.

Sec. 4: State Control: Appears to allow each Member State to pick and choose at the outset of the compact which federal health care laws it wishes to override or retain. The bill says that states shall be responsible for any related funding obligations for federal laws not "superseded" as of the compact's effective date. *The meaning of this provision is not entirely clear*; it seems to imply that Member States may pick and choose among federal laws to keep in force in that state, but that regardless of whether or not federal law is superseded the state will get 100% of federal health care funding set at the 2010 level. For example, a state might leave federal Medicare laws in place, but the state would still receive the full allotment of federal funds (including funds for Medicare) and would take over responsibility for administering Medicare and paying health care providers. The same state could void all federal laws and standards for Medicaid, and re-shape that program in any way it chose.

Sec. 5: Funding. Member states would get an initial annual funding amount approved by Congress and audited by the GAO. (Again, it does NOT specify that the funding amount applies only to the areas of federal and regulation that that state has chosen to supersede,) No strings are attached to the funds. To be treated as mandatory funding in federal budget, with an annual inflator based on population growth over 2010 and the GDP deflator.

Sec. 6: Interstate Advisory Health Commission. Two members per state. Majority rule. May study health regulation and develop non-binding recommendations. Collect & share information (e.g., pricing and performance), protecting privacy. Legislatures will establish responsibilities and duties; no powers to override state laws.

Sec. 7: Compact takes effect if 2 states adopt it, and Congress approves, unless Congress alters these fundamental purposes:

- States will self-regulate health care and can void any conflicting federal law or regulation;
- Federal government gives the state all the federal funds for the federal laws the state chooses to void.

Sec. 8: Member States can amend their compact by unanimous agreement, and changes take effect unless disapproved by Congress within one year.

Sec. 9: Withdrawal& Dissolution. State law must be adopted and Governor must give 6 months prior notice. Withdrawing state is liable for any obligations entered into prior to notice. Dissolution of compact occurs if get down to one remaining state.

Section 2: Effectively immediately if 2/3 vote, or 9/1/2011.

Major Questions

- The bill appears to allow states in the compact to take on any and all federal health care programs including Medicare (except military and Indian health services) and receive all related federal funds based on a 2010 base year. Presumably, a Member State could choose to take over responsibility for Medicaid, Medicare, CHIP, FQHCs, and all federal health block grants.
- The bill includes no requirement that state continue to serve the same populations or provide the same benefits in Medicare, Medicaid, CHIP, etc.
- The bill makes no provision for building additional capacity to cover Texas 6.4 million uninsured.
- The bill proposes no common methodology for calculating "Member State Base Funding Level" across member states.
- The use of an interstate compact structure in the manner contemplated here is unprecedented, and based on widely circulated materials from conservative groups, may be based on some legal assumptions that are at best speculative.

Interstate Compact: Background

- Interstate Compacts are a much-used vehicle for executing important interstate activities such as port authorities, flood control, water allocation, conservation efforts, credentialing reciprocity, fishing rights and controls, et cetera.
- The Constitution clearly requires Congress to approve all compacts, and also to approve changes to or dissolution of same. Congress does not relinquish any powers simply by consenting to a compact.
- The author of this bill may believe, as some proponents of this concept have voiced, that compacts do not require the signature of the President. However, Article 1, Section 7 of the Constitution is clear on the point:

> *Every order, resolution, or vote to which the concurrence of the Senate and House of Representatives may be necessary (except on a question of adjournment) shall be presented to*

the President of the United States; and before the same shall take effect, shall be approved by him, or being disapproved by him, shall be repassed by two thirds of the Senate and House of Representatives, according to the rules and limitations prescribed in the case of a bill.

- See Cornell University Legal information Institute for a helpful summary of law related to interstate compacts: http://www.law.cornell.edu/anncon/html/art1frag105_user.html. (Be sure and hit "next" to see the second page.)

Taking Interstate Compacts into Uncharted Territory

- Compacts have never before been used in this way, i.e., to allow states to opt out of existing federal law.
- Thus, it is not at all clear that Congress could consent to (approve) a compact that varied from already existing federal law without also enacting a new law signed by the President. It is one thing to approve a compact about a boundary dispute where there is no federal law, and another thing to say Congress could amend or modify federal law through approval of a compact but without going through the lawmaking process.
- A couple of relevant points to note: Even after it approves a compact, Congress can always set it aside later. But, a state that agrees to a compact normally can't simply set it aside, without Congressional approval. This bill seems to contemplate having Congress prospectively approve a mechanism whereby state would be able to drop out of the compact at will, but there may not be a precedent for Congress ever approved any such mechanism in an interstate compact.
- Given that Congress would have to approve and the President assent to the compact contemplated here, the interstate compact proposed in this bill would be unlikely to gain approval from either the current President or Congress. And, if Republicans were to gain both the Senate and the Presidency, they would not need this structure to undo health reform. The current effort may simply be a symbolic organizing vehicle for some proponents, and a genuinely radical alternative vision of the federal system nation for others—one where Medi**care** coverage could vary dramatically from state to state, for example.

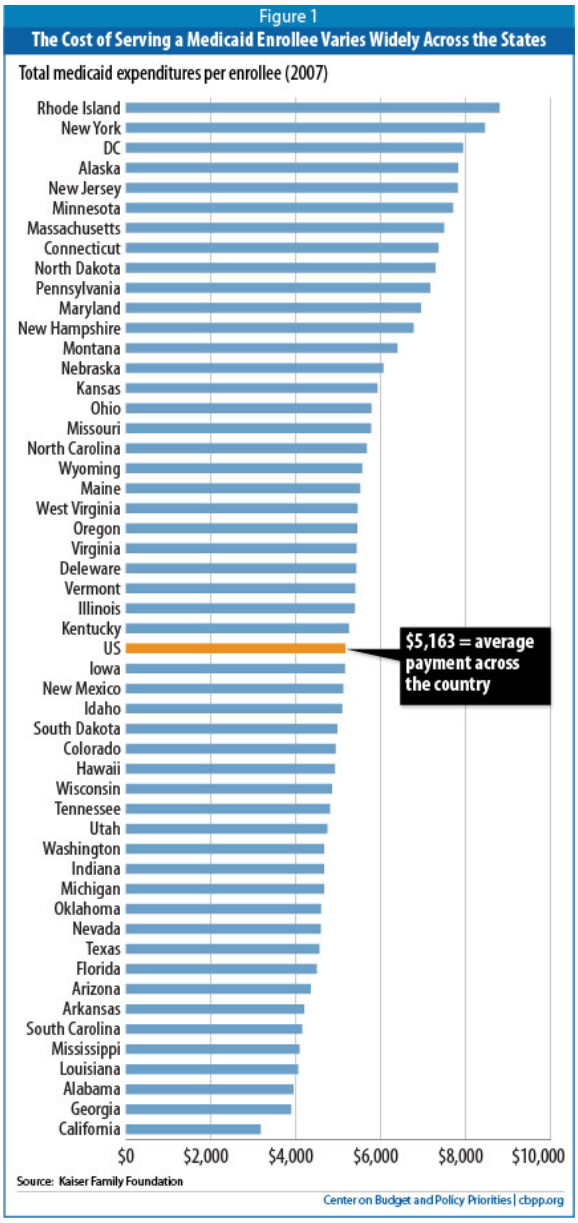
Concerns Related to accepting capped global Federal funding stream with a simple inflator

- As written, States would be allowed to roll up all Medicare, Medicaid, CHIP, and health care Block Grant funding (presumably including Maternal and Child Health, Mental Health & Substance Abuse, Primary Care, FQHCs, Family Planning, etc.) into one big block grant, but without any federal rules governing who is served, how they are served, etc.
- Bill does not say anything about continuing to cover same populations at same levels. Chairman Kolkhorst staff reports that her intention is to serve the same; however, that is not addressed in the bill. Given that the ACA's MOE is popular complaint, it is assumed that cutting back Texans covered is one of the desired "flexibilities" being sought. Who would be cut?
- Texas has no experience administering Medicare. Seniors would likely have grave concerns about the future of Medicare under state operation.
- No money is provided in this block grant to create solutions for our 6.4 million uninsured, if this funding cap at 2010 levels were sought. Texas would have to finance any subsequent improvements to health care access entirely with state dollars, since no additional federal funds beyond the 2010 federal spending allocation (plus update factor) would be available.

Focus On Medicaid Caps

- Medicaid ACA expansion in 2014 to the parents of our 2.5 million Texas kids on Medicaid (and other poor US citizen adults without children) would be lost (both the coverage and the federal dollars) if this funding cap at 2010 levels is in place.

- **$120 billion in new Federal funds for Texas under the Affordable Care Act Exchange premium tax credits and Medicaid expansion would be lost:** Texas Comptroller and Texas HHSC estimate for Medicaid 2010-2019:
    - State Medicaid costs will increase **$5.8 B**
    - Federal funds for Texas will grow **$76.3 B**
    - Texas will gain **$43.5** B in sliding-scale Exchange help to buy private coverage.
    - **This would be lost under this proposal to lock in at 2010 federal funding.**



- See Texas CPA's June 2010 report (http://www.cpa.state.tx.us/specialrpt/healthFed/; also HB 497 by Zerwas report from HHSC http://www.hhsc.state.tx.us/HB-497_122010.pdf, pp 16-17.

- **Texans would not get a discount on their federal income taxes; meanwhile other states that did not join the compact would get the ACA's enhanced federal support to cover their uninsured.**

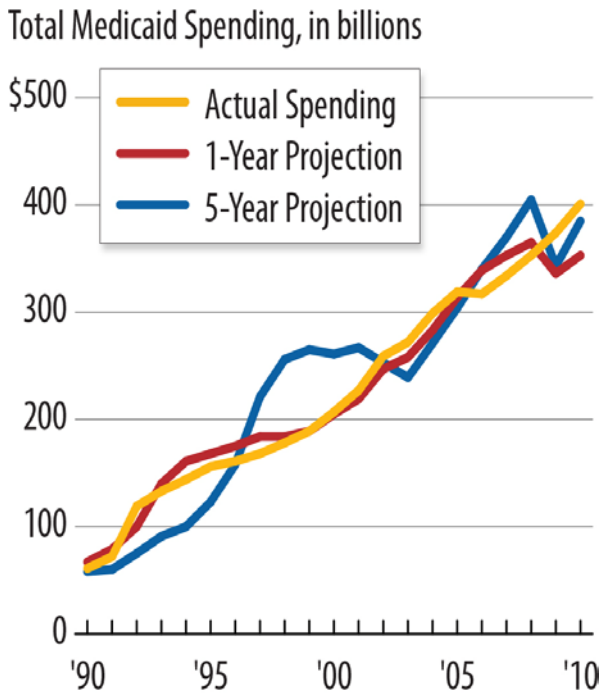
- **Texas, with current Medicaid expenditure levels well below the national average, would receive less initial funding relative to population and uninsured than other states.** The formula in this bill and under other block-grant proposals sets each state's initial federal funding level typically relies to a large extent on a state's current level of expenditures. **It thus would effectively lock in all the existing variations across state Medicaid programs.**

- **If Texas Medicaid costs rise relatively quickly as in the current recession**, under a compact or block grant we would be especially likely to have inadequate federal funding. Without the federal ARRA (stimulus) Medicaid funds, Texas' current-biennium 2010-2011 shortfall would have been far greater.

- **Medicaid is NOT uniquely troubled by rising care costs:** The Congressional Budget Office reports that growth rates for Medicare, Medicaid, and "All Other" (private insurance and self-pay) U.S. health spending have consistently outstripped GDP growth since 1975. Medicare logged the highest cost

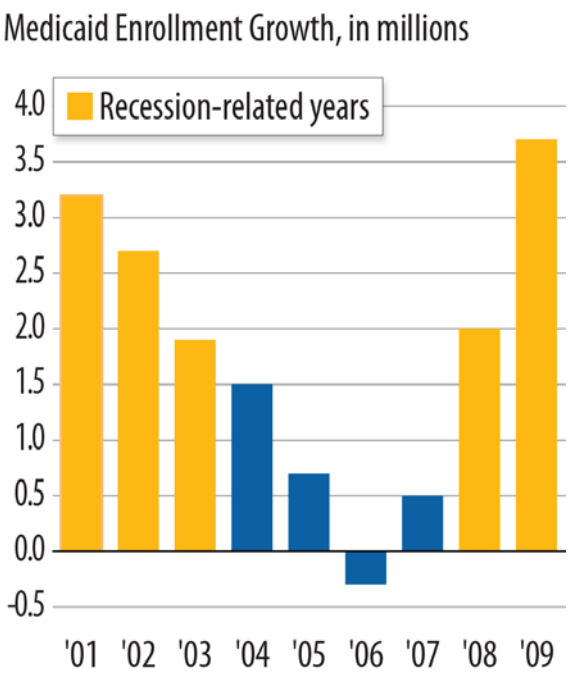
growth in excess of GDP, and Medicaid "tied" with "All Other" U.S. health spending over that entire period, despite having grown at a much slower rate than the rest of the system since 1990.

CBO Estimates Illustrate Difficulty of Projecting Medicaid Costs



Source: CBPP analysis based on data from the Congressional Budget Office.

Recessions Spur Medicaid Enrollment Growth



Source: Kaiser Family Foundation.

Graphics Source: Center on Budget and Policy Priorities, *Medicaid Block Grant Would Shift Financial Risks and Costs to States: States Would Bear Impact of Recessions, Higher Medical Costs*; Edwin Park and Matt Broaddus, February 23, 2011.

As noted in the above-cited report,

Health care costs are difficult to predict even a year or two in advance, and in a number of years, CBO projections have significantly overestimated or underestimated actual Medicaid costs (see Figure 1). Consider just the last three years:

- Total Medicaid costs in 2008 were approximately 13 percent **lower** than CBO had projected they would be in the estimate it issued five years earlier (in 2003), and 3 percent **lower** than CBO had projected just one year earlier, in 2007.
- In 2009, total Medicaid costs were 9 percent **higher** than CBO had projected five years earlier and 12 percent higher than CBO had projected in 2008.
- In 2010, total Medicaid costs were about 4 percent **higher** than CBO had projected five years earlier and 14 percent **higher** than CBO had projected in 2009, [5] likely because the recession turned out to be larger and deeper than had earlier been expected.

As discussed above, differences between projected and actual costs often result from unexpected factors: economic downturns, pandemics, even natural disasters that can drive increases in enrollment and/or per-beneficiary costs. Under a compact with 2010-level funding, federal funding would no longer increase automatically to help cover these unanticipated costs.

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