CPPP Center for Public Policy Priorities

Testimony

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HHSC'S 1115 WAIVER CONCEPT

The Center for Public Policy Priorities appreciates this opportunity to comment on the Medicaid 1115 waiver concept which has been developed by HHSC, with today's focus on the benefit package and financing assumptions. CPPP shares the belief expressed by many other groups today that while the concept presented today includes some very positive components, at this point it also includes such serious deficiencies that we cannot support it in the current form. Two critical improvements are needed before CPPP could support the waiver.

Recommendations

1. **Add a Program to meet the needs of the 20% of uninsured Texans whose health conditions drive 80% of total health care spending.**

2. **Revise Co-payment Structure to treat the mother of 2 earning $450 per month differently from the mother of 2 earning $1,450.**

- **38% of Texans, and 47% of Texas children live below 200% FPL today: less than $42,400 annual pre-tax income for a family of 4.**

#1: Add a Program to Meet Needs, Cover Costs of the Ill and the Injured

CPPP believes that many low income Texans (38% of Texans, and 47% of Texas children live below 200% FPL today: less than $42,400 annual pre-tax income for a family of 4) would enroll in the limited coverage proposed, and that it would in fact improve those individual's access to routine health care. Unfortunately, the 20% of uninsured Texans whose health conditions drive 80% of total health care spending will find their needs for care unmet by this plan. Those with chronic illness who need more than 2 prescriptions a month to avoid hospitalization, those who are injured, those fighting cancer or another serious acute illness will not know whether they will get the care they need, or whether they will be financially liable for those costs. The flip side of this issue is of course that health care providers are also uncertain about their legal and ethical obligation to provide care after the benefit run out, and cannot expect to be paid under the current plan. Our proposal is that HHSC create a formal program component under which all uninsured adults in the waiver who exceed the modest Rx limits, diagnosis and hospital limits are referred by their physician to a linked program of benefits and intensive care management, which will cover the additional drugs, tests, treatments, and hospitalization needed by the Texans whose needs are the real cost drivers in the uncompensated care population today. Project Access in Dallas and other Texas cities models offer a helpful model, and data that show this effort will reduce ER use and avoidable hospital care. Only in this way can the waiver truly address the benefits of improved primary care access, directly attack the cost drivers of the 20% of patients who drive 80% of the costs, and meaningfully reduce the uncompensated care burdens of our public and safety net hospitals.

#2: Adjust Cost Sharing for the Poorest Uninsured Adults

The current structure would expect a mother of two children who earns $450 per month per month (who now earns "too much" to qualify for traditional Texas Medicaid) to pay exactly the same amount as a mother of two earning $1,450 per month. CPPP raised this issue early with HHSC staff, and we recognize this latest benefit scenario does include a reduction in the hospital co-payment for the <150% FPL group, but no reduction in any of the other costs.

We strongly believe that the cost sharing scheme must be constructed in a manner that insures that out-of-pocket costs will not exceed 5% of family income for this group. This is the cap allowed under federal CHIP law for the total out-of-pocket costs for the children in a low-income family, and also the cap imposed by CMS on cost-sharing in the recently-approved Indiana 1115 waiver. Under this limit, a family could be at risk for up to 10% of their income, as they would have a 5% limit for the children's cost, and another 5% for those of the parents. This "fair share approach" is one which CPPP could support, and it will require HHSC to construct a model that creates smaller ranges of costs (e.g., for less than 50% FPL, 51-100% FPL, and 100-150% FPL). The experience of 1115 waivers in other states has shown that point-of-service co-payments that are too high can essentially create a program that is biased in favor of higher-income enrollees who can afford the co-payments, while lower-income enrollees go without the care they need because of costs that are too high for their family. In Utah, over 75% of adults enrolled reported needing services beyond the waiver benefits, and a third reported going without or delaying care due to cost share.

Eligibility System Must Be Functional, or Waiver Will Not! HHSC proposes to "piggy-back" parents' waiver enrollment on the systems that support their children's Medicaid and CHIP coverage (1.8 million children in Medicaid, 358,000 in CHIP in February). Currently, our eligibility system remains severely distressed, with fewer than 65% of Medicaid applications processed within the 45-day federal law limit here in Travis county, and an equally low percentage of children in the TIERS computer system statewide are processed on time. In fact, in November, HHSC sent formal guidance to eligibility staff on how to process children's Medicaid applications and renewals which have sat unprocessed for 90 days—twice what the federal law allows. This is such a common situation now that formal policy is needed to address it. We agree with our colleagues at TMA and THA that this system must be put back on its feet before we create another major new program depending on its functioning.

The Goal: Comprehensive affordable care for all uninsured Texans. CPPP is committed to a vision of affordable health care for every Texan. One concern raised by this waiver proposal is that the capped funding approach to such programs can create an illusion that the issues of the target income population have been addressed, while in reality the funding caps result in only a fortunate few actually improving their access to care. For example, the Utah 1115 waiver created under then-Governor Leavitt now enrolls some 17,000 adults below 150% FPL, while another 122,000 Utah adults below 150% of FPL remain uninsured. This approach raises equity issues for the hundreds of thousands in Texas who would not have a "waiver slot" for their care, including critical concerns about the continued disadvantages faced by rural and small-town Texans where there is no hospital district to provide the care they need, to do what the state has not done.

While we will accept that a sixth or a quarter of a loaf is better than none, we look for leadership who will pursue the vision of affordable, fair-share health care that cannot be taken away for every Texan. We can do better. The rest of the industrialized world has done it, and Texas and the U.S. can do it too.

Thank you for this opportunity to speak, and we will continue to work with you, the HHSC, and our colleagues in the public interest and health care worlds to seek real solutions for Texas' uninsured.