

## Testimony: House Committee on Appropriations, Article II Subcommittee Public Hearing, Interim Charge 11

April 4, 2018

*Interim Charge 11: Monitor Congressional action on federal healthcare reform and CHIP reauthorization. Identify potential impacts of any proposed federal changes. Identify short- and long-term benefits and challenges related to converting Texas Medicaid funding to a block grant or per capita cap methodology. Determine how Texas should best prepare for federal changes, including statutory and regulatory revisions, as well as any new administrative functions that may be needed. Explore opportunities to increase the state's flexibility in administering its Medicaid program, including but not limited to the use of 1115 and 1332 waivers.*

The Center for Public Policy Priorities appreciates the opportunity to testify on Charge 11. The Benedictine Sisters of Boerne, Texas, founded CPPP in 1985 to advance public policy solutions for expanding access to health care. We became an independent, tax-exempt organization in 1999, and over time our focus has expanded to include economic opportunity and fiscal policy. We are based in Austin, Texas, and work statewide. At CPPP, we believe in a Texas that offers everyone the chance to compete and succeed in life. Legislative advocacy is one important way we use data and analysis to enable Texans of all backgrounds to reach their full potential.

**Re: Short- and long-term benefits and challenges related to converting Texas Medicaid funding to a block grant or per capita cap methodology.**

Attempts to legislate restructuring Medicaid to a block grant or per capita cap methodology met strong opposition in 2017, and while we know they will be revisited, they are not in play at the moment in Congress.

March 2018 polling showed a favorable view of the Affordable Care Act (ACA), up from 50 percent in January 2018 to 54 percent in March, the highest level of favorability of the ACA measured in more than 80 Kaiser Health Tracking Polls since 2010.

**Medicaid is considerably more popular with the public.** Congressional battles over Medicaid in 2017 have

educated more Americans to the program's indispensable role in covering children, pregnant women, seniors, and people with disabilities. This, too is reflected in polling; the Kaiser poll below shows 74% of Americans have a favorable view of Medicaid, and even among Republican voters 65% have a favorable view.

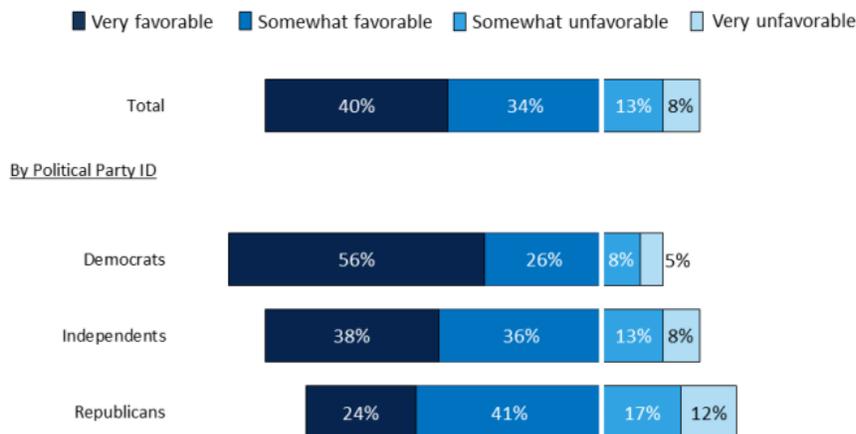
### Problems with Capped Medicaid Funding Restructuring

All of the Congressional proposals to date have been

Figure 5

### Large Shares Across Parties Say They Have a Favorable Opinion of Medicaid

In general, do you have a favorable or an unfavorable opinion of Medicaid?



NOTE: Don't know/Refused responses not shown.  
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)



## Texas Enrollee Medicaid Spending Varies by Category

State Ranking of Medicaid Spending (Federal and State) per Full Benefit Enrollee, FY 2011

#	Total	Children	Adults*	Disabled	Aged
1	MA \$11,091	VT \$5,214	NM \$6,928	NY \$33,808	WY \$32,199
2	NY \$10,307	AK \$4,082	MT \$5,939	CT \$31,004	ND \$23,155
3	RI \$9,541	NM \$4,550	AK \$6,471	AK \$28,790	CT \$30,560
4	AK \$9,481	RI \$4,290	AZ \$6,460	ND \$28,692	NY \$28,336
5	DC \$9,083	MA \$4,173	VT \$6,062	DC \$28,604	DE \$27,866
11	MD \$7,878	<b>TX \$3,010</b>	KY \$5,055	OH \$21,892	MN \$25,030
22	VA \$6,477	MA \$2,528	<b>TX \$4,371</b>	VA \$18,952	MS \$18,592
26	KS \$6,267	TN \$2,470	OH \$4,225	<b>TX \$17,709</b>	KS \$18,328
36	<b>TX \$5,668</b>	IA \$2,116	WI \$3,765	MT \$16,352	TN \$15,745
40	HI \$5,506	LA \$2,082	OK \$3,551	LA \$15,099	<b>TX \$14,739</b>
47	AL \$4,976	NV \$1,940	FL \$2,993	MS \$12,960	CA \$12,019
48	FL \$4,893	MI \$1,926	CA \$2,855	KY \$12,856	UT \$11,763
49	IL \$4,682	IN \$1,858	NV \$2,367	SC \$12,830	IL \$11,431
50	GA \$4,245	FL \$1,707	ME \$2,194	GA \$10,639	NC \$10,518
51	NV \$4,010	WI \$3,650	IA \$2,056	AL \$10,142	NM N/A
U.S. Average	\$6,502	\$2,492	\$4,141	\$18,518	\$17,522

\* Includes low-income parents and pregnant women.

- Texas' spending per enrollee was 36<sup>th</sup> overall, though spending per enrollee varied by eligibility category
- Texas spent more than most states on Children (\$3,010 vs. US, \$2,492)
- Texas spent less than most states on the Aged (\$14,739 vs. US, \$17,522)
- Texas' Adult and Disabled spending were on par with national averages

designed specifically to reduce federal budget spending on Medicaid, and shift Medicaid costs to the states. Texas' funding would be locked into decades of uncoordinated, often crisis-driven choices in Medicaid that have resulted in irrational rankings on per capita spending by type of Medicaid enrollee.

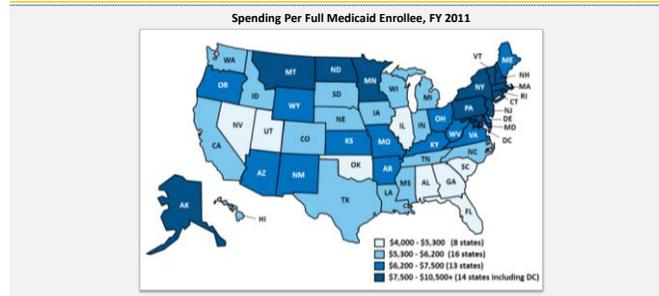
In particular, rate structures that historically favored institutional care and make it hard to access primary

and preventive care would be "baked into" Texas' allotment. Per-capita caps lack one harmful characteristic of block grants: they allow funding for enrollment growth, but in all recent proposals only at rates significantly below historical growth rates. Per-capita caps could be built many different ways: a single per-enrollee cap that applies to all Medicaid recipients (children, adults, the elderly, and persons with disabilities) or with different caps for each group.

Whether per-capita cap or block grant, the same fundamental trade-off remains: to save money at the federal level, the caps must keep spending below projected levels—in effect shifting the burden to states, much the same as block grants do. Texas would not be a "winner" in this fundamental restructuring, and the Legislature would likely shift even more costs of Medicaid onto our urban county taxpayers.

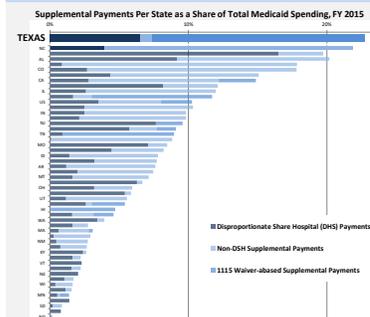
## Capped Funding: Locks in Disparities Across States

Capped funding freezes in historic differences in spending



## Capped Funding, Waivers, and Supplemental Payments

Supplemental payments are a major revenue source for Texas hospitals, but treatment of supplemental payments under funding caps is unclear



Texas spends the greatest percentage of total Medicaid dollars on supplemental payments and waiver funds of any state.

Supplemental Payments account for:

- 1 in 4 Medicaid dollars spent
- 53% of Medicaid payments to hospitals participating in DSH and waiver programs

# Medicaid Work Requirements: Bad Medicine for Texans

by Anne Dunkelberg

In January, federal Medicaid officials published [guidance](#) announcing for the first time that state Medicaid programs can make coverage for parents and other “non-aged, non-disabled” adults<sup>1</sup> conditional on mandatory participation in work programs. Where approved, adults in the Medicaid program who don't have a job, or don't submit proof of their work on time could be kicked out of the program.

Medicaid is a critically important program that pays for more than 50 percent of births in the United States, and covers four in ten Texas children and virtually all Americans with life-long serious disabilities. Kicking people out of the program who would be better workers and parents if they had healthcare will have damaging impacts on public health and American poverty.

Shortly after the Medicaid announcement, the federal Centers for Medicare and Medicaid Services (CMS) also gave permission for Kentucky, Indiana, and Arkansas to impose work requirements and deny health benefits to those failing to comply.

There are many important issues in the weeds of the guidance and waivers, but there's a big risk of not seeing the forest for the trees if we take them all on at once. So, let's start with 5 key topics for now—and at the end we'll point you to some excellent resources for diving into all those details.

## **1. It's Not Just Work Requirements: Medicaid Lock-outs, Delays, and Lifetime Limits are all on the table now.**

The programs now approved for KY and IN would deny coverage for adults who don't comply with the work requirements, unless they qualify for an exception or exemption. Both states assume that substantial numbers of otherwise-eligible adults will lose their Medicaid as a result of the new policies: 95,000 fewer in KY, and 25,000 fewer in Indiana. Arkansas has not revealed how many they expect to lose coverage, but they have been approved to lock non-compliant adults out of coverage for as long as 12 months.

But that's not all: both states also include policies that lock adults out of coverage for three- to six-month stretches if they fall behind on payments or miss deadlines for turning in renewal paperwork. Both states also eliminated retroactive Medicaid coverage that previously could cover unpaid back bills for newly enrolled adults (sometimes called “three months prior” coverage). Both states also make adults in poverty wait two months for new coverage to take effect if they can't or don't pay their first-month premium promptly. As a result, some adults in or near poverty will not be able to get their back bills paid and may also have to postpone accessing care they need for another 60 days.

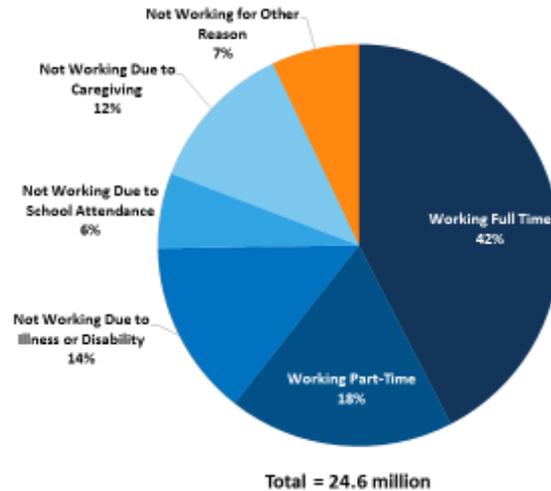
Both Arizona and Kansas have submitted waiver requests to allow them to impose lifetime limits on adults' Medicaid coverage: five years in AZ and three years in KS. The state of AZ projects 269,000 will lose Medicaid due to work requirements and time limits.

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<sup>1</sup> Work requirements are not being applied to Supplemental Security Income (SSI) beneficiaries in Medicaid, which includes both people aged 65 and older in poverty, and those under 65 and in poverty [with a serious disability](#).

Work requirements, time limits, and denials of coverage are largely justified by their proponents based on incorrect assumptions about work, poverty, and who receives Medicaid. Most adults on Medicaid are actually working—and those not working have good reasons for not doing so.

### Work Status and Reason for Not Working Among Non-SSI, Nonelderly Medicaid Adults, 2016



Notes: "Not Working for Other Reason" includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job. Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

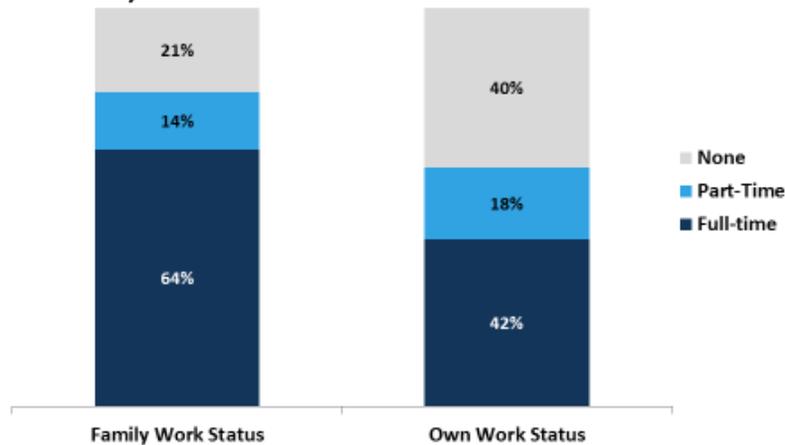


## 2. Most adult Medicaid enrollees ARE working.

The notion that a work requirement for “non-aged, non-disabled” adults on Medicaid is needed at all is at odds with the reality that the substantial majority (60 percent) of adults enrolled in Medicaid today are working—more two-thirds of them full time.

And, as the Kaiser Family Foundation’s (KFF) graphics here demonstrate, 32 percent of the remaining adults are either ill, have a disability, are in school full time, or caring for children or an adult with a disability. Only seven percent are “non-working” for other reasons. Further, when KFF looked at these

### Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016



Total = 24.6 Million Non-Elderly Adults without SSI

NOTE: Totals may not add due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI). SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



adults signed up for Medicaid by family unit, they found that 78 percent are in worker-headed homes: 64 percent headed by a full-time worker, and another 14 percent in a home headed by a part-time worker.

### 3. Full time work does NOT include health benefits for many Texas adults, and families headed by workers are too often still in poverty.

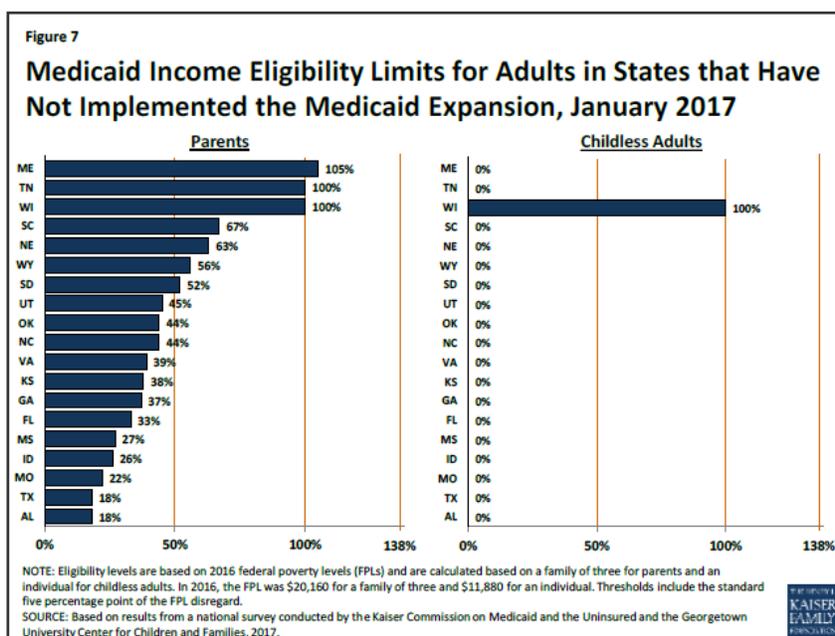
Behind the push for adult Medicaid work requirements is the incorrect belief that gaining full-time employment will bring with it employee health benefits. A top federal Medicaid official said, “people moving off Medicaid is a good outcome because we *hope* that means they don’t need the program anymore.” According to the U.S. Census, 54 percent of Texans (and 59 percent of Americans) under age 65 had employer-sponsored health coverage in 2016.

Though work is the #1 way adults get health coverage, the Census also reports that over one in ten U.S. workers is uninsured—over 16 million Americans—with the result that among uninsured adults, workers outnumber non-workers by more than a 3:2 ratio. **Over 2.8 million Texas workers were uninsured in 2015:** that’s more than one in every 5 adult workers.

Full-time work does not reliably provide family income that will shift the worker out of poverty, up above the Medicaid income range, and into the subsidized Affordable Care Act insurance marketplace. Poverty despite work is real, all too common, and it is not limited to fast-food restaurants. In Texas:

- **One in 8 Texas working families is in poverty.** Texas is home to about 388,000 working *families* who are in poverty.
- **Over 1 million Texas children in working families are in poverty.**
- **Texas families in poverty are much more likely to be working than the U.S. average:** 62 percent of all Texas families in poverty are worker-headed, about 8 percentage points worse than the national average.

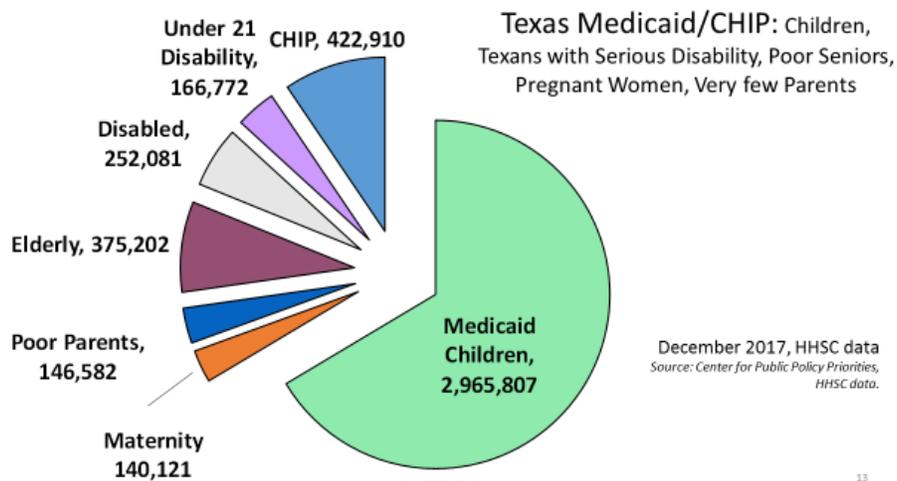
**Work requirement programs lack funding for work supports.** The new Medicaid work requirement guidelines encourage but do not require states to provide any job training, child care, or transportation supports for their work requirement programs, and they specify that no Medicaid funds may be spent on these activities.



**4. Several states without Medicaid Expansion have already asked federal permission to add work requirements: Kansas, Mississippi, Maine, Utah, and Wisconsin.**

In most of the 18 states (including Texas) that have not expanded coverage, the adults facing new work requirements would be **low-income parents, and former foster youth under the age of 26**. It is too early to know whether states like Kansas and Mississippi, which cover only a small number of parents in Medicaid will gain federal approval to apply work requirements to such a small group in such deep poverty. But, it is important to know that some states are considering it, and it is not only “single, childless, healthy adults” who may be facing these new work policies and potential time limits.

**5. Texas Medicaid today covers only a small number of extremely poor parents.**



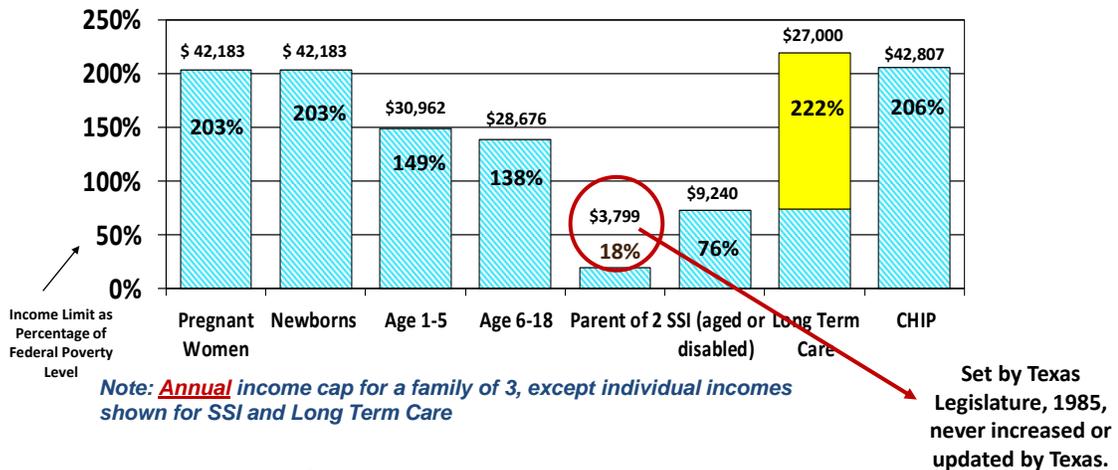
As the Kaiser Foundation graphic above shows, Texas is tied with Alabama for the lowest income cap for parents to get Medicaid.

The Texas Legislature has not raised the income cap for parents on Medicaid since the late 1980’s—not even to update it for inflation. In 2018, a single parent with two children cannot earn more than \$316 a month and still get Medicaid: working 11 hours a week at minimum wage (\$7.25 an hour) would make the parent ineligible.

In December 2017, fewer than 147,000 Texas parents in poverty received Medicaid, compared to over 3 million Texas children. Because Texas Medicaid covers only a small number of parents, and covers no poor uninsured adults without dependent children (i.e., we cover only seniors and adults with disabilities in poverty), our current Medicaid program resembles those of Alabama or Mississippi more than Maine or Wisconsin.

## Why 3 million children, only 150,000 Parents?

### Income Caps for Texas Medicaid and CHIP, 2018



Source: HHSC data, Center for Public Policy Priorities.

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## 6. Legality of Medicaid Work Requirements, Time Limits is in Question.

Federal approval of Kentucky’s work requirements and coverage lock-outs was followed immediately in January by a [lawsuit filed by Kentucky Medicaid enrollees](#) challenging CMS’s authority to approve the work requirement policy and the Kentucky waiver. Until now, imposing a work requirement has been widely believed to violate the Social Security Act requirement that section 1115 waivers must further the specific goals of the Medicaid statute, which are limited to providing health care and do not include other societal or governmental goals. The Trump administration’s CMS leadership argues that evidence of better health among employed adult Medicaid enrollees is caused by that work, and not simply a reflection that healthier enrollees have a greater ability to work. An injunction to delay implementation of the work program, and certification of the lawsuit as a “class action” on behalf of all affected Kentucky Medicaid adults have been requested. You can read more from the Kaiser Foundation about the lawsuit [here](#).

### What’s next?

Stay tuned to CPPP and the [Cover Texas Now](#) website for more updates.

### Learn More

- **Kaiser Family Foundation** – resources on states requesting these major Medicaid changes; start with [Understanding the Intersection of Medicaid and Work](#).
- **Families USA** – what states are doing with Medicaid and the threats posed by new requirements and restrictions; start [here](#).
- **Center on Budget and Policy Priorities (CBPP)** – briefs on [how work requirements will affect people with disabilities, older Americans, and people who need substance use treatment](#).

- **Georgetown University Center for Children and Families (CCF)** – expertise on Medicaid waivers and the impact on children and families. Check out their [blog](#) and this special section with [detailed comments on state waiver proposals](#).
- **National Health Law Program** – by lawyers, for lawyers, but chock full of great information for the rest of us, too. See NHELP's [Health Advocate Blog](#) and [Sec. 1115 Waivers](#) page for updates, and the [Save Medicaid Kentucky](#) website, a project of NHELP and the Kentucky Equal Justice Center.

Thank you for the opportunity to testify. Any questions may be directed to Anne Dunkelberg, Associate Director, CPPP; [dunkelberg@cphp.org](mailto:dunkelberg@cphp.org).

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The **Center for Public Policy Priorities** is an independent public policy organization that uses research, analysis and advocacy to promote solutions that enable Texans of all backgrounds to reach their full potential.

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