CPPP CENTER for PUBLIC POLICY PRIORITIES
WORKING FOR A BETTER TEXAS™

**Testimony, Senate Committee on Health and Human Services**

**Charge #4: August 14, 2014**

**Medicaid, the Affordable Care Act, and Connecting low-income Texans to health care services**

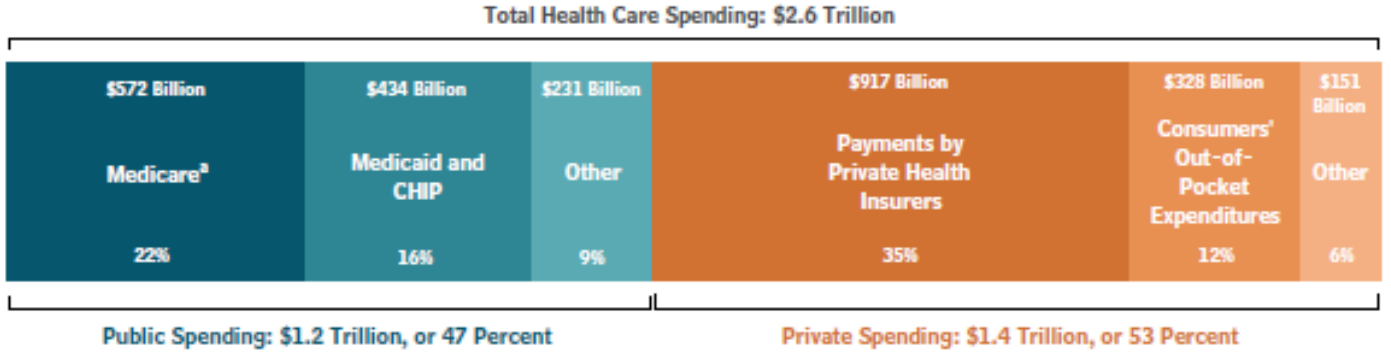
The Center for Public Policies (CPPP) is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core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

The center appreciates the opportunity to testify today.

1) **Medicaid is not the driving force in the U.S.' health care cost/expenditure challenges.** Congressional Budget Office graphic below shows Medicaid spending in proportion to Medicare and all other US health spending. (CBO, The 2014 Long Term Budget Outlook, July 2014).

**Figure 2-1.**

**Distribution of Spending for Health Care, 2012**




Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Note: CHIP = Children's Health Insurance Program.

a. Gross Medicare spending (excludes offsetting receipts from premium payments by beneficiaries and amounts paid by states from savings on Medicaid's prescription drug costs).



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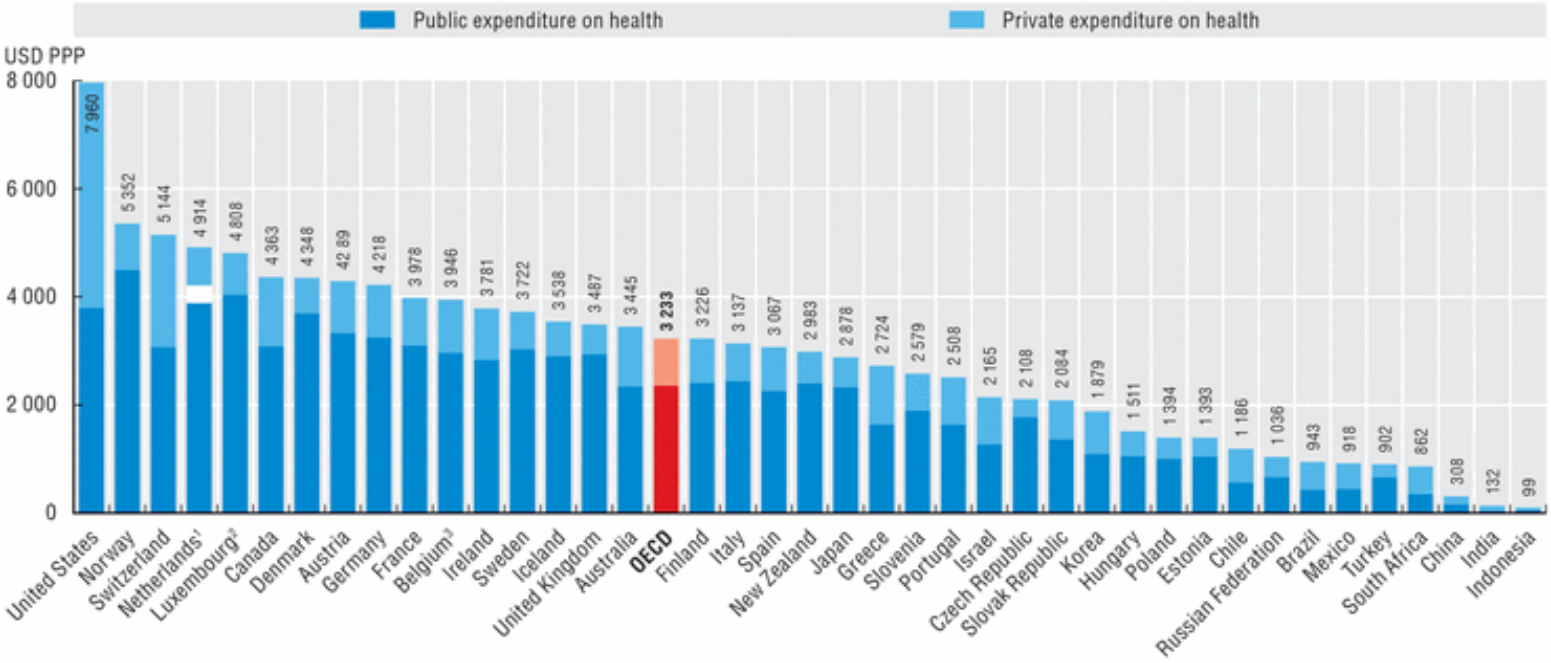
2) **The US needs system-wide health care spending cost containment that will lower health inflation to near the rate of general inflation or per capita GDP growth.** This graphic from the Organization for Economic Cooperation and Development (OECD) show how the U.S. spends dramatically more per capita on health care than all other developed countries.

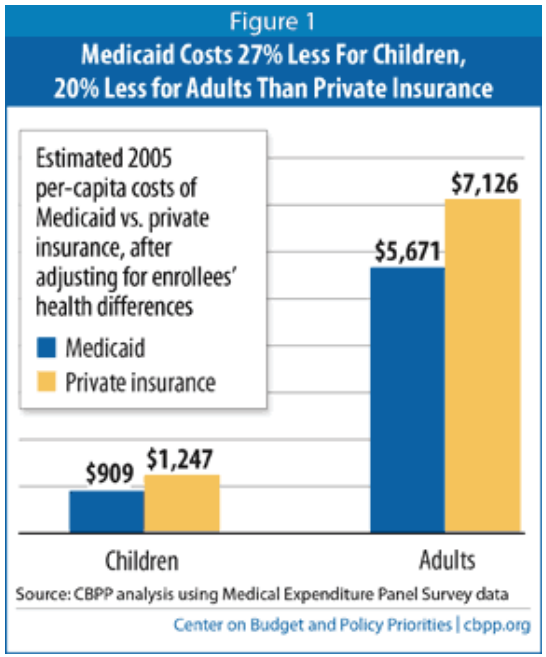
Figure 7.1.1 **Total health expenditure per capita, public and private, 2009 (or nearest year)**

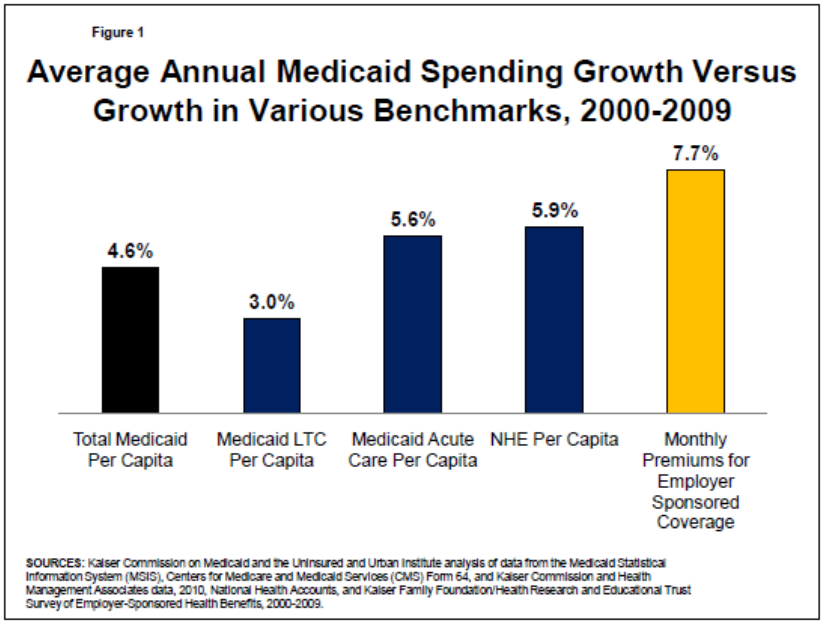



Total expenditure excluding investments.

**Source:** *OECD Health Data 2011*; *WHO Global Health Expenditure Database*.

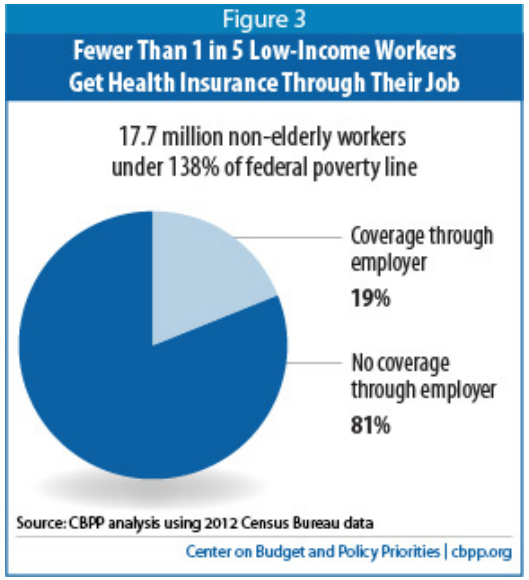
3) **Medicaid has controlled per-enrollee inflation more strictly than either Medicare or the commercial insurance sector.**




Center on Budget and Policy Priorities analysis of MEPS data. Kaiser Commission on Medicaid and the Uninsured

4) Very few low-income workers can access Employer-based coverage today.



**5) Recent Conservative and Red State Alternatives to expanding traditional Medicaid to adults to 138% FPL**

The Texas Legislature and state leadership can look to examples set by other conservative states and Republican governors, who have already found ways to negotiate solutions with federal Medicaid officials to make this work in their states. (Examples: Arizona, Indiana, Iowa, Michigan, Nevada, New Jersey, New Mexico, North Dakota, Ohio, and Pennsylvania.)

These alternative structures have been proposed and negotiated by states and accepted by federal Medicaid officials:

- ***Benefits for the new coverage group that are based on commercial and small business plan standards;***
    - States must screen for "medically frail" persons in the newly-covered adult population, to make sure they retain access to traditional Medicaid benefits.
    - Iowa's waiver allows the state to experiment for one year with whether and how non-emergency medical transportation is provided to the newly-covered adults.
- ***Personal Responsibility Provisions***: ***Cost-Sharing for the newly-covered adults is allowed***.
    - Waivers experiment with new approaches outside of the basic federal rules, including modest premiums, and co-pays for non-emergency ER visits, mostly targeted to the new adults who are above the poverty line.
    - Both MI and PA are looking at reducing out-of-pocket costs for enrollees who get check-ups or meet other wellness goals.
    - Affordable cost-sharing (e.g., co-payments and premiums for newly-covered adults), but with protections to ensure coverage remains affordable for family members with serious or chronic health condition; and
    - Financial incentives for wellness behaviors (such as check-ups, immunizations, and participation in chronic condition management programs), with protections to ensure they are based on medical research and are not harmful to persons who are ill;
- Including reasonable policies to ensure ***ongoing access to community safety net health care providers*** such as Community Health Centers;
- ***Maximizing the use of private insurers through HMO-style managed care.*** Like Texas, most states now have "mature" Medicaid Managed Care sectors with the capacity to serve more adults.
    - Arkansas got permission to use Marketplace coverage for <u>all</u> of its adult expansion group, but only because managed care markets were not established for either Medicaid or commercial insurance.
    - Some states are seeking a combination of Medicaid Managed Care and Marketplace coverage, e.g., Medicaid Managed Care below poverty and marketplace for adults 100-138% of the federal poverty line (FPL).
- ***Flexibility—Within Limits.*** There is flexibility available to state and federal Medicaid officials, but it is not unlimited.

The Legislature and State Leaders rely on the input and voices of Texas communities, local and county officials, and safety net health care providers to help guide Legislative progress toward a solution to accept federal funding and close the Texas Coverage Gap.

Any questions regarding this testimony can be directed to:

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