

Closing the Texas Coverage Gap: How Texas Leaders Can Still Help Over 1 Million Texans This Session

Anne Dunkelberg, dunkelberg@cphp.org

What is this Coverage Gap thing?

In Texas (and each of the other states that have not yet adopted a coverage solution), **most uninsured adults with incomes below 138 percent of the federal poverty level (FPL) are not eligible for Medicaid benefits.** The hardest-hit among these are the lower-income families and individuals, because subsidies to reduce premiums and co-payments in the health insurance Marketplace are only available to Texans **above** the poverty level. This is a direct result of the 2012 Supreme Court decision that made Medicaid Expansion to adults to 138 percent of the FPL optional (e.g., annual household income of \$16,243 for individuals, or \$33,465 for family of four), but left in place the original Affordable Care Act (ACA) rule that **subsidies are only available to persons above poverty**—drafted that way based on the assumption that all lawfully present Americans below poverty would have Medicaid coverage. **The senseless result is the Coverage Gap: Texas parents at 105 percent of the FPL can get good coverage for \$43 per month, but the same health plan would cost an unaffordable \$440 per month for their lower-income neighbors at 96 percent of the FPL.**

As of early April, 28 states (and DC) have adopted either a traditional Medicaid Expansion, or a waiver-based alternative to coverage expansion. Another six states have coverage expansion under discussion. Texas is one of the 16 states that have not yet adopted an expansion and are not in active discussion of any solution.

In 2015, a dozen bills have been filed in the Texas legislature proposing ways to close the Coverage Gap. New findings from states with coverage expansions are emerging about the positive impact on state budgets, economies, and hospitals. In fact, some states are projecting savings in excess of their expansion-related costs. **In spite of these positive outcomes in other states, as of publication, Texas' legislative leaders have not yet allowed any of the bills to close the Coverage Gap to be scheduled for a public hearing.** The Center for Public Policy Priorities calls upon Texas' Legislative leaders to hold public hearings on these bills, and offer constructive leadership to find a Coverage Gap solution. A coverage solution for Texas would:

- provide badly needed revenues to all our hospitals,
- provide coverage to about a million uninsured, U.S. citizen adults who do not qualify for premium subsidies in the private Marketplace,
- bring \$6 billion in Texas taxpayers' dollars back home every year,
- create an estimated 200,000 to 300,000 new Texas jobs,
- relieve pressure on local property taxes for uncompensated health care, and
- allow Texas to negotiate and retain the largest possible 1115 waiver renewal, for the longest possible period ([more about the 1115 waiver](#)).

This policy brief summarizes highlights from the most recent impact reports and research, and analyzes the Texas bills filed by the 84th Legislature in search of a Coverage Gap solution.

Positive Impact of Medicaid Expansion Supported in Latest Round of Research

In addition to the benefits of having access to health care coverage, a new crop of research studies demonstrate the need for and positive impact of expansion. New estimates from [The Kaiser Family Foundation](#) show that certain Americans are more likely to be in the coverage gap depending on their race/ethnicity. Highlights include:

- In the 22 states that have not expanded coverage, a total of 3.7 million uninsured adults are in the Coverage Gap. Of these, about 43 percent are White, 27 percent Black, and 24 percent Hispanic.
- Texas accounts for 61 percent of the uninsured Hispanic adults (lawfully present and U.S. citizens) in the U.S. Coverage Gap.

A new report from [Manatt Health Solutions for the Robert Wood Johnson Foundation](#) summarizes findings from eight states with Medicaid or 1115 Waiver coverage expansions: AR, CO, KY, MI, NM, OR, WA, WV. Highlights include:

- Combined savings for the 8 states for just 18 months of expanded coverage are projected at \$1.8 billion;
- Arkansas (1115 Waiver) and Kentucky (Traditional Medicaid expansion) each project state-budget savings in excess of their expansion-related costs through 2021.

The [U.S. Department of Health and Human Services](#) released briefs that compile recent research on the positive state economic impact of Medicaid expansion, and reductions in hospitals' uncompensated care. Highlights include:

- Kentucky's state government [reports](#) a reduction of \$919 million in state budget costs in fiscal year 2014, with 12,000 new jobs created that year. (KY population is about 4.4 million, compared to Texas' 26.5 million.)
- Four large hospital chains (Community Health Systems, Hospital Corporation of America, LifePoint, and Tenet) all [saw dramatic reductions in uncompensated care](#) in states with Medicaid or 1115 waiver expansions, but only small declines in non-expansion states.

Texas news outlets have reported in recent weeks on the financial woes of Texas hospitals, struggling from Medicare payment cuts that were intended to be offset by a big surge in paying patients from Medicaid Expansion—but Texas hospitals never got that surge. Highlights include:

- The [Quorum Report](#) described the fragile state of East Texas hospitals, with closures since late last year in Clarksville, Mount Vernon and Gilmer. Texas has accounted for a 25 percent of U.S. hospital closures since 2010, though we account for just 8.5 percent of the U.S. population.
- The Texas Tribune [explained](#) the dilemma for hospitals in Texas and noted that 10 Texas hospitals closed in the last two years. The [Lubbock Avalanche-Journal](#) reported that the Texas Legislature's 2011 Texas Medicaid hospital pay cuts are aggravating the fiscal injury from Congressional Medicare cuts.
- In the Young County city of Graham (west of Fort Worth), the Graham Regional Medical Center (GRMC) [recently terminated 15 employees](#), and the local newspaper and hospital officials identified inaction on closing the Coverage Gap as a contributing cause. Southeast in Houston, Harris County's public safety-net health system officials also named the federal funds lost in their [decision to eliminate 254 jobs](#); and the dean of Baylor College of Medicine says the Coverage Gap [threatens trauma care systems](#).

These are only the most recent reports and findings. Here is a listing of [key research on the Texas Coverage Gap](#). The CPPP website also contains county-specific fact sheets and an interactive tool that compiles estimates from respected experts on [how Texas counties would benefit](#) from closing the Coverage Gap. Based on expert sources including Texas HHSC, the U.S. Census, Dr. Ray Perryman, and former Deputy Comptroller Billy Hamilton, the fact sheets include estimates of the number of uninsured who could gain coverage, new health care spending, jobs created, new tax revenues, and uncompensated care for each Texas county.

Coverage Expansion Bills: Many Different Ways to Close the Gap

A dozen bills to expand coverage for low-income Texans have been filed in the 84th session. These include simple and complex bills, as well as several that would cover smaller groups of Texans.

In 2013, Representative John Zerwas of Richmond (Fort Bend County) authored legislation seeking a conservative solution to the Coverage Gap. In contrast, none of the bills filed in the current 2015 session was authored by a Republican. Most observers agree no bill without a Republican author and the Governor’s support will progress.

Several of the bills in this collection offer up provisions for a coverage program that are popular with conservatives and have been adopted in other conservative states: co-payments, premiums, tailored benefit packages, wellness and work incentives, and health savings accounts. The authors of the pending bills are sending a message: that federal Medicaid officials have already negotiated and approved in other states exactly what Texas conservative leaders have been asking for in recent years.

Quick Reference Table: Coverage Expansion Bills Filed, 84th Texas Legislature	
“Traditional” Medicaid Expansion Bills	SB 89, Senator Rodney Ellis; HB 116 by Representative Trey Martinez Fischer; HB 1138 by Representative Celia Israel, coauthor Representative José Menéndez
Bills Directing Texas to Pursue Alternative Coverage Expansion Approach	SB 423 by Senator Royce West; HB 977 by Representative Nicole Collier; SB 1039 by Senator José Rodríguez; HB 3045 by Representative Garnet Coleman; HB 4054 by Representative Trey Martinez Fischer;
Bills Seeking Limited Coverage Expansions	HB 3934 by Representative César Blanco HB 3195 by Representative Diego Bernal HB 2270 by Representative Sergio Muñoz Jr. HB 4000 by Representative César Blanco

“Traditional” Medicaid Expansion

Of the 12 bills, three call for a simple “Traditional” Medicaid Expansion; that is, they simply direct Texas HHSC to create coverage for adults up to 138 percent of the FPL as allowed under the ACA (e.g., household income of \$16,243 for individuals, or \$33,465 for family of four). This approach, which has already been adopted in 23 states, would not require Texas to apply for a “waiver” of federal Medicaid laws.

Traditional Medicaid Expansion would allow Texas to:

- 1) use a commercial-style benefits package for the newly covered adults;
- 2) charge co-payments to the newly covered adults for office visits, prescriptions, and non-emergency use of the E.R.; and
- 3) deliver their benefits through contracts with private HMOs.

Bills using this approach include:

SB 89 by Senator Rodney Ellis;

HB 116 by Representative Trey Martinez Fischer;

HB 1138 by Representative Celia Israel with coauthor Representative José Menéndez (filed prior to his election to Senate)

Bills Directing Texas to Pursue Alternative Coverage Expansion Approach

Five states—Arkansas, Iowa, Michigan, Pennsylvania, and Indiana—have won federal approval to expand coverage for adults under alternatives to Traditional Medicaid. Each state has negotiated its own unique program design, but common elements include Marketplace enrollment for some adults (generally above the poverty line), co-payments, enrollee choice between Managed Care health plans, monthly premiums, healthy behavior incentives, and Health Savings Account-type elements. Expansions in these states were all negotiated as “1115 waivers” that allow federal Medicaid authorities and states to depart from federal Medicaid laws for purposes of demonstrating new ways to improve access to health care ([more about the 1115 waiver](#)).

Four 2015 session bills call for Texas to pursue federal authorization to extend coverage to adults statewide under an alternative to Traditional Medicaid.

Two of these bills, HB 3045 and HB 4054, recycle part of all of Representative John Zerwas’ [House Committee Report for HB 3791](#) from the 2013 session, which included substantial input from conservative advocates and legislators. The 2015 authors filed these bills presumably to make the point that they are willing to support a conservative alternative to traditional Medicaid Expansion in order to achieve a solution to the Coverage Gap for Texas.

Key features of the bills are described below.

SB 423 by Senator Royce West/HB 977 by Representative Nicole Collier

These nearly identical bills direct Texas HHSC to create coverage for adults up to 138 percent of the FPL as allowed under the ACA, and clarifies that (as required by federal law) coverage may not be provided to undocumented immigrants. They provide that if Congress should fail to provide less than the 90 percent federal match promised in the ACA for these adults, that Texas will eliminate the coverage expansion. HHSC is directed to include cost-sharing designed to promote preventive care and discourage emergency room (E.R.) care, and to guarantee quality health care. The agency could allow for Marketplace or employer-based coverage premium assistance; incentives for evidence-based wellness programs; and targeted benefits for those with chronic illnesses.

A required annual report would track the impact of the new coverage on the number of uninsured Texans, state and local-government-funded health care spending, and uncompensated/charity care provided by hospitals.

The HHSC could request a federal waiver if needed for the coverage expansion, which would begin January 2016.

SB 1039 by Senator José Rodríguez

This bill directs Texas HHSC to create coverage for adults up to 138 percent of the FPL as allowed under the ACA. The agency is directed to seek an 1115 waiver to allow the expansion to use Marketplace insurance with sliding-scale subsidies, co-payments and health savings account measures to “encourage appropriate use of health care benefits and wellness.” The waiver would also include employment incentives, penalties for non-emergency use of the E.R., and incentives for small employers to provide coverage. A system to track cost savings to local governments and taxpayers resulting from reduced indigent health care costs would be required.

The bill gives HHSC rule-making authority, calls for rules by December 2015, and would take effect September 2015.

HB 3045 by Representative Garnet Coleman

This bill opens with a section describing the million uninsured Texas adults below the poverty income who cannot access Medicaid and who are also denied subsidies for Marketplace insurance, and calls for the state to seek a unique state solution as Indiana and Arkansas have already done. It states that Texas should close the Coverage Gap in a way that uses the insurance Marketplace, promotes personal responsibility, reduces emergency room care, and protects citizens insured through the private Marketplace from losing subsidies.

The remainder of the bill reflects many elements of committee substitute versions of HB 3791 by Representative John Zerwas from 2013, which had strong bi-partisan support but was ultimately stopped in its tracks by a veto threat from the Governor.

Existing Medicaid Restructured. The bill first proposes to restructure the existing Medicaid program (i.e., for children, seniors, adults with disabilities, and maternity enrollees), if the federal government allows Texas to operate Medicaid under a block grant or waiver that would allow the fundamental changes laid out in the bill.¹ Clarifying that federal law prevails in case of any conflict with the restructuring provisions, it directs the use of Medicaid Managed Care, and proposes to roll eligibility categories back to September 2013² (*Texans not covered under the September 2013 Texas eligibility standards would be eligible instead for a new, separate program, described below*). The restructured Medicaid program would incorporate sliding-scale premium subsidies to purchase coverage, cost-sharing subsidies, co-payments and premium contributions by the enrollees, and health savings accounts. Enrollees could access counselors who would help them select the best plan to meet their needs.

Any Texas insurer could sell coverage as long as the coverage met minimum standards. The Texas Department of Insurance (TDI) would research creating a “reinsurance” program to protect insurers from excessive losses, and thus encourage them to participate.

Long Term Services and Supports would also be restructured for the current Medicaid population, which includes about two-thirds of Texans in nursing homes, the great majority of Texans with intellectual disabilities, and most Texans with serious disabilities that were present before adulthood. The bill proposes a list of objectives for HHSC to incorporate into a plan: consumer direction (e.g., adults with disabilities manage their own services) ; simplification and streamlining of service delivery; individualized benefits (different kinds of consumers get different benefit packages); cost-effectiveness and sustainability; reduced institutional care; and incorporation of family-member cost sharing. No timeline for this plan or its implementation is specified.

New Coverage Program for Adults. The bill calls for a new program to serve low-income adults up to 138 percent of the FPL as allowed under the ACA through “private market solutions.” The bill specifies that the new program is distinct from the restructured Medicaid proposed for current enrollees, and that the bill does not establish an entitlement to assistance. HHSC (in cooperation with TDI) is directed to negotiate with federal authorities a program that is cost neutral to the state when considering offsets including health insurance premium tax revenues and reduced general revenue health care spending. HHSC is required to seek reduced duplication of care, reduced health care costs shifted to local government, and minimal impact on Texas business. The agency is

¹ Currently, there is no provision in federal Medicaid law, including 1115 waiver authority that could allow a state to operate Medicaid as a block grant. Congressional action would first have to be taken to allow such a fundamental change.

² This would appear to require children moved from CHIP to Medicaid in 2014 to be moved back into CHIP.

allowed to negotiate a program that is time-limited and which may be discontinued in the event of reduced federal support.

The new program would share similar features with the restructured Medicaid: options for premium assistance for managed care coverage, private Marketplace coverage, or employer-based coverage; tailored benefits; cost sharing and wellness incentives; performance-based payments to health insurers; incentives to use appropriate lower-cost care settings; and health savings account features.

This bill would take effect September 2015, and the HHSC would be directed to request federal approvals “as soon as possible.”

HB 4054 by Representative Trey Martinez Fischer

This bill shares most of its key elements with HB 3845 (and HB 3791 from 2013), above. However, this bill includes additional sections on long term care, programs for seniors and adults with disabilities with both Medicaid and Medicare coverage, and establishing a legislative Medicaid Reform Task Force. Like HB 3845, it directs HHSC to restructure and operate the current Medicaid program with fundamental changes, if permitted to via block grant or waiver under federal law. It defines the population to be included in restructured Medicaid to be based on the rules in place September 2015 (avoiding the potential shifting of children under HB 3845, noted in footnote #2). The restructured Medicaid program features, minimum coverage standards, reinsurance provisions, and long-term services and supports reform plan are the same as in HB 3845. The directives for establishing the new coverage program for low-income adults up to 138 percent of the FPL are also shared with HB 3845.

HB 4054 also includes a section directing HHSC to adopt benefits packages that “prevent overutilization” for seniors and adults with disabilities receiving long term services and supports (LTSS) in the community, and calls for a demonstration project for seniors and adults with disabilities with both Medicaid and Medicare coverage to receive all services through a single managed care health plan.³ It calls for a variety of changes in income and asset treatment, cost-sharing, and eligibility for Medicaid LTSS consumers. Finally, it includes a section establishing a Medicaid Reform Task Force.

Bills Seeking Limited Coverage Expansions

Four bills have been filed proposing coverage of a specific group, or limited-location coverage expansions.

HB 3934 by Representative César Blanco

This bill would exercise Texas’ option to extend Medicaid eligibility to adult “qualified aliens” (lawfully present immigrants) after they have resided in the U.S. for five years, **under the same current strict income limits as for U.S. citizen adults**. This would reverse Texas’ current choice—in place since 1996—to exclude qualified alien adults from Medicaid. In 2001, the Texas Legislature passed an omnibus Medicaid bill that would have reversed that decision and allowed post-1996 qualified immigrants to qualify for Texas Medicaid, but that bill was vetoed by the Governor.

Today, Texas is one of just six states that exclude lawfully present immigrant adults from Medicaid if they came to the U.S. after the 1996 federal welfare law took effect; Alabama, Mississippi, North Dakota, Virginia, and Wyoming are the others. Most lawfully present immigrant adults who meet Texas Medicaid’s very restrictive income limits for adults are nevertheless excluded from coverage, including pregnant women.⁴ This bill would also allow Texas

³ Texas Medicaid is currently in the process of implementing a single managed care plan [demonstration project for dual eligibles](#).

⁴ Exceptions include active duty military, and qualified immigrants with 10 years of U.S. work history.

to provide lawfully present immigrant pregnant women Medicaid maternity benefits without any “five-year bar” waiting period, which has been allowed under federal law since 2010.

Today Texas only allows lawfully present immigrant children to enroll in Medicaid and CHIP, and those children are not subject to a five-year wait.

HB 3195 by Representative Diego Bernal

This bill proposes to establish a health care pilot program to cover parents with children enrolled in Children's Medicaid under 138 percent FPL in certain areas of the state with above average uninsured rates and shortages of health care professionals. The program would include the use of community health workers or “promotoras/es” to help balance the shortage of health care professionals. The author seeks to fund the pilot using a portion of state funds made available after the abolishment of the Texas Health Insurance Pool (SB1367, 83rd Legislature). (**Note:** These funds from the former “high-risk” health insurance pool are being eyed for multiple purposes this session.)

HB 2270 by Representative Sergio Muñoz Jr./HB 4000 by Representative César Blanco

These two bills seek to establish the ability for individual counties to request expansion of eligibility for Medicaid for adults up to 138 percent of the FPL as allowed under the Affordable Care Act. Texas would seek a federal waiver to allow this. HB 2270 does not specify source of state’s share of costs, while HB 4000 directs that counties would provide the state’s share of coverage and administrative costs.

Note: It is expected that the federal government would not approve a waiver request to take this approach. In 2013, federal policy guidance indicated that expansions that were less than statewide, or which did not extend to 138 percent of the FPL, could not qualify for the ACA’s high expansion matching rate (100 percent in 2015 and 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and all years following). Instead, they would receive only the standard Medicaid rate, currently about 58 percent for Texas.

A Call for Leadership

For the good of all Texans, the 84th Legislature should move forward with any of the conservative solutions described above to cover these disenfranchised low-income Texans. Rather than allowing 1 million uninsured Texans to continue to be effectively denied access to coverage, the Governor and our state elected leaders should exercise strong leadership to create a coverage solution for Texas. In the process, we will also gain protections for our threatened hospitals, over 200,000 new jobs, significant state budget savings offsets, and billions in annual health care spending as our “homesick Texas tax dollars” return to our state.

For more information or to request an interview, please contact Oliver Bernstein at bernstein@cphp.org or 512.823.2875.

About CPHP

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. Learn more at CPPP.org.

Join us across the Web

Twitter: [@CPPP_TX](https://twitter.com/CPPP_TX)

Facebook: [Facebook.com/bettertexas](https://www.facebook.com/bettertexas)