

Written Statement for the Record by
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For the U.S. House of Representatives
Energy and Commerce Committee
Health Subcommittee

Hearing on Health Care Reform

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Mr. Chairman, Members of the Subcommittee,

Thank you for inviting Families USA to participate in today's hearing on health care reform. Families USA is the national organization for health care consumers. Our analysis of the House bill, grounded in our consumer perspective, finds that the House bill will provide significant help to *both* uninsured and *insured* Americans. We applaud the three House Committees that worked cooperatively to draft this proposal. It will end discrimination and unfair practices by insurance companies, make high-quality health insurance coverage truly affordable for hard-working families, give Americans the choice to keep the coverage they have now or choose from new options, and make sure that all Americans have access to health insurance coverage we can count on to protect our families.

From our perspective, the House bill achieves the two most important core goals for health care reform: that everyone who currently has satisfactory health care coverage can keep that coverage, and that those who do not currently have health care coverage can get it. We believe that the most effective and efficient way to achieve both of those goals is to build upon the existing health care system. The House bill does just that in the following ways:

- It strengthens employer-based health coverage by improving regulation of the market,
- It subsidizes coverage for those workers with low and moderate incomes to enable them to obtain and keep health coverage, and

- It expands the Medicaid program to fill in the gaps for low-income people whose needs are not met by private health insurance.

Today, I would like to focus my comments on why expanding the Medicaid program is the best approach to expanding coverage for low-income people. There is no question that moderate-income individuals will benefit greatly from the subsidized coverage available in a reformed private insurance market as contained in the House bill. But for the lowest-income Americans, the most appropriate coverage vehicle is undoubtedly the Medicaid program. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not.

That Medicaid is the best way to provide coverage for people with low incomes is widely acknowledged by health care stakeholders. In fact, virtually all major health care stakeholders—including the American Medical Association, the American College of Physicians, the Federation of American Hospitals, the U.S. Chamber of Commerce, the National Federation of Independent Businesses, the Business Roundtable, the AARP, the Pharmaceutical Researchers and Manufacturers of America, and America’s Health Insurance Plans, to name only a few—are on record expressing support for serving the lowest-income populations through Medicaid. These diverse groups recognize that the Medicaid program provides unique services and protections for our most vulnerable Americans.

The public also supports expanding Medicaid. An April 2009 Kaiser Health Tracking Poll found that 77 percent of the public support or strongly support expanding government health insurance programs for low-income people.¹

Medicaid Meets the Unique Needs of Low-Income People

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What’s more, it is specially designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.²

Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A few people have claimed that the Medicaid program suffers from inefficiencies due to waste, fraud and abuse by providers and consumers. This is simply not true. Medicaid, in fact, is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs at least 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.³ In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Both the federal government and states have taken steps in the last several years to improve oversight and enhance Medicaid program integrity to ensure that all of the resources supporting the Medicaid program are used to provide high-quality, comprehensive health care. The House bill includes additional funding to improve even further on these efforts and requires that Medicaid providers adopt programs to reduce waste, fraud and abuse.

Cost-sharing protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits concerning how high other forms of cost-sharing can be. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments on individual services are limited to so-called “nominal” amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much on out-of-pocket costs as do low-income adults with Medicaid.⁴ Research abounds demonstrating the serious burden these out-of-pocket health care costs can pose for low-income people. A study published in *Health Affairs* in early June found that even minimal cost-sharing requirements would greatly increase the financial burden low-income families face.⁵ When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on. Because Medicaid incorporates such strong cost-sharing protections, people enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive benefits

Medicaid's comprehensive benefits package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnosis, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and, as a result, people enrolled in Medicaid are less likely than both the uninsured

and those with private coverage to lack a usual source of health care or to have an unmet health care need.

Medicaid appeal rights and protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing ongoing treatment. They can also appeal enrollment or eligibility decisions, and have the right to a fair hearing. Also, unlike the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past, and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

People in Medicaid Have Better Health Outcomes

People enrolled in Medicaid are less likely than both the uninsured *and those with private coverage* to lack a usual source of health care or to have an unmet health care need.⁶ A study published by the Kaiser Commission on Medicaid and the Uninsured in May this year found that people enrolled in Medicaid were less likely than people who were uninsured and people with private insurance to lack a usual source of care, not to have had a doctor's appointment in the last year, and to have had an unmet health care need due to costs. It also found that low-income women in Medicaid are more likely to have had a Pap test in the previous two years than low-income women with private coverage or low-income women who are uninsured (16% had NOT had a Pap in the past two years compared to 20% of those w/private coverage and 41% of the uninsured).⁷

The Importance of a National Medicaid Eligibility Floor

But under current federal and state laws, there are significant gaps in eligibility for Medicaid. To be eligible for Medicaid, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children, pregnant women, parents with

dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. See the chart at the end of this testimony for state-by-state eligibility levels for children, parents, and childless adults.

Only 16 states and the District of Columbia cover working parents at least up to the federal poverty level (\$18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty (\$12,268 for a family of three). The picture is even grimmer for low-income adults who do not have dependent children: In 43 states, these individuals are ineligible for Medicaid no matter how low their income. An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.

Let me give you a few examples of specific states. In Texas, a state that has traditionally had very low eligibility levels for Medicaid, a parent with two children who earns more than \$4,944 in a year makes too much to be eligible for Medicaid (based on the 2009 poverty guidelines for a family of three), and adults who do not have dependent children are ineligible, even if they are literally penniless. In Michigan, a somewhat more generous state, eligibility levels are still dismal: Parents are only covered up to an annual income of \$12,085 a year (for a family of three), and while Michigan provides coverage to adults without dependent children through a Section 1115 waiver, it only covers these individuals if they earn less than \$3,790 a year (based on the 2009 poverty guidelines for a single adult).

Further, a study in *Health Affairs* released yesterday highlighted the importance of having the same Medicaid eligibility levels for parents and all children.⁸ The study found that families with two or more children with different income eligibility levels for public health insurance programs are more likely to have an uninsured child, even if all the children are eligible for coverage. In other words, arbitrary differences in eligibility levels based on categories are as confusing and illogical to families as they are to all of us. If we want to make sure that currently eligible children are enrolled, we need to make sure that everyone in the family is also eligible

and enrolled. Families often function as family units so the Medicaid program should not arbitrarily split up families in to different eligibility units.

The House bill addresses the illogical and often gaping holes in the health care safety net by making sure that all low-income Americans are covered in all states—all Americans below 133 1/3 percent of poverty (\$24,413 for a family of three). Families USA applauds the House bill for establishing a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental, or health status. This will allow families with incomes below the floor to all enroll in the same coverage, which will make it easier for families to enroll in coverage, get the services they need, and stay enrolled. Moreover, it will mean that individuals who need Medicaid's protections the most will be able to get Medicaid coverage. More than one in three uninsured Americans has an income below the poverty level. This federal floor for Medicaid would significantly reduce the rate and number of uninsured Americans.

While an expansion of the Medicaid program is the best way to provide effective, efficient health coverage to these low-income uninsured people, there is no question that such a significant expansion would put significant strain on state budgets. The current Medicaid program is a state-federal financial partnership; the rising costs of health care, an aging population, and turbulent economic times have challenged states' abilities to balance the costs of Medicaid with other state funding priorities. Health reform will help improve that dynamic by lowering the rate of health care cost growth, but states will still not be able to take on the additional costs of covering such a large number of newly eligible people without significant federal assistance. The House bill strikes an important balance that will help fulfill the goals of health reform by providing full federal funding for new Medicaid coverage requirements while requiring states to maintain coverage that they are already providing.

Why Wait Five Years to Allow Low-Income People to Choose the Exchange?

The House bill includes provisions that will some allow states to choose whether to allow individuals to enroll in the exchange rather than directly in Medicaid, but not until year five after health reform is enacted. This is a critically necessary timeline. Here are some reasons why.

First, moving this additional large number of Americans into the Exchange all at once would create enormous challenges for the Exchange (or exchanges, if some states opt to create their own). It makes sense to move some populations into the Exchange (including larger employers and their workers) using a phased-in timeline. Even for the initial eligible populations, it will be extremely difficult and time-consuming to put into place all of the necessary components of an effective Exchange. We can meet the challenges, but let us not be naïve about the time it will take to do it right. There will be time needed to complete the bidding and contracting process with insurers, to establish effective education and outreach to the public, to create on-line and other screening and enrollment procedures, and to establish the tiers of benefits packages with the overlay of cost-sharing protections. We can *immediately* provide coverage through the existing Medicaid program to the most vulnerable low-income people. Lives are at stake—let’s not wait.

Second, it is unclear at this point in time how the Exchange benefits packages, cost-sharing protections and other elements will look like from the perspective of low-income people. Will the needs of people at the very lowest income levels be served by the plans available in the Exchange as well as they are Medicaid? We need to be sure that coverage that does meet the needs of this very vulnerable and often sicker population is offered. The House bill requires the Commissioner to approve Exchange coverage suitable for low-income, Medicaid-eligible people before they can be given the choice to enroll in it, and if they do enroll in coverage through the Exchange, the state must provide a benefits wrap-around. These protections are critically important, but may not go far enough in guaranteeing that low-income people get the same level of coverage through the Exchange as they would through Medicaid. People with very low incomes cannot afford to pay for a service out-of-pocket; if a service isn’t covered, they won’t receive it. Likewise, cost-sharing requirements that are too high pose a real barrier to care for these individuals.

Third, we need to make sure that we have in place an effective outreach campaign and enrollment materials that are specifically targeted to Medicaid eligible populations. Choice is only real if we first educate low-income people about the differences—positive and negative—

between Medicaid coverage and coverage through the Exchange. For a low-income individual or family, the source of coverage can literally be a life-and-death decision, and we want to be sure that low-income people are given accurate, well-designed tools to make informed, appropriate decisions.

Improving Access to Care

As in any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees without compromising access to care. As mentioned previously, research shows that people enrolled in Medicaid have better outcomes than low-income people with private health coverage. The House bill makes it better by including provisions that will increase the availability of primary care by increasing the payment rates for primary care providers and supporting a new pilot program for medical homes. These provisions will be important for ensuring that everyone in Medicaid has access to necessary, high-quality health care.

Conclusion

Strengthening the Medicaid safety net, improving employer-based health coverage, and bending the cost-growth curve are key components of health care reform. The House bill achieves these objectives. As a result, the bill takes important strides towards ensuring access to high-quality, affordable health coverage for all Americans. We commend the drafters of this bill, and we will work tirelessly with you to achieve its enactment.

Upper Public Program Eligibility Levels for Children and Adults (2009)

	Children (age 0-18) ⁹	Parents/ Caretakers ^{10, 11}		Childless Adults ³
		Non-Working	Working	
Alabama ¹²	200%	11%	25%	
Alaska	175%	80%	85%	
Arizona	200%	200%	200%	100%
Arkansas ¹³	200%	14%	17%	
California ¹⁴	250%	100%	106%	
Colorado ¹⁵	205%	60%	66%	
Connecticut	300%	185%	191%	
Delaware	200%	100%	106%	100%
District of Columbia	300%	200%	207%	
Florida	200%	21%	55%	
Georgia	235%	29%	52%	
Hawaii	300%	100%	100%	
Idaho	185%	22%	28%	
Illinois ¹⁶	200%	185%	185%	
Indiana	250%	20%	26%	
Iowa ¹⁷	200%	30%	86%	
Kansas ¹⁸	200%	27%	34%	
Kentucky	200%	36%	62%	
Louisiana	250%	12%	26%	
Maine	200%	200%	206%	100%
Maryland	300%	116%	116%	
Massachusetts ¹⁹	300%	300%	300%	300%
Michigan	200%	39%	66%	35%
Minnesota ²⁰	275%	275%	275%	
Mississippi	200%	25%	46%	
Missouri	300%	20%	26%	
Montana ²¹	175%	33%	58%	
Nebraska ²²	185%	46%	58%	
Nevada	200%	26%	91%	
New Hampshire	300%	41%	51%	
New Jersey	350%	200%	200%	
New Mexico	235%	30%	69%	
New York ²³	400%	150%	150%	100%
North Carolina	200%	37%	51%	
North Dakota ²⁴	150%	45%	62%	
Ohio ²⁵	200%	90%	90%	
Oklahoma	185%	32%	48%	

	Children (age 0-18) ¹	Parents/ Caretakers ^{2, 3}		Childless Adults ³
		Non-Working	Working	
Oregon ²⁶	185%	42%	67%	
Pennsylvania	300%	27%	36%	
Rhode Island	250%	175%	181%	
South Carolina	200%	49%	90%	
South Dakota	200%	54%	54%	
Tennessee	250%	73%	134%	
Texas	200%	13%	27%	
Utah	200%	40%	68%	
Vermont	300%	185%	191%	150%
Virginia	200%	24%	30%	
Washington	300%	38%	77%	
West Virginia	250%	17%	34%	
Wisconsin ²⁷	250%	200%	200%	*
Wyoming	200%	40%	54%	

¹ Kaiser Family Foundation, “April 2009 Health Tracking Poll,” (<http://www.kff.org/kaiserpolls/upload/7891.pdf>).

² Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, “Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States,” *Health Affairs* 24, no. 4 (July/August 2005): 1073-1083.

³ Jack Hadley and John Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” *Inquiry* 40, no. 4 (Winter 2003/2004): 323-342; Leighton Ku and Matt Broaddus, “Public and Private Insurance: Stacking Up the Costs,” *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.

⁴ Leighton Ku and Matt Broaddus, “Public and Private Insurance: Stacking Up the Costs,” *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.

⁵ Thomas M. Selden, Genevieve M. Kenney, Matthew S. Pantell, and Joel Ruhter, Cost Sharing In Medicaid And CHIP: How Does It Affect Out-Of-Pocket Spending?, *Health Affairs* 28, no. 4 (2009): w607-w619 (published online 2 June 2009; 10.1377/hlthaff.28.4.w607).

⁶ Kaiser Commission on Medicaid and the Uninsured analysis of 2007 National Health Interview data

⁷ *Medicaid As A Platform For Broader Health Reform: Supporting High-Need and Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, May 2009

⁸ Julie L. Hudson, “Families with Mixed Eligibility For Public Coverage: Navigating Medicaid, CHIP, and Uninsurance” *Health Affairs* 28, no. 4 (2009): w697-w709 (published online 23 June 2009; 10.1377/hlthaff.28.4.w697).

⁹ The eligibility levels for children reflect the upper eligibility level for Medicaid and/or CHIP.

¹⁰ This chart reflects different income eligibility levels for non-working and working parents because many states disregard a certain amount of earned income when determining eligibility for Medicaid.

¹¹ Parent and childless adult eligibility levels reflect Medicaid programs that are currently open to new enrollment, provide comprehensive benefits and cost-sharing protections, offer an adequate provider network, and allow individuals to enroll regardless of an employer decision to participate.

¹² Alabama enacted legislation in June 2009 expanding CHIP eligibility to 300 percent of the federal poverty level (FPL). Implementation is scheduled to begin in October 2009.

¹³ Arkansas enacted legislation in February 2009 increasing CHIP eligibility to 250 percent of FPL. Implementation is expected to begin July 1, 2009.

¹⁴ Infants in California (age two and under) are eligible for CHIP up to 300 percent of FPL if they are born to women on the Access for Infants and Mothers (AIM) program, unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal.

¹⁵ Colorado enacted legislation in April 2009 increasing CHIP eligibility for children to 250 percent of FPL, and eligibility for parents in Medicaid to 100 percent of FPL. No implementation date had been set as of April 28, 2009.

¹⁶ Illinois covers children regardless of income, but subsidies for children with family incomes over 200 percent of FPL are paid for with state-only funds.

¹⁷ Iowa passed legislation in 2008 increasing CHIP eligibility to 300 percent of FPL in July 2009.

¹⁸ Kansas enacted legislation in 2008 increasing CHIP eligibility to 225 percent of FPL in fiscal year 2009 and to 250 percent of FPL in fiscal year 2010; however, funding for the expansion was not approved until 2009. The expansion to 250 percent of FPL is scheduled to begin January 1, 2010.

¹⁹ Massachusetts provides premium assistance to children with family incomes up to 400 percent of FPL, but receives no federal funding for that assistance.

²⁰ Infants (age two and under) in Minnesota are eligible for coverage up to 280 percent of FPL.

²¹ Montana voters passed a ballot initiative in 2008 to increase CHIP eligibility to 250 percent of FPL, and the legislature approved funding for the expansion in March 2009. The expansion is scheduled to begin in October 2009.

²² Nebraska enacted legislation to expand CHIP (Kids Connection) to 200 percent of FPL. As of June 23, 2009, an implementation date had not been set.

²³ In addition to the coverage listed above, New York also provides coverage for 19-21 year olds to 150 percent of FPL. It enacted legislation in April 2009 increasing eligibility for all adults with incomes up to 200 percent of FPL if funding is approved.

²⁴ North Dakota enacted legislation to expand CHIP eligibility to 160 percent of FPL. As of June 23, 2009, an implementation date had not been set.

²⁵ Ohio received federal permission to expand children's coverage to 300 percent of FPL in December 2008, but has not yet implemented the expansion.

²⁶ Oregon enacted legislation in June 2009 expanding CHIP eligibility to 200 percent of FPL and increasing funding for the Oregon Health Plan (OHP) for adult coverage. OHP provides coverage to all adults up to 100 percent of FPL, but is currently closed to new enrollees. "Categorically eligible" parents (those who qualify as a "mandatory eligibles") can still enroll. Implementation of the CHIP expansion will begin July 1, 2009, but it is unclear when enrollment will reopen for OHP.

²⁷ Wisconsin subsidizes coverage for children in families with incomes up to 300 percent of FPL with state-only funds. It also received a Medicaid waiver to provide a more limited benefit package to childless adults with income up to 200 percent of FPL.