

January 27, 2011

The Honorable David Dewhurst
Lieutenant Governor of Texas
Members of the Texas Senate
Texas State Capitol
Austin, Texas 78701

Dear Lieutenant Governor Dewhurst and Fellow Members:

The Senate Committees on Health and Human Services and State Affairs of the 81st Legislature hereby submit their joint report on interim charge 1. This charge directed our committees to evaluate federal legislation relating to health care reform and its impact on Texas, the health care industry, and public and private insurance. The committees held joint hearings on March 31, 2010 and November 23, 2010.

We appreciate your leadership in asking these committees to study this key issue.

Respectfully submitted,



Senator Jane Nelson, Chair
Committee on Health and
Human Services



Senator Bob Deuell, Vice Chair



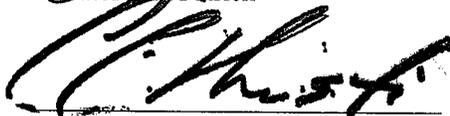
Senator Joan Huffman



Senator Robert Nichols



Senator Dan Patrick



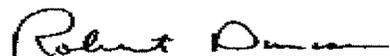
Senator Carlos Uresti



Senator Royce West



Senator Judith Zaffirini



Senator Robert Duncan, Chair
Committee on State Affairs



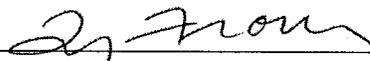
Senator Bob Deuell, Vice Chair



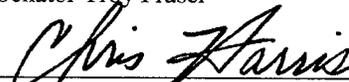
Senator John Carona



Senator Rodney Ellis



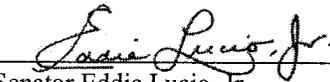
Senator Troy Fraser



Senator Chris Harris



Senator Mike Jackson



Senator Eddie Lucio, Jr.



Senator Leticia Van de Putte

Interim Charge #1: *Upon passage of federal legislation relating to reform of the health care industry and health insurance industry that the Texas Health and Human Services Commission estimates will cost the State of Texas \$2 to 2.5 billion per year in General Revenue beginning as early as 2013, study the implications of such legislation on Texas, the health care industry, and public and private insurance. Study and monitor the implementation of the insurance regulatory changes, changes to high risk pool, and any other insurance mandates. Study the health care policy changes and the impact to the Medicaid and CHIP programs and the state budget. Assess the impact to all uninsured and uncompensated care programs and county programs for the uninsured, including county property tax programs to pay for the uninsured. Make recommendations for the efficient implementation of programs.*

Section I. Background

The federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, was signed into law March 23, 2010.

Like other states, Texas will face a number of challenges as it implements this new law. To help the Legislature better understand these challenges, the Senate Health and Human Services Committee and the Senate Committee on State Affairs were asked to study the impact of the new federal law on Texas. The committees held hearings on March 31, 2010 and November 23, 2010. The audio/video recordings and the presentation documents providing implementation outlines and budgetary estimates can be found at:

<http://www.senate.state.tx.us/75r/senate/commit/c570/c570.htm> or
<http://www.senate.state.tx.us/75r/senate/commit/c610/c610.htm>

Testimony received during the committees' hearings highlighted major issues the Texas Legislature will face in the upcoming legislative session.

Section II. Analysis

State policymakers face a number of challenges as they attempt to understand the new federal law and its impact on Texas. Specific details of many of the new federal requirements are still to be determined through regulations and directives from the federal Department of Health and Human Services (HHS). In addition, Texas, joined with 20 other states, has filed a lawsuit to challenge the constitutionality of the law. The lawsuit will likely continue beyond the conclusion of the 82nd legislative session. These uncertainties will undoubtedly create challenges for Texas policymakers as they consider the requirements of the new federal law.

Major Provisions

The federal health care legislation included a number of provisions that impact both private health insurance plans and public health care programs. In March, the Health and Human Services Commission (HHSC) and Texas Department of Insurance (TDI) outlined major provisions for the Senate Health and Human Services and State Affairs committees, which are summarized in this section.

Private Health Insurance Reforms

Immediate Market Reforms

A number of changes to the private health insurance market went into effect on September 23, 2010, six months after the bill's passage. Federal law now:

- prohibits lifetime benefit limits;
- restricts allowable annual benefit limits;
- prohibits rescissions (except in cases of fraud or intentional misrepresentation);
- provides coverage of dependents up to age 26;
- prohibits pre-existing condition exclusions for children up to age 19; and
- requires coverage for preventive services with no cost-sharing.¹

In addition to these requirements, several major regulatory changes have taken effect. The federal law requires states to review insurer rate increases and determine whether they are reasonable. Health plans will be required to provide a written explanation of rate increases found to be unjustified and post an explanation on the health plan's website.²

Beginning January 1, 2011, health plans are also now federally required to meet certain medical loss ratios. The medical loss ratio is the percent of premium dollars spent on medical care and health care quality improvement rather than administrative costs and profits. Health plans not meeting the minimum medical loss ratio (80 percent for small group and individual plans and 85 percent for large group plans) will be required to provide rebates to consumers.³

Future Market Reforms

The federal health care reform legislation also requires major changes to the health insurance market that take effect January 1, 2014. Specifically, the new law will:

- prohibit medical underwriting and discrimination based on health status (guaranteed issue);
- prohibit pre-existing condition exclusions for adults;
- eliminates annual limits on coverage;
- limit waiting periods for group plans to 90 days;
- limit annual deductibles in the small group market to \$2,000 (individual) and \$4,000 (family);
- redefine "small employer" from 2-50 to 1-100 employees; and
- require that health plans provide routine care for individuals participating in clinical trials.⁴

Insurance Mandates

Beginning January 1, 2014, the federal law requires individuals to obtain health insurance coverage that meets federal standards or face financial penalties.⁵ Certain exemptions to this requirement will be made, including an exemption for those who do not meet the income threshold for filing taxes (currently \$12,050 for an individual and \$18,700 for a couple).⁶ The legislation will provide subsidies to individuals with incomes up to 400 percent of the federal poverty level to help them purchase qualifying health insurance.

In 2014, the federal legislation will also require that employers purchase health insurance coverage for their employees or pay financial penalties. Small employers with 50 or fewer employees are exempted from this requirement.⁷

Temporary High-Risk Pool

One of the immediate requirements of the federal legislation was the creation of a temporary high-risk pool in each state for individuals with pre-existing conditions. To qualify for the pool, individuals must have been uninsured for at least six months.⁸ The temporary risk pools are intended to provide a "stop-gap" for individuals with pre-existing conditions until 2014 when insurers are no longer allowed to deny coverage for pre-existing conditions.

In April, federal HHS asked state governors to submit letters of intent indicating whether their state would establish the new temporary high-risk pool itself or defer to the federal government to establish one. In a letter sent to HHS Secretary Sebelius on April 30th, Governor Perry stated that Texas could not commit to operating the new high-risk pool due to a lack of program details and funding uncertainty. Federal HHS has established the Pre-existing Condition Insurance Plan (PCIP) for Texas. More information regarding this program is available at: <http://www.healthcare.gov/law/provisions/preexisting/states/tx.html>.

Texas has operated its own high-risk insurance pool, the Texas Health Insurance Pool (THIP), prior to federal health care legislation. Federal requirements for the new PCIP make premiums in the PCIP lower than those available to enrollees in THIP. However, current THIP enrollees are not eligible for the new risk pool unless they have been uninsured for six months.

Consumer Ombudsman Program

Effective immediately upon passage, each state was required to establish an office to serve as a health ombudsman to assist consumers with insurance-related questions and complaints, provide education on their rights and responsibilities, and help them enroll in a health plan. In response to this federal requirement, TDI has established the Texas Consumer Health Assistance Program (CHAP). More information about CHAP can be found at: <http://www.texashealthoptions.com/cp2/cpmchap.html>.

Health Insurance Exchange

The federal law requires that by January 1, 2014, each state have one or more operating health insurance exchanges for individuals and small employers administered by a governmental agency or non-profit organization. By January 1, 2013, states that choose to establish their own exchange will need to demonstrate that they will be able to have an operational exchange by January 1, 2014. States that choose not to establish their own exchange will have one established for them by federal HHS.⁹

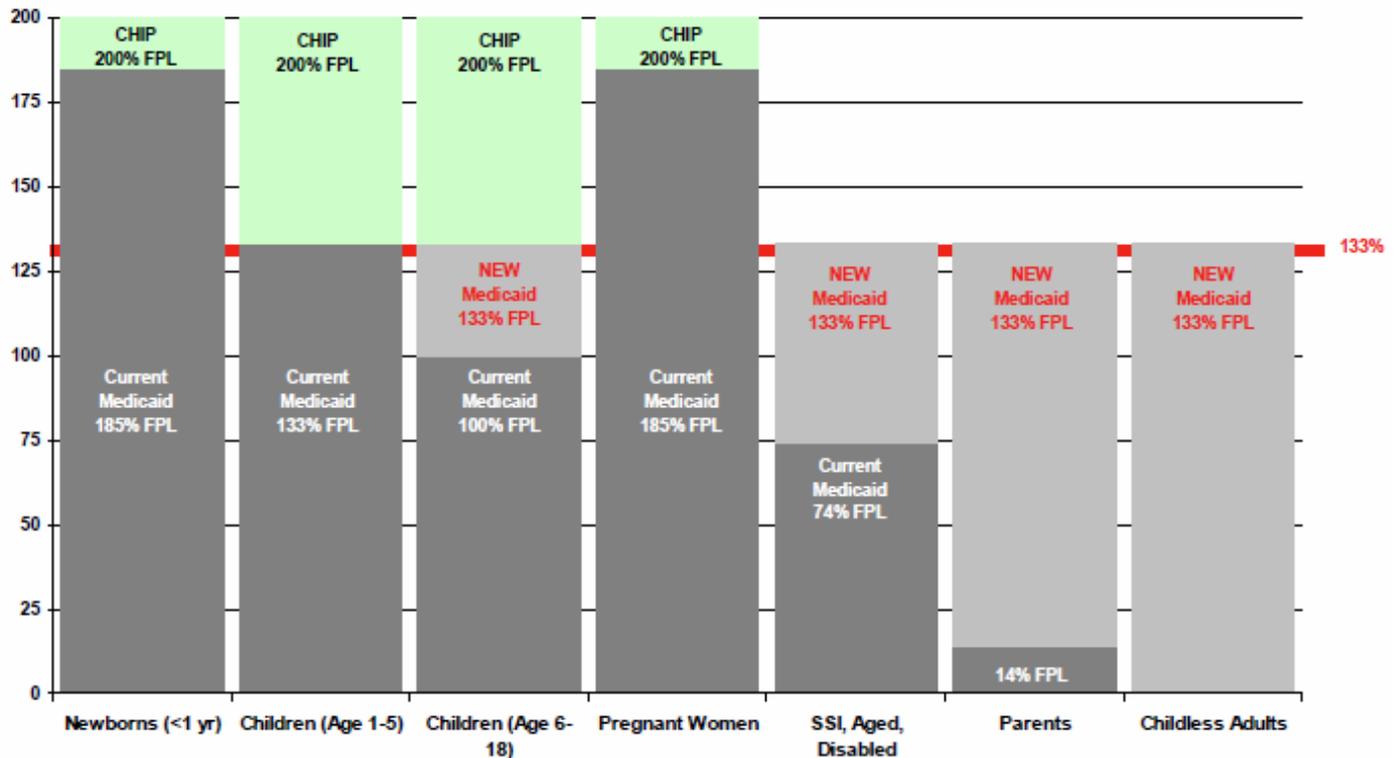
Because the exchanges are federally required to provide a seamless, no wrong door portal for health insurance application and enrollment, exchanges will need to coordinate with the state Medicaid and Children's Health Insurance Program (CHIP).

Medicaid Reforms

Medicaid Eligibility Expansion

Beginning January 1, 2014, states will be required by the federal law to expand Medicaid eligibility to citizens and legal residents under age 65 with incomes up to 133 percent of the federal poverty level (FPL). New client populations in Texas will include parents and caretakers between 14 and 133 percent of FPL, childless adults up to 133 percent FPL, emergency Medicaid in expansion populations, and foster-care through age 25. Figure 1 compares current and future Texas Medicaid/CHIP eligibility levels.¹⁰

Figure 1. Current and Future Medicaid/CHIP Eligibility



At the March 31, 2010 hearing, HHSC estimated that changes to Medicaid/CHIP under the new federal law would increase Medicaid and CHIP rolls by 2.1 million individuals and cost the state \$27 billion in general revenue between fiscal years 2014 and 2023. This cost estimate included:¹¹

- changes to the existing Medicaid program including increased enrollment by currently eligible but not enrolled individuals;
- Medicaid expansion to 133 percent FPL;
- estimated administrative costs; and
- changes in vendor drug rebate revenue.

States will receive a 100 percent federal match for Medicaid expansion populations from 2014 until 2017 at which time the federal match will decrease each year until it reaches 90 percent in 2020.¹²

Provider Rate Increases

In 2013 and 2014, federal law will require Medicaid reimbursement for certain primary care services to be increased to 100 percent of Medicare rates. For these two years, rate increases will be 100 percent federally funded. State policymakers will have to decide whether to continue these rate increases once the full federal match ends after 2014.

Prescription Drug Carve-In

Historically, federal regulations have not allowed states to receive prescription drug rebates under Medicaid managed care. However, the federal legislation reversed this policy. States will now have the policy option to carve-in prescription drugs in managed care and still claim drug rebates. HHSC estimates that this policy change could save \$84.1 million in state general revenue for the 2012-13 biennium.¹³

Disproportionate Share Hospital Payments

The federal legislation also reduces funding for Medicaid disproportionate share hospital (DSH) allotments across all states. Federal HHS is responsible for developing a methodology for reducing DSH allotments for each state. States with the lowest percentage of uninsured will receive the largest percentage reductions in DSH allotments. The exact impact to Texas will be unknown until federal HHS develops the reduction methodology.

Grant Programs

The federal law included numerous grant opportunities and demonstration projects. As state agencies determine whether to apply for these opportunities, it will be important to assess the impact to the state, including:

- requirements that states provide matching funding;
- entitlements that might be created by accepting federal funding; and
- maintenance of effort requirements that would limit the legislature's flexibility in determining state funding levels in the future.

Legislative Considerations for the 82nd Texas Legislature

Fiscal Implications

Evolving regulations on the federal level have made it difficult for the Texas Department of Insurance (TDI) and the Health and Human Services Commission (HHSC), the two state agencies primarily responsible for implementing the law's provisions, to estimate the exact costs to the state of the new law. However, both agencies have released budget estimates related to implementation of federal health care reform for the 2012-13 fiscal year.

In its Legislative Appropriations Request for FY 2012-13, TDI included an exceptional item request for \$11.4 million to fund federal health care reform implementation. Specifically, this item would fund costs associated with:

- initiating a statewide public awareness campaign;
- revising and drafting necessary rule and statutory changes to comply with the new federal law; and
- reviewing the additional filings TDI will receive from health insurers as a result of new federal requirements.¹⁴

In its Consolidated Budget for FY 2012-13, HHSC estimated that agency activities in the upcoming biennium to prepare for major changes to the HHS system in 2014 would cost the state \$35.7 million. This included \$24.2 million to build system capacity and \$11.5 million to establish the connection between the Medicaid/CHIP eligibility system and the future health insurance exchange. In November, HHSC updated these cost estimates based on new federal guidance that indicates that states may receive a higher federal match. As Figure 2 shows, HHSC now estimates these costs to be \$16.6 million and \$7.6 million, respectively.¹⁵

Figure 2. HHS Implementation Costs (FY 2012-13)

	From Consolidated Budget: FY 2012-2013 Biennial Total		Updated Estimates FY 2012-2013 Biennial Total	
	GR	All Funds	GR	All Funds
Build System Capacity – includes claims processing changes (Table v.1)	\$24,242,475	\$71,643,840	\$16,600,785	\$61,041,427
Establish Connection between Medicaid Eligibility System and the Exchange (Table v.3)	\$11,476,800	\$24,000,000	\$7,594,560	\$24,000,000

It is important to note that the impact of federal health care reform on the HHS eligibility system workforce is still difficult to fully assess and is not included in the above estimates.¹⁶

Establishing the Health Insurance Exchange

As discussed previously, each state will be required by the federal law to have one or more health insurance exchanges beginning in 2014, either established by the state or federal HHS. On November 23, 2010, HHSC outlined major decisions for state policymakers related to the health insurance exchange:

- Should Texas establish the health insurance exchange or default to the federal government?
- If Texas establishes an exchange, should it be a new agency or an existing agency?
- If Texas establishes an exchange, how should it be structured? (e.g. state agency, quasi-state agency, other)
- If Texas establishes an exchange, how should it be financed?

If Texas chooses not to establish its own exchange, or does not pass the federal readiness review by January 1, 2013, federal HHS will establish an exchange for Texas.

Health Care Workforce Shortages

As a result of the new law, HHSC estimates that the uninsured population in Texas will drop from 6.5 million to 2.3 million, with roughly 2 million of these individuals moving into the Medicaid program.¹⁷ As more Texans enter the private health insurance market or Medicaid, the demand for health care services will increase as individuals who have typically delayed care or sought treatment in the emergency room will try to access health care providers under their new

health insurance coverage. How successful the newly and previously insured are in accessing health care will depend largely on how the state addresses its workforce shortage.

For a detailed discussion of the state's health care workforce shortages, see the Senate Health and Human Services Committee's interim report on charge 5.

States' Constitutionality Challenge

On March 23, 2010, Texas joined 12 other states in challenging the constitutionality of the newly enacted federal law. Specifically, the multi-state lawsuit asserts that the law's requirement that individuals purchase health insurance or face a financial penalty exceeds Congress' authority under the U.S. Constitution. The lawsuit also argues that the new law fundamentally changes the Medicaid program through a drastic expansion of eligibility and will leave states with an unsustainable increase in Medicaid costs.¹⁸

The lawsuit has since grown to include 20 states. On October 14, 2010, a U.S. district judge in Florida found that the states' legal challenge does raise significant constitutional concerns and rejected a motion to dismiss the case.¹⁹ Oral arguments began in December 2010.

As Texas policymakers work to implement what is currently required of them by federal law, they will also have to take into account that the state is still waiting for its legal challenge to work its way through the court system.

Section III. Conclusion

The members of the Senate Health and Human Services Committee and the Committee on State Affairs will continue to monitor the implementation of this legislation as new guidelines are issued by the appropriate federal agencies.

¹ Texas Department of Insurance, *Testimony before the Senate Committees on Health and Human Services and State Affairs*, p4, (Austin, TX, March 31, 2010).

² *Id.* at p5.

³ *Id.* at p6.

⁴ *Id.* at p9.

⁵ *Id.* at p20.

⁶ *Id.* at p19.

⁷ *Id.* at p21.

⁸ *Id.* at p11.

⁹ *Id.* at p15.

¹⁰ Health and Human Services Commission, *Testimony before the Senate Committees on Health and Human Services and State Affairs*, p3, (Austin, TX, March 31, 2010).

¹¹ *Id.* at p4-5.

¹² *Id.* at p9.

¹³ Health and Human Services Commission, *Legislative Appropriations Request FY 2012-13*, Available: <http://www.hhsc.state.tx.us/LAR/2012-2013/Summary-Exceptional-Items-Request.pdf>.

¹⁴ Texas Department of Insurance, *Legislative Appropriations Request FY 2012-13*, Available: http://www.lbb.state.tx.us/External_Links/LAR_82R/Insurance_2012-13.pdf.

¹⁵ Health and Human Services Commission, *Testimony before the Senate Committees on Health and Human Services and State Affairs*, p14, (Austin, TX, November 23, 2010).

¹⁶ *Id.* at p15.

¹⁷ Health and Human Services Commission, *Testimony before the House Select Committee on Federal Legislation*, p6 , 21-22, (Austin, TX, April 22, 2010).

¹⁸ Attorney General of Texas, "Attorney General Abbott Challenges the Constitutionality of Federal Health Care Takeover," Available: <https://www.oag.state.tx.us/oagNews/release.php?id=3273>.

¹⁹ Attorney General of Texas, "Federal Court Rules States' Challenge to Federal Health Care Bill Can Proceed," Available: <https://www.oag.state.tx.us/oagNews/release.php?id=3517>



*The Senate of
The State of Texas
Austin, Texas 78711*

January 26, 2011

The Honorable Robert Duncan
Chair, State Affairs Committee
Texas Senate
Room 3E.10
Austin, Texas 78701

The Honorable Jane Nelson
Chair, Health and Human Services Committee
Texas Senate
Room 1E.5
Austin, Texas 78701

Dear Chairs Duncan and Nelson:

Thank you for your leadership as Chairs of the Senate State Affairs and Health and Human Services Committees and your work on the Committees' joint report to the 82nd Legislature regarding federal health care reform. We are honored to serve with you as we work to address issues vital to the future of our state. We know that the joint report reflects months of hard work by the Committees, and the recommendation to continue monitoring the new law's implementation is sound. Therefore, we will sign the report. However, we would respectfully like to clarify our position on certain aspects of health care reform that are addressed in the report.

The report only mentions in passing the numerous positive aspects of health care reform that will transform and improve Texas. As you know, the uninsured population in Texas is estimated to drop from 6.5 million to 2.3 million, thus providing access to coverage for 4.2 million more Texans. Additionally, health reform provides tax credits that will aid small businesses in Texas with purchasing coverage effective in January of 2010. Interim re-insurance is already being provided for early retirees from the Teachers Retirement System, Employee Retirement System, American Airlines, HEB, Valero, and over 170 other Texas employers through 2014. Further, over 160,000 young Texas adults are already able to stay on their parents' insurance plans until 26 years of age and more federal funding is already being provided to help our 318 Community Health Centers and to build new centers across the state. Over 2.8 million Texas seniors have gained new coverage for annual check-ups and critical preventive tests like mammograms and colonoscopies, and over 160,000 have already benefitted from reduced medication costs through closing the prescription drug "donut hole."

Even under the HHSC's high-end estimate, 2.1 million more uninsured Texans would gain coverage through Medicaid and CHIP — an enormous human benefit for the investment. The 90 percent federal matching contribution for costs for expansion will result in a large net influx in federal tax dollars returned to our state as well. From 2014-2019, HHSC projects a federal funds gain of \$76.3 billion, or more than 13 times the state's \$5.8 billion cost. These extra federal funds flowing to our state have a dramatic multiplier effect, as Texas economists have estimated that every \$1 in federal matching Medicaid funding will result in **\$3.25** worth of local economic activity.

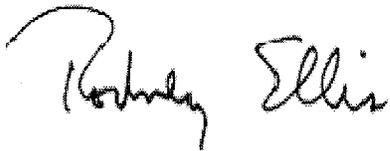
On top of increased state economic activity, economists note that increased federal funding for Medicaid results in increased state tax revenues and decreased need for local taxes. Furthermore, the state will see a reduction in insurance premiums, direct uncompensated care, out-of-pocket medical costs for individual Texans and businesses, and cost-shifting inflation of health care prices as a result of more insured Texans.

The report should also note the federal funding already received by Texas: a \$1 million dollar grant to support rate review implementation; a \$2.8 million dollar grant for the establishment of a consumer ombudsmen office; and a \$1 million dollar planning grant for an exchange. The health reform law includes numerous additional grant opportunities and demonstration projects. As state agencies determine whether or not to apply for these opportunities, it will be important to assess the value of these enhanced services, the potential savings to Medicaid from demonstrations, and the magnitude of federal funding foregone if these opportunities are not pursued.

Finally, in regard to Texas' constitutionality challenge, it should be noted that while a final determination will likely be made by the U.S. Supreme Court, two other U.S. District Court judges have already upheld the law.

We thank you in advance for considering our concerns and we look forward to working together in the 82nd Legislative Session. We are confident that under your leadership we will ensure that Texas has access to affordable health insurance.

Sincerely,



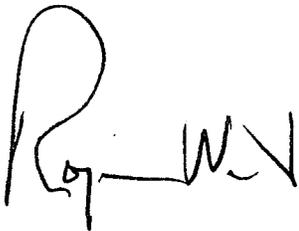
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The Senate of the State of Texas

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Senator Eliot Shapleigh
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December 13, 2010

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The Honorable Jane Nelson
Chairwoman
Senate Committee on Health & Human Services
420 SHB

The Honorable Robert Duncan
Chairman
Senate Committee on State Affairs
380 SHB

VIA HAND DELIVERY

RE: Interim Charge 1 (Joint Charge for Senate Committees on State Affairs and Health & Human Services)

Dear Chairwoman Nelson and Chairman Duncan:

We appreciate your leadership and the committees' work on interim charge 1:

On passage of federal legislation relating to reform of the health care industry and health insurance industry, study the implications of such legislation on Texas, the health care industry, and public and private insurance. Study and monitor the implementation of the insurance regulatory changes, changes to high risk pool, and any other insurance mandates. Study the health care policy changes and the impact to the Medicaid and CHIP programs and the state budget. Assess the impact to all state uninsured and uncompensated care programs and county programs for the uninsured, including county property tax programs to pay for the uninsured. Make recommendations for the efficient implementation of programs.

In recent weeks, a few of the state's more extreme leaders, including Governor Perry, have suggested that Texas "opt out" of Medicaid. To provide a fair and balanced view of the state of health care in Texas, I ask that you include this letter in your committees' interim report on interim charge 1 to the 82nd Legislature.



If Texas were to leave the joint federal-state program, the state's uninsured rate would increase from 26 percent to 40 percent. Of the more than three million Texans enrolled in Medicaid, 2.3 million are children. The remainder of Medicaid clients comprise some of the most vulnerable populations in Texas, including 100 percent of disabled Texans living in residential centers and 70 percent of nursing home patients.

In addition, according to HHSC, \$24.7 billion will be spent on Medicaid during fiscal year 2011; \$16.6 billion of that sum will be paid by the federal government. If Texas chooses to no longer participate in Medicaid, the state would lose all of these federal dollars. Furthermore, we will no longer be able to participate in the Children's Health Insurance Program. Finally, Medicaid dollars have direct benefits on local economies (e.g., payments to nursing homes, hospitals, pharmacies, physicians and other health care professionals). According to Texas economist Ray Perryman, federal Medicaid dollars spent on health services have a short-term economic multiplier effect of 3.25. In other words, a loss of \$20 billion in federal funds would have a negative impact of \$65 billion in near-term economic activity.

Aside from these figures, local entities, such as counties and public hospitals, would experience increased utilization of emergency services, which will undoubtedly correlate with significant increases in uncompensated care. Given the anticipated \$20+ billion budget shortfall for the next biennium, Texas is in no position to replace these federal funds or to even attempt to build another safety net for poor, disabled, or elderly Texans who rely solely on Medicaid for their health care.

In an effort to illustrate the state of health care in Texas today, the chart below provides key health-related statistics:

	TEXAS' RANKING
Percentage of population with health insurance	50th
Percentage of children with health insurance	50th
Percentage of poor covered by Medicaid	41st
Percentage of adults with employer-based health insurance	48th
Number of diabetes deaths per 100,000 population	9th
Teen birth rate per 1,000 population	1st
Percentage of children who are immunized	41st
Obesity rate	3rd
Mental health expenditure per capita	49th
Percentage who visited dentist/dental clinic within past year	43rd

Source: The Henry J. Kaiser Family Foundation, available at www.statehealthfacts.org

Let's review the history of health care in Texas after a decade under Governor Rick Perry. By any measure, Texas is now "the ground zero" of health care in America. Texas has more uninsured than any state in the country. One out of four Texans—over six million—does not have health insurance. Not a single Texas city meets the national average in citizens covered with insurance—not Austin, not Dallas, not Houston. In fact, El Paso has more uninsured by percentage than any large city in the U.S. today. Contrary to the claims of some, even if non-citizens (who include legal residents as well as undocumented immigrants) were removed from the statewide estimate, Texas would still have the highest uninsured rate in the country with well over 4 million uninsured citizens. If any state in the U.S. needs health reform, it's the Lone Star state.

Consider this: one in six uninsured American children lives in Texas. We have 1.4 million uninsured children, more than any other state in percentage and total number. As many as 500,000 to 700,000 of these children are eligible currently for Medicaid and CHIP but not enrolled due to inadequate state agency funding.

Here's more:

- From 1996 to 2006, the cost of family coverage in Texas increased 86 percent—ten times faster than Texans' wages increased (8.6 percent). Rates are projected to increase another 7.3 percent in 2009.
- Texas businesses and families shoulder a hidden health tax of roughly \$1,800 per year on premiums as a direct result of subsidizing the costs of the uninsured.
- 17 percent of middle-income Texas families spend more than 10 percent of their income on health care.
- The percent of Texans with employer-sponsored coverage fell from 57 to 50 percent between 2000 and 2007.
- In 2008, only one out of three businesses with fewer than 50 employees offered health insurance. For businesses with fewer than 10 employees, only one out of four offered health insurance. In comparison, 92 percent of medium and large businesses offered their employees coverage.
- As you might expect in a state where one in four has no health insurance, health care professionals are in short supply. Texas ranks 46th in physicians per capita (only Idaho, Mississippi, Oklahoma and Utah have fewer physicians) and 47th in nurses per capita. Along the Texas-Mexico border, where I live, fewer doctors and nurses serve us than anywhere else in the United States.

Despite these alarming statistics, Governor Perry has chosen to play politics with children's lives. Last regular session, when it looked likely that the popular Children's Health

Insurance Program (CHIP) was set to insure more Texas children via a bill filed by Senator Kip Averitt (R-Waco), Perry killed it by trumpeting to the media that he was opposed to any expansion of CHIP. That bill passed the Texas Senate by a vote of 29 to 2, but died in the House.

In 2003, Perry intentionally kicked over 230,000 Texas children out of CHIP and another half a million out of Medicaid. Then, he went to the Bahamas with Grover Norquist to brag about it. As you know, the federal government pays for the majority of CHIP. In Texas, for every total \$1 spent on CHIP, the federal government pays 72 cents while the state pays the remaining 28 cents. So, instead of using the nearly \$1 billion that the federal government set aside for Texans to expand CHIP to cover as many Texas children as possible, Gov. Perry sent scarce taxpayer dollars back to the federal government so that other states like Illinois could cover all of their children.

Perry's failed leadership results in real life tragedies. According to a 2008 Families USA study based on U.S. Census Bureau data, approximately 2,700 uninsured Texans of working age died because they didn't seek medical care. In other words, seven Texans a day died last year due to lack of health insurance.

Moreover, failed leadership on Texas health care is increasingly shifting health care costs to local taxpayers at county hospitals and clinics at the highest possible emergency room rates. Parkland Hospital in Dallas and the Harris County Hospital District in Houston have provided nearly half a billion dollars a year in uncompensated care.

Why is Texas so far behind when it comes to providing basic health care to more citizens? Because nowhere in America has Perry's basic hostility to responsible governance become so engrained and been so costly to working families. Even President George W. Bush's Centers for Medicare and Medicaid Services (CMS) refused to approve Rick Perry's Medicaid waiver application because it simply redirects scarce DSH and UPL dollars from Texas hospitals, which already use it to fund care for millions of uninsured Texans, to instead fund his proposed Health Opportunity Pool (HOP).

The HOP is intended to provide private insurance to the uninsured parents of children enrolled in Medicaid and CHIP. However, after Perry's administration released details as to how the HOP would work, consumer advocates expressed serious concerns as to the adequacy of the limited benefits and whether these low income Texans would even be able to afford the premiums. Hospitals in particular were concerned that Perry's plan would end up costing them millions of dollars more. In August of 2008, four months after Perry's plan was submitted to President George W. Bush's administration, CMS officials sent Perry a letter stating that they could not approve the demonstration proposal as written. Negotiations of this waiver application effectively ended as Perry and state officials never submitted a revised proposal.

In other words, despite the illusion that Perry is hard at work trying to resolve the health care crisis in Texas, no significant action has been taken to move this proposal forward in the last

year. Perry's tactic of robbing Peter to pay Paul—taking scarce direct care dollars to fund insurance companies in this case—is a tactic all too common in Republican health care plans. And now, Gov. Perry and Attorney General Greg Abbott have filed suit to stop real health care reform under which Texas is the big winner.

The truth is that Texas can no longer afford to do nothing. The Robert Wood Johnson Foundation recently released a report compiled by researchers from the Urban Institute who used their Health Insurance Policy Simulation Model to estimate how coverage and cost trends would change between now and 2019 if nothing is done to reform the current system. The report, entitled "The Cost of Failure to Enact Health Reform," shows that within 10 years:

- The number of people without insurance could increase by more than 30 percent in 29 states. As many as 8.3 million Texans would be uninsured, up from 6 million this year.
- Businesses would see their premiums increase—more than doubling in 27 states. In Texas, employers' premiums would increase as much as 121 percent.
- Every state would see a smaller share of its population getting health care through their job. Half of the states would see the number of people with employer-sponsored insurance fall by more than 10 percent.
- Every state would see spending for Medicaid/CHIP rise by more than 75 percent. Texas' Medicaid/CHIP spending would increase as much as 117 percent.
- The average Texan's health care spending would increase as much as 81 percent, with those in middle-class working families impacted the most.
- The amount of uncompensated care in the health system would more than double in 45 states. In Texas, uncompensated care would increase by as much as 138 percent.

Sadly, our history in Texas over the last decade is this: unless the federal government by and through courts that enforce equal protection provisions of the U.S. Constitution aggressively step in—under this governor, the state government in Texas does the least possible to enforce a colorable claim to equal protection under federal minimum program requirements to protect a federal allocation—and never more. After nearly a decade under the leadership of Rick Perry, tax cuts for the wealthy trump care for kids, and resulting cuts to budgets rank Texas dead last in state per capita expenditures on our own citizens. All too often, the casualties are children and those in border regions and rural counties who cannot afford to pay for an insurance policy that now costs almost twice as much as it did a decade ago. Over the years, from Medicaid to state services for the developmentally disabled to public education, we bear witness to government by lawsuit because that is the only refuge for those who seek equal protection under the law.

Here are some recent examples:

Frew v. Hawkins, a Medicaid class action lawsuit against the state of Texas, was filed in 1996. The plaintiffs sued the state for failing to provide adequate health care for children enrolled in Medicaid. The charges included poor screening, case management and outreach. Despite what seemed like an early resolution of the case with the state of Texas agreeing to improve children's access to and awareness of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment program, the state did not honor the consent decree and years of litigation followed. Although the U.S. Supreme Court ruled in favor of the plaintiffs in 2000, the state persisted in its efforts, claiming that the consent decree could not be enforced because the state could not be sued. In early 2007, the case culminated when the U.S. Supreme Court declined to review the case again. As a consequence, the state of Texas entered into a corrective action plan with the plaintiffs. The Legislature in 2007 had to provide significant increases in reimbursement rates for doctors and dentists (25 percent and 50 percent, respectively) as well as set aside \$150 million each biennium for strategic initiatives intended to provide better, comprehensive health care to children enrolled in Medicaid. However, given that the state has only spent \$16 million of the \$150 million set aside for this biennium, the state might very well be in court again for failure to meet the requirements of the corrective action plan.

In another example of government by lawsuit, the Department of Justice (DOJ) has been conducting a civil rights investigation of Texas' state schools for the mentally retarded since early 2005. What started out as an investigation of one state school for abuses by direct care staff has broadened, first to another state school, and then the entire system. On December 1, 2008, the DOJ concluded that:

numerous conditions and practices at the Facilities violate the constitutional and federal statutory rights of residents. In particular, ... the Facilities fail to provide consumers with adequate: (A) protection from harm; (B) training and associated behavioral and mental health services; (C) health care, including nutritional and physical management; (D) integrated supports and services and planning; and (E) discharge planning and placement in the most integrated setting.

The DOJ's letter signified that the serious problems found initially at the Lubbock State School were not unique to one state school and indicative of systemic issues. The DOJ attributed these systemic issues to high staff attrition and vacancy rates for direct care staff and clinical professionals. Until the state can successfully train, supervise and retain their staff, we cannot begin to address the problems and deficiencies identified by the DOJ.

Over and over, government by lawsuit is all that those of us who believe in government by and for *all* people have had to protect those whom the Constitution binds us to protect. For many of us, health in Texas is the last frontier of civil rights, where the largest southern state continues to devalue the lives of minorities, the poor, and those most in need. In 2008, U.S. Senator John Cornyn showed just how out of touch he is when it comes to understanding the health care crisis in Texas. Despite the fact that Texas has led the country for years as the state with largest uninsured population, Senator Cornyn stated, "[w]e have created greater access to

quality health care in Texas... [s]o, you have to understand what I mean when I say I want to make Washington, D.C., and the rest of our country more like Texas [because], frankly, we know the policies that actually work." Texas needs leaders who can and will acknowledge that our current health care system is broken.

Now is the time for reality-based, responsible leaders to act to reform an unsustainable, woefully inadequate health care system—this is not the time for more posturing. Lack of health insurance, lack of sufficient health care professionals, and inadequate access to health care affect more and more Texans each day, especially during a nationwide economic recession. I hope that you will use the various provisions of the Patient Protection and Affordable Care Act to address these issues in the upcoming legislative session.

Very truly yours,



Eliot Shapleigh

ES/ss

cc: Members of Senate Committee on Health & Human Services
Members of Senate Committee on State Affairs