AMERICAN LEGISLATIVE EXCHANGE COUNCIL

ALEC

Prepared Statement

of

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to the

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Introduction
Good afternoon Chairman Alquist, Vice-Chairman Strickland, and Members of the Committee:

My name is Christie Herrera and I am the director of the Health and Human Services Task Force at the American Legislative Exchange Council, or "ALEC." As you may know, ALEC is the nation's largest nonpartisan membership organization of state legislators, with 2,000 legislator members from all 50 states and 78 members of Congress. Since 2005, 22 states have enacted model legislation drafted by ALEC's Health and Human Services Task Force.

Senate Bill 92: Common Sense Health Care Reform
I submit written testimony today regarding Senate Bill 92. Among other provisions, it would allow the uninsured to purchase health insurance across state lines; establish patient-centered Medicaid reform pilot projects; and provide a state income tax deduction for Health Savings Account (HSA) contributions.

ALEC applauds Senate Bill 92 because it will empower patients, improve health outcomes, and save taxpayer dollars.

Senate Bill 92 Provides Choice and Affordability with Out-of-State Insurance Plans
It's no surprise that one of the biggest issues facing California is access to affordable, meaningful health coverage. More than 6.6 million Californians, or one in five, are uninsured—and this statistic ranks the Golden State with the seventh-highest uninsured percentage in the country. Like most states, the uninsured population in California is very diverse. Many Californians lack access to employer-sponsored coverage; are eligible, but not enrolled, in Medicaid or SCHIP; and are denied coverage due to costly chronic diseases.

But increasing numbers of California's uninsured don't choose to purchase coverage because it just isn't a good "deal" for them. Over 40 percent of California's uninsured are between the ages of 18 and 34—what we call the young and healthy "invincible" population. More than 16 percent of California's uninsured earn more than $75,000 per year, but still don't have coverage. And despite assertions that most uninsured are in poor health, nationally 60 percent of the uninsured consider themselves to be in "excellent" or "very good" health.

It is clear that a one-size-fits-all solution will not help California's diverse uninsured population. That's why ALEC believes that—by allowing consumers to purchase health insurance across state lines—Senate Bill 92 will be an effective target in helping uninsured Californians find coverage that fits both their needs and their budgets.

Many Californians are near surrounding states where better health insurance deals can be found just across the state line. When compared with its border states, California has the second-highest monthly premiums for individual health insurance coverage.

Average Monthly Premium, Individual Coverage (2007)

State	Cost
NV	$172
CA	**$151**
OR	$147
AZ	$132

Source: ehealthinsurance.com, "Cost and Benefits of Individual and Family Health Insurance Plans," 11/2008

But cost isn't the only consideration for the uninsured. Many consumers are stuck in a stagnant health insurance market with fewer carriers and plan choices than their cross-border neighbors. Senate Bill 92 would allow the uninsured to access different carrier and more plan choices—sometimes, at lower prices—even by simply allowing California's border states to sell plans within the state.

Consider a Los Angeles-area single mom with two daughters, and without access to health insurance. Senate Bill 92 would allow her to access more affordable coverage, as well as more plan and carrier choices just across the California border.

Individual Insurance Choices: Single Mother (35 years); Two Daughters (15 and 10 years)

	CA 114 plans 8 carriers	NV 106 plans 7 carriers	OR 92 plans 7 carriers	AZ 103 plans 8 carriers
Premium	$196-$1905	$146-$1971	$106-$776	$101-$1197

Source: ehealthinsurance.com

It is clear that, despite low-cost insurance options in the individual insurance market, California must do more to encourage its uninsured to gain meaningful coverage without added government regulation. Senate Bill 92 would allow countless uninsured the opportunity to access more health plan choices, while expanding coverage choices for those who are already insured.

Senate Bill 92 would also help the uninsured access a more-customized benefits package that meets their health needs. California's 49 government-imposed mandates—which includes mandates for "essential" medical services like acupuncture—require the uninsured to purchase coverage they might not want or need.

Number of Health Benefit Mandates by State (2008)

State	# of Mandates
NV	52
CA	**49**
OR	36
AZ	29

Source: Council for Affordable Health Insurance, Health Insurance Mandates in the States 2008

Similarly, Senate Bill 92 would allow Californians who want more extensive benefits to "top-up" for richer coverage in other states.

In addition to bringing greater choices and access to health insurance, Senate Bill 92 will also allow California to benefit from innovative plans in other states. Cross-border purchasing of health insurance will cause pressure to create a more competitive California health insurance market. It will bring about quicker access to innovative plans because insurers would face fewer "barriers to entry" into California. In other words, California could benefit from new ideas in other states while maintaining core consumer and licensing protections important to this state.

Senate Bill 92 Provides Patient-Centered Medicaid Reform

Like other states, California is experiencing the "perfect storm" of skyrocketing Medicaid spending, increasing enrollment, and an aging population—meaning that state lawmakers must act now to preserve the Medicaid safety net.

In 2006, states spent about 16.8 percent of their budgets on Medicaid, which is more than state spending on higher education, transportation, and all other forms of public assistance combined. California is not immune to this budgetary breakdown; in 2007, the state spent over $35 billion on Medicaid. Medicaid enrollment is also increasing at an alarming rate. Twenty-nine percent of California's population is on Medicaid—making it the largest program in the country—and 45 percent of all California births are paid with Medicaid funds. Rising Medicaid spending and enrollment will force California's policymakers to either cut benefits, raise taxes, or drastically reform the program.

Medicaid's Perverse Incentives

There are a number of perverse incentives plaguing the Medicaid program that increase costs and decrease quality of care. Perhaps the most pervasive of these perverse incentives is the Federal Medical Assistance percentage ("FMAP," or "federal match"), the mechanism through which the federal government pays for more than half of all Medicaid spending.

FMAP provides a guaranteed return-on-investment for state Medicaid dollars—so whatever states spend, the federal government must pay their share. Because there's no limit to the amount of federal matching funds available to states, FMAP triggers a spending free-for-all as states spend more to get more federal money.

The average federal match is about 60 percent. California's federal match is about 61 percent. In other words, every dollar that California spends on Medicaid will yield approximately $2.60 in total Medicaid benefits.

Some state lawmakers seek to maximize FMAP dollars because they regard state revenues as "theirs" while thinking that federal revenues are "someone else's money." But all taxpayers, including Medicaid recipients, pay federal, state, and local taxes—and when states attempt to game the federal match, all taxpayers are worse off because of it.

Another perverse incentive plaguing state Medicaid programs is the explosion of expanded Medicaid eligibility. As of 2001, only 40 percent of Medicaid spending was spent on mandatory coverage; similarly, "optional" Medicaid expansion populations comprised nearly 30 percent of the program's beneficiaries. A recent Cato Institute study found that 21 percent of Medicaid-eligible adults and 27 percent of Medicaid-eligible children actually had private insurance.

Because the Medicaid program imposes weak cost-sharing requirements, Medicaid beneficiaries also face a perverse incentive to overspend. Critics of market-based reforms contend that cost-sharing in the Medicaid program would create barriers to coverage, resulting in a "race to the bottom" of worsening health outcomes.

The "gold standard" of health policy studies—the RAND Health Insurance Experiment—refutes that claim. RAND found that, with the exception of blood pressure control, there were no significant health differences between those who had free care and those who participated in cost sharing.

Providers face a different kind of perverse incentive—one that makes it easy for them to stop seeing Medicaid patients altogether. To blame are Medicaid's below-market-value reimbursement rates, which result in an ever-narrowing physician network, fewer choices for patients, and higher program costs. A doctor who treats a Medicaid patient will only get about 69percent of what they would receive for treating a Medicare patient—and Medicare reimbursements are notoriously well below what the private sector would pay. By 2006, more than one in five doctors were not accepting new Medicaid patients.

Critics of market-based reforms commonly perpetuate the myth that "market failure" leads to emergency rooms teeming with uninsured patients. Instead, lawmakers should consider that the "government failure" of low Medicaid provider reimbursements is the real culprit of crowded ERs. Medicaid patients use emergency rooms for non-ER care more than twice as much as the uninsured.

Medicaid Reform That Works: The Florida Example

In these tough economic times, legislators must sustain the Medicaid program without massive tax increases or service cuts. The answer is patient-centered Medicaid reform—a solution that allows beneficiaries to better manage their own care and save state dollars.

Senate Bill 92 builds on this patient-centered idea. The legislation would establish several pilot projects—including Health Opportunity Accounts, "cash and counseling" and Health Savings Accounts—that would allow beneficiaries a stake in their own health care decisions. Several states—including Florida and Texas—are successfully implementing similar policies to slow skyrocketing spending, help beneficiaries become better health care consumers, and reduce the perverse incentive for beneficiaries to overutilize Medicaid services.

Florida is one such example of a market-based Medicaid reform success story. In 2005, Florida experienced the "perfect storm" of Medicaid problems. Two-thirds of Florida's Medicaid population were enrolled in the traditional fee-for-service model, which invited rampant fraud and abuse. Patient care was worsening. And at the time, Florida Medicaid covered 47 different services through fee-for-service, managed care, and case management systems, as well as the operation of 20 existing Medicaid waivers. As a result, costs were hard to predict, and too many people had to wait for special waiver services because of bureaucracy.

Florida's Section 1115 Medicaid reform waiver was approved by both CMS and the Florida Legislature in late 2005. In July 2006, Florida's Medicaid reform went "live" in two test counties—Broward County, an urban center in the heavily populated southeastern part of the state, and Duval County, which boasts a more-rural population near the Georgia border. In July 2007, three additional rural counties—Baker, Clay, and Nassau Counties—also implemented Medicaid reform. Eventually, all of Florida's 67 counties will implement the state's Medicaid reform plan.

Under the plan, insurance companies compete in a "Medicaid marketplace" and offer varying benefit packages that specialize in certain health needs. The plan also allows beneficiaries to opt-out of Medicaid and purchase insurance through an employer, as well as earn extra money in "Enhanced Benefit Accounts" that provide incentives for healthy lifestyles. "Choice counselors" employed by Florida's Agency for Health Care Administration (AHCA) help beneficiaries choose the benefits package that's right for them.

Has Implementation Been a Success?

More than two years into Florida's Medicaid reform implementation, beneficiaries are experiencing better, more efficient patient care that yields more predictable program costs for taxpayers.

- *Beneficiaries can choose one of many plans tailored to fit their needs.* Beneficiaries in Broward County may choose one of 16 competing plans; beneficiaries in Duval County can choose from among seven plans, and beneficiaries in Baker, Clay, and Nassau counties may choose one of two plans.

- *Plans are offering many optional services, as well as many new benefits not covered by Medicaid.* Participating insurers are becoming innovative in expanding services so they can attract new plan enrollees, while enrollees are experiencing new opportunities to self-direct their care. In 2008, reform plans offered up to 11 services not covered by Medicaid, including an over-the-counter drug benefit, acupuncture, vision upgrades (such as scratch-resistant lenses), and nutrition therapy. Beneficiaries in Medicaid HMOs could choose from among 28 customized benefit packages, 71 percent of which require no copayments at all. What's more, the average value of these benefit packages are increasing each year without additional costs to the state.

- *"Choice counseling" has been a success—nearly 80 percent of Medicaid reform enrollees are making voluntary, informed decisions about their care.* Florida has implemented a first-in-the-nation choice counseling certification program in which counselors are trained with the knowledge and interpersonal skills necessary to help beneficiaries choose a plan, change a plan, and field questions or complaints. Despite critics' claims that establishing a choice counseling program would create additional bureaucracy, just 32 full-time English-, Spanish-, and Creole- speaking counselors staff the call center, in which more than 67 percent of calls are answered in under three minutes (additional counselors comprise a "Special Needs Unit" that conducts on site meetings with vulnerable populations). Critics often cite the "paradox of choice" as a major "flaw" of Florida's Medicaid reform plan. They contend that the abundance of

Medicaid reform plans will force ill-educated beneficiaries to make an involuntary or uninformed choice about their own health care—or no choice at all. But the success of Florida's choice counseling program proves the critics wrong. Nearly 80 percent of Medicaid reform enrollees voluntarily chose their own plan—and that percentage is rising each year.

- *Beneficiaries are responding to wellness incentives tied to Enhanced Benefit Accounts.* In September 2008 (the most recent month for which data was available), over 38,000 Medicaid reform beneficiaries earned nearly $700,000 in their Enhanced Benefit Accounts.

While Florida has the most well-established and well-documented market-based Medicaid reform program, other states have proposed successful Medicaid reform plans similar to Senate Bill 92, including South Carolina, Oklahoma, Kentucky, West Virginia, Idaho, Texas, Missouri, Rhode Island, and Louisiana.

Senate Bill 92 Expands Access to Health Savings Accounts (HSAs) Through Tax Equity
Health Savings Accounts (HSAs) are becoming an important tool to cover the uninsured. Since its inception in 2003, more than six million Americans own an HSA—which is a tax-free medical savings account coupled with a high-deductible health policy. In California, just three percent of those with private insurance own an HSA.

That's because California is one of only four states that tax HSA contributions. While these state laws are not necessarily a barrier to offering HSAs, they could be a disincentive to having one. Senate Bill 92 would bring tax equity to HSA owners and allow them to pay for their health costs tax-free.

Critics of HSAs claim that this consumer-driven insurance tool is primarily for the young and healthy. However, nearly half of HSA owners are over the age of 40, and one in four HSA owners is aged 50 or older. A large health insurance broker reports that, of its customers, 41 percent of HSA owners were previously uninsured, and nearly half of HSA plan purchasers have incomes of $50,000 or less. And roughly the same percentage of individuals with HSA coverage consider themselves to be in "fair/poor health" as those with non-HSA coverage—meaning that patients with chronic illnesses are also choosing high-deductible plans. In fact, the BlueCross BlueShield Association reports that HSA owners are offered more wellness incentives, are more likely to use preventive care, and typically do not forgo needed care because of costs.

Conclusion
Chairman Alquist, thank you for holding this hearing and for this opportunity to submit written testimony. California has an opportunity to solve the crisis of the uninsured, provide better care for Medicaid enrollees, and bring tax equity for HSA owners. ALEC believes that Senate Bill 92 is a win for California, and we look forward to working with you in the weeks ahead on developing this proposal. I would be pleased to answer any questions you might have at (202)742-8505 or christie@alec.org.