Texas CHIP Coalition:
2015 Legislative Principles and Supporting Information

Principle 1: To ensure that outreach, enrollment, and the eligibility system are user-friendly and support continuous coverage for Texas children and families

1. **Ensure that the Health and Human Services Commission (HHSC) has the resources and support needed to:**

    a. **Operate an eligibility system that is fully interoperable with the Health Insurance Marketplace and able to provide "No Wrong Door" access for Texans;**

As Texas children and families apply for health care coverage through two different portals – HHSC and the federal Marketplace – we must ensure that they encounter user-friendly eligibility systems that are accurate and timely in the determination of coverage for various family members. This will require effective information exchanges and communication between the state's HHSC, which administers CHIP and Medicaid, and the federal Marketplace, which administers private coverage for 734,000 Texans. Often families will have children on Medicaid and CHIP and parents in the Marketplace, making the interaction between HHSC and the Marketplace important to Texas families.

    b. **Ensure a robust and diverse network of Community Partners to maximize the benefit of the web portal and increase efficiency and access in the public benefits enrollment process;**

Texas is home to 1.2 million uninsured children, nearly a million of which are citizens and legal permanent residents. Over half of these children are currently eligible, but not enrolled, in Medicaid and CHIP. HHSC's Community Partner Program provides access to application assistance through local faith and community-based Community Partners. There are currently 700 Community Partners. Ensuring a robust and diverse network of Community Partners to maximize reach and the use of the promising and relatively new application webportal is critical reducing the number of uninsured children in Texas.

    c. **Enhance the agency's capability to provide consumer assistance and ombudsmen services to the growing Medicaid population receiving services through managed care.**

Over the last 20 years, enrollment in Texas Medicaid managed care has expanded from serving less than 3% of Medicaid clients in state fiscal year 1994, to serving about 85% of Medicaid clients in 2014. Service delivery expansions planned for the next few years will extend managed care to a projected 340,000 additional Medicaid enrollees. HHSC's Medicaid Managed Care Helpline and ombudsmen have been instrumental in assisting individuals with navigating the health care system, understanding Medicaid coverage and resolving problems with access to care. However, the number of staff serving in this capacity has not increased commensurate with the expanded population in managed care.

2. **Provide 12-month continuous coverage for Children's Medicaid and eliminate the CHIP waiting period.**

Texas has the highest number of children in the country who are eligible for CHIP or Medicaid, but are unenrolled.[1] One of the most effective ways to reduce this number and connect children to the health care services is through blocks of continuous eligibility. Continuous eligibility reduces a child churning in and out of health coverage programs from month to month, and allows for improved continuity and quality of their care. Eliminating the CHIP waiting period is also important. Waiting periods were originally developed to help prevent parents from dropping their employer-based health care coverage to get their children onto CHIP. But, in a world where children at all income levels have access to health care coverage it no longer makes sense. If a child today is subject to the 90-day CHIP waiting period, they would be eligible for Marketplace coverage for those 90 days and then be transferred back to CHIP, likely experiencing gaps in coverage along the way. Both continuous coverage and the elimination of the waiting period have potential for administrative savings.[2]

3. **Remove unnecessary monthly eligibility reviews for Children's Medicaid and any other unnecessary or redundant policies and procedures that prevent eligible children from receiving the health care coverage they need to grow and thrive.**

States are required by the Affordable Care Act to implement 12-month periods of certification for Children's Medicaid. Due to Texas' unique 6-month continuous eligibility standards, HHSC has determined that a child cannot begin a second block of 6-month continuous eligibility because they are unable to be recertified prior to a year. This leads to unnecessary and burdensome monthly income checks that can result in discontinuing a child's health care coverage. This is completely contrary to the spirit of continuous and stable coverage for children in both the Affordable Care Act and state statute.

4. **Extend Medicaid coverage to foster care youth who move to Texas from other states, as Texas did for children living in Texas in 2013.**

The Affordable Care Act ensures that Texas foster care children who aged out of care in Texas can receive Medicaid coverage till their 26th birthday. However, each state is able to determine if it will allow children aging out of other states' programs to receive Texas Medicaid when they move here to reunite with family or for employment or higher education opportunities. Texas' HHSC recently determined those children will not be eligible for Texas Medicaid. Limiting a youth's health coverage options at this important transitional period in life can have lasting, damaging effects at a time when they have stopped receiving critical services and have entered adulthood without the benefits of ever having found a family.

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[1] Genevieve Kenney, et. al, *Medicaid and CHIP Participation Rates Among Children: An Updata, Timely Analysis of Immediate Health Policy Issues*, Urban Institute, September 2013, http://www.urban.org/uploadedpdf/412901- Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf.

[2] Georgetown University Health Policy Institute Center for Children and Families, *Program Design Snapshot: 12-month Continuous Eligibility*, (March 2009), http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf.

5. **Ensure implementation of an effective hospital presumptive eligibility policy with achievable standards that assist in accessing coverage appropriately.**

The Affordable Care Act has given hospitals the ability to use presumptive eligibility to connect qualified patients to health care coverage at the point of service. Presumptive eligibility is an effective tool for ensuring immediate access to health care services for eligible populations and can help reduce our state's uninsured population and related uncompensated care costs. However, unrealistically strict standards proposed by HHSC would be difficult for hospitals to achieve and essentially limit their participation in the program. Other states have not adopted specific standards or are collecting baseline data to determine appropriate criteria.

6. **Identify opportunities to improve continuity of health care for women, including:**

   a. **Extending Medicaid eligibility beyond 60 days postpartum and extending CHIP perinatal coverage for mothers beyond two postpartum doctor visits;**

Texas can achieve healthier outcomes for moms and babies by ensuring that women have continuity of health care before, during, and after pregnancy. Pregnant women who are eligible for Medicaid for Pregnant Women and CHIP perinatal coverage receive a limited number of postpartum visits. However, too often the termination of this postpartum period marks the end of any health services for women. Nationally, over half of women who have a Medicaid financed birth lose coverage 60 days postpartum.[3] Women who fall out of services at this point miss out on basic health services, interconception care, and services for issues like postpartum depression that are critical for ensuring their health and the health of their baby.

   b. **Ensuring that women who deliver a baby through Medicaid are auto-enrolled into appropriate women's preventive health care services when their Medicaid eligibility expires.**

Auto-enrolling women who have just had a baby though Medicaid or CHIP in the appropriate women's preventive health care program can ensure women are receiving the family planning services needed to space their pregnancies and stay healthy. Spacing pregnancies appropriately is associated with decreased risks of adverse perinatal outcomes and helps to improve the financial stability of the family.

Additionally, streamlining enrollment from one program to another helps to ensure that women do not go without critical preventive health care services when they are eligible and produces savings associated with a decrease in enrollment and disenrollment administration.

[3] Kay Johnson, "Addressing Women's Health Needs and Improving Birth Outcomes: Results from a Peer-to-Peer State Medicaid Learning Project," The Commonwealth Fund, August 2012, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Aug/1620_Johnson_addressing_womens_htl_needs_improving_birth_ib.pdf.

Principle 2: To ensure that children can get the health services that they need

1. **Ensure that provider networks in Medicaid, CHIP and private insurance are adequate to meet the needs of children who are healthy as well as children who require highly specialized care.**

Texas has a large and growing population. Indeed, between 2015 and 2025, the state demographer anticipates the number of children who call Texas home to grow by nearly 1.2 million. But there are too few physicians, nurses, and health care professionals to meet Texans' health care needs. There is a shortage of every kind of health professional in Texas except licensed vocational nurses. Texas today has the second-worst primary care provider supply in the U.S. For children, Texas lags other states in the number of general pediatricians and woefully short of many of pediatric subspecialists, particularly developmental pediatricians and child and adolescent psychiatrists. Texas' mental health provider shortage, including psychologists, social workers, and psychiatric nurse specialists, is the deepest of any category of care.

2. **Strengthen provider participation in Medicaid and CHIP by:**

    a. **Increasing Medicaid and CHIP health care provider rates to reasonable levels that reflect the cost of delivering services;**

Fewer physicians are now accepting Medicaid, making network adequacy especially critical for children in this program. Inadequate Medicaid payment rates is a key reason Medicaid physician participation plummeted over the past decade. According to preliminary results from the Texas Medical Association's 2014 physician survey, 34% of physicians accept new Medicaid patients and another 23% limit how many Medicaid patients they accept.[4] In 2000, 67% of physicians reported accepting all new Medicaid patients. Texas Medicaid has not made regular inflation updates to physician and other health professional fees for 20 years, and in that time rates have been cut more often than increased. Provider rate reductions made by the 82nd Legislature were not uniformly restored in 2014 and 2015 and cost growth for health care services was not adequately addressed. The 83rd Legislature also assumed the Medicaid program would implement a list of cost containment measures in the 2014-15 biennium, ranging from renegotiation of more efficient contracts, to maximizing co-payments, to further reductions in non-emergency use of hospital emergency departments. Failure to realize $962 billion (All Funds) in projected savings may force additional reductions in Medicaid provider payments or benefits. The cumulative impact of Medicaid and CHIP budget reductions jeopardizes access to care and the quality of health care in Texas.

Physicians and providers strongly support Medicaid as a means to cover low-income Texans. Without the program, another 4 million low-income Texans would be uninsured. Texas must reverse the provider exodus by reinvesting and expanding resources to build provider capacity so that both existing and future Medicaid

[4] The survey's margin of error is 5+/-, meaning the 2014 results are statistically unchanged from the 2012 survey, which found 32 percent of Texas physicians accepted all new Medicaid patients.

and CHIP enrollees and privately insured children alike will be able to obtain the health care services they need.

b. **Maintaining parity with Medicare for Medicaid primary care service payments, increased in 2013 and 2014;**

Texas Medicaid rates for physician services provided to children average 78% of Medicare rates, which in turn are below commercial rates. These rates are set entirely by the Texas Legislature; federal Medicaid law does not set minimum standards for state programs. As a result of the Affordable Care Act, Medicaid payment rates for primary care services were increased to Medicare parity for calendar years 2013 and 2014, using 100% federal funds for the cost of the increase. Without Congressional or legislative action, the higher rates expire on December 31, 2014, further discouraging provider participation in Medicaid.

c. **Analyzing Medicaid and CHIP program integrity policies and practices to ensure proper balance between due diligence and administrative burdens, for both providers and clients.**

Providers contend with redundant credentialing requirements, excessive and confusing prior authorization requirements, payment delays, and daunting fraud and abuse audit reviews, all of which increase costs. The 84th Legislature directed HHSC and the Texas Department of Insurance to implement meaningful reforms to address provider concerns. Currently, the agencies are working with stakeholders to identify best practices. Further, lawmakers strengthened due process protections for providers accused of Medicaid waste, fraud or abuse. In 2015, the coalition supports augmenting the work begun last session to simplify Medicaid.

3. **Include safety net providers in the Medicaid and CHIP HMO networks, offer them a contract in network, and provide reimbursement methodologies for safety net providers to assure access to the full array of available services offered from that provider.**

Safety net providers, like community health centers (or Federally Qualified Health Centers) have established relationships in communities as the medical home for families of mixed insurance status (Medicaid, Medicare, CHIP, private) and the uninsured. Safety net providers can also provide health care to patients when they are in between insurance products and have no other source of health coverage for primary health care needs. Including safety net providers in the Medicaid and CHIP HMOs and offering them in network contracts will allow patients continued access to significant traditional providers and maintain their relationship with their provider of choice. The contracted reimbursement methodology for safety net providers has to be sufficient to ensure full access to the array of preventive and primary care needed to keep communities healthy.

4. **Maintain comprehensive benefits for children in Medicaid and CHIP and avoid benefit and policy changes that make children's coverage unaffordable through cost-sharing obligations that are excessive relative to family income.**

Some contemporary state and federal proposals propose re-structuring Medicaid and CHIP in ways that could reduce access to quality care for the over 3 million Texas children who rely on the programs today to stay healthy. Our Coalition supports reforms to our public health insurance programs that reduce the rate of health

care spending growth while raising standards for quality of care, promoting evidence-based cost-effective care, and improving outcomes; and redirect financial incentives away from rewarding either the over- or under-provision of care. We oppose restructuring and deficit reduction methods that reduce children's access to comprehensive medically necessary care; reduce children's eligibility for affordable comprehensive coverage; and make children's coverage unaffordable through cost-sharing obligations that are excessive relative to family income

Principle 3: To ensure adequate funding for critical health and human services

1. **Avoid policy changes that eliminate the current federal funding partnership guaranteeing that Texas can depend on increased federal funding to reflect both population and inflation growth, as well as when greater need occurs in times of economic downturns and major disasters.**

Medicaid is a jointly funded partnership between the federal government and each state. As an entitlement, states provide health and long-term care services to all individuals determined to be eligible. The federal government sets minimum parameters for eligibility and benefits, but states have some flexibility in the provision of services. States may also seek waivers from many of the federal requirements.

Because the population of Texas has grown significantly and a high level of poverty persists, the number of individuals enrolled in Medicaid continues to rise. Proposals surface every year to secure additional flexibility and limit spending to a defined amount. Under a block grant (or some type of capped allocation), states would receive an allotment of federal funds, which could be determined based on historical expenditures, population, or other factors. States would then make decisions on eligibility, benefits, cost-sharing provisions, etc.

Although a block grant may provide funding stability and predictability, there are significant risks that could undermine Medicaid's traditional function as a safety net. Funding levels may not recognize the fast rate of population growth in Texas or health care inflation. Economic circumstances or natural disasters could alter the need for health care. Conversion to a block grant does not guarantee cost control or program efficiencies. A state may turn to measures such as freezing enrollment, establishing waiting lists, eliminating services, or reducing provider rates to the point of compromising quality. Vulnerable, low-income Texans could face diminished access to health benefits and long-term care services. Federal law requires states to provide all medically necessary services to children enrolled in Medicaid—a policy that could be compromised with a block grant.

2. **Preserve revenue for needed health services while improving public health.**

Using tax policies to discourage unhealthy behaviors related to tobacco, alcohol and sugary beverages can generate additional revenue for health and human services, avert future health care costs and improve the health of Texans. People should be held personally responsible for some of the costs that the public will bear when they develop chronic health conditions and are supported by the Medicaid and Medicare programs.

Each year more than 31,000 Texas kids become new daily smokers. More than 500,000 Texas kids will ultimately die prematurely from smoking. Estimates of annual health care costs in Texas directly caused by

smoking range from $5.8 to $7.5 billion. Increasing the cost for cigarettes has been shown to deter smoking, particularly among teens. Nearly 9 out of 10 smokers started by age 18. An increase in tobacco taxes could save lives and reduce health care costs. Raising the cigarette tax a dollar per pack could generate almost $1 billion per year to support health and human services.

The economic cost in Texas of alcohol abuse in 2000 was estimated at $16.4 billion, including $779 million for medical care, $286 million for treatment services, and $305 million for Fetal Alcohol Syndrome. Abuse of alcohol during pregnancy is associated with many complications for labor and delivery and may result in physical and mental disabilities for infants. It has been 30 years since the beer tax was raised, 29 years since the tax on distilled spirits was raised, and 24 years since the tax on mixed beverages was raised. Increasing the tax on beer alone from 11 cents to 17 cents per six-pack would raise about $50 million per year.

The Texas Comptroller estimates that obesity cost Texas businesses $9.5 billion in 2009, and these costs are expected to rise to $32.5 billion by 2030. Increased consumption of sweetened beverages accounts for 43% of the rise in caloric intake over the past 30 years and sugar-sweetened beverages account for 10 to 15% of the calories consumed by children. A penny-per-ounce tax could reduce consumption of sugar-sweetened beverages by 23% and generate more than $1 billion per year in Texas.

Principle 4: Bolster the Texas health care workforce

1. **Increase investments in health care provider education and training programs with particular emphasis on expanding training and residency capacity to ensure that there are enough physicians and other providers to serve our fast growing population.**

The 83rd Legislature wisely invested new dollars to bolster the state's health care workforce. But more must be done to keep pace with the state's rapidly growing population and patient needs for services. Given the time it takes to train new doctors, dentists, nurses, pharmacists, mental health professionals, and others in the health care workforce, the 84th Legislature must build on the important work done in 2014 to train and recruit more health care professionals and reinstate funding for Medicaid Graduate Medical Education (GME). In 2003, Texas eliminated this program except for state-owned facilities, undercutting teaching hospitals' ability to train Texas' future physicians. We support increased funding for planning grants to help hospitals not currently offering GME offer training within their facilities. Texas should also establish and implement a plan to increase residency slots to match the number of incoming medical students, as the Texas Higher Education Coordinating Board has recommended, so that we may retain here in Texas more of the doctors we have invested in and trained.

2. **Maintain funding for the Texas Nursing Shortage Reduction Program, a program that incentivizes increasing the number of nursing graduates in the state.**

The Texas Legislature has invested significantly in increasing the number of pre-licensure RNs that have graduated over the past decade from Texas schools of nursing. That investment has resulted in the doubling

not only of enrollments but also in the number of RNs graduating. However, Texas' shortage of registered nurses has not gone away. The economic downturn has created some temporary relief because nurses delayed retirement, returned to practice from retirement, or worked full time instead of part time. As soon as the economy fully recovers, these RNs who have returned to the workforce, delayed retirement, and are working fulltime instead of part time are expected to leave the workforce or return to part time. If Texas eliminates or significantly reduces funding for the Nursing Shortage Reduction Program, Texas likely will lose the significant gains it has made over the past decade.

3. Invest in and develop innovative ways to recruit and retain mental health professionals at all levels of care.

The Texas Department of State Health Services' 2014 report, "The Mental Health Workforce Shortage in Texas," found that Texas must increase the number, distribution and diversity of Texas' mental health workforce in order to meet Texans' mental health needs. The report, which the 83rd Legislature required, outlined a number of strategies aimed at improving the recruitment and retention of mental health professionals, ranging from addressing payment disparities to early exposure to career opportunities in the mental health field to expanding loan repayment programs. Further, the Hogg Foundation for Mental Health (2011) has further recommended that the state work to increase the number of intern sites across professions and address the problems of inadequate pay and reimbursement in the public system.

Expanding GME has the most potential to bolster the number of psychiatrists, yet the availability of funded residency slots remains inadequate. Further, research has shown that targeting graduate medical and undergraduate pre-medical students with specialty clerkships and curriculum tracks is effective in recruiting students into residencies of that specialty (Grobler, Maraias, Mabunda, Marindi, Reuter, & Volmink, 2009).

4. Ensure that all available funding for the physician and dental loan repayment programs be appropriated to encourage more physicians and dentists to practice in medically underserved areas and other areas of need for the Medicaid and CHIP populations.

Recruiting and retaining a sufficient number of physicians to care for Texas patients is an ongoing challenge for the state. Given the size of the state and growing demographics, many urban and rural communities continue to suffer a physician shortage. The demand for physicians is particularly acute in the rural and border areas.

The Physician Education Loan Repayment Program (PELRP) has been one of the most successful models to address the state's physician shortage. The PELRP provides loan repayment funds for up to $160,000 over a period of four years to qualifying physicians. Priority is given to primary care physicians who agree to practice

in a Health Professional Shortage Area for at least four years. Participating physicians must provide health care services to recipients enrolled in Medicaid and CHIP. The 2013 session of the legislature appropriated $33.8 million for 2014-15, an increase of more than 500% above the $5.7 million in the 2012-13 budget. The state must continue to fund the program so that physicians and dentists are encouraged to practice in our state's underserved areas.

Principle 5: To improve the value of state spending by supporting practices that improve the quality and outcomes of care for children, mothers, and newborns.

The CHIP Coalition supports policies and programs to increase quality of care for children, mothers, and newborns. In Texas, the rates for preterm births and low birth weight are above the national average, and over 10% of births are to women who received late or no prenatal care. Policies addressing these issues include those that reduce preterm births; support healthy birth spacing; improve maternal access to smoking cessation and substance abuse services; broaden adoption of innovative programs and practices that improve the effectiveness of prenatal care; and support breastfeeding, all of which will improve health outcomes and reduce future taxpayer costs.

1. **Ensure adequate resources for the Maternal Mortality and Morbidity Task Force and ongoing support for Fetal, Infant and Child Fatality Review Programs.**

Texas has seen a marked increase in maternal deaths in the past 10 years. Between 2007 and 2011, the maternal mortality rate increased from 13.7 to 24.4 deaths per 100,000 live births, and the maternal mortality rate for black women is more than double that of white women.[5] Recognizing the need to study and address the state's high rate of maternal mortality and morbidity, the Texas Legislature passed legislation in 2013 creating a Maternal Mortality and Morbidity Task Force to study cases of pregnancy-related deaths and trends in severe maternal mortality, as well as make recommendations for reducing these rates. Throughout Texas, state and local fetal, infant, and child fatality review programs work to understand the causes and reduce the rates of preventable child deaths. Existing initiatives to reduce preventable maternal and child deaths need ongoing support and resources to enable them to continue improving health outcomes in the state.

2. **Ensure access to critical maternal and neonatal services through:**
   a. **Continued support for Neonatal Intensive Care Unit (NICU) policies and procedures that promote American Academy of Pediatrics (AAP) levels of care.**

Babies who are born premature, at very low birthweight, or have a serious medical or surgical condition experience better outcomes when they are delivered and cared for in a hospital that provides them with the appropriate level of care. The AAP has published guidelines on establishing regionalized systems of perinatal care. Recognizing the opportunity to improve birth outcomes in the state, the 83rd Legislature established a Perinatal Advisory Council to recommend criteria for neonatal and maternal levels of care in Texas. Continuing to support policies promoting AAP levels of care is an important strategy for improving infant health outcomes in the state.

   b. **Support for maternity services that reflect best practices identified in current, peer-reviewed obstetrical literature.**

All pregnant women in Texas deserve the opportunity to receive the most up-to-date prenatal and obstetrical care provided in a setting that is best suited to their risk. We support a coordinated system of care that

[5] Texas Department of State Health Services, *Maternal Mortality and Morbidity Task Force Report*, September 2014.

provides the appropriate array of services based on whether a pregnant woman is low or high-risk and promotes collaboration among health care providers and state and local health agencies to ensure women achieve optimal birth outcomes.

3. **Continue collaborative, evidence-based efforts with physicians, hospitals and other stakeholders to reduce preventable preterm births, including:**
   a. **Providing low-income women with preventive care before and between pregnancies**

Providing women with preventive care before and between pregnancies helps women plan and space their pregnancies, ensures healthier outcomes for moms and babies, and helps reduce the risk of prematurity and low birthweight. Following substantial cuts to preventive health care in 2011, the 83rd Legislature took important steps to restore funding for women's preventive health care, including creating the Expanded Primary Health Care program. However, the state only has the capacity to reach three in ten of the 1.3 million low-income women age 20-44 in need of access to affordable preventive care.[6] Moving forward, the state must continue to invest in prevention, ensure adequate health care access, and coordinate care across programs to maximize resources and improve delivery of health care services.

   b. **Eliminating non-medically necessary early elective deliveries while also ensuring the provider network is not jeopardized**

Babies born before 39 weeks are at higher risk for low birth weight and subsequently more likely to be admitted to the NICU, readmitted to the hospital in their first year of life, and suffer from the long-term health consequences of low birth weight. Despite recommendations from the American College of Obstetricians and Gynecologists against early deliveries without medical indication, rates remain high both nationally and in Texas. The Legislature has in the past taken steps to reduce non-medically necessary early elective delivery rates, including prohibiting Medicaid from reimbursing non-medically indicated deliveries prior to 39 weeks. Texas should continue to identify opportunities to improve non-medically indicated early elective delivery rates.

   c. **Strengthening access to prevention, intervention, and treatment services to address substance use among pregnant women and substance-exposed infants**

Additional opportunities exist to reduce health care costs and improve infant and maternal outcomes by strengthening access to prevention, intervention, and treatment services to address substance use among pregnant women and substance exposed infants. Prenatal exposure to alcohol, tobacco, or illicit drugs can have long-lasting impacts on infants' physical wellbeing and development. Reducing the impact of substance use requires a non-stigmatizing, coordinated system that supports women's participation in services designed to reduce incidences of substance use and promote recovery from addiction.

4. **Improve maternal and child health outcomes through:**
   a. **Continued expansion of and support of home visiting**

[6] The Texas Women's Health care Coalition, "Increase Funding for Texas Women," October 2014.

Home visiting is an evidence-based strategy targeting maternal, infant, and early childhood health, family self-sufficiency, child abuse and neglect, school readiness, and parent-child relationships, among other domains. Recent investments from the state and funding from the federal Maternal, Infant, and Early Childhood Home Visiting Program have helped build a strong, coordinated home visiting program in the state. Continued investment in home visiting will allow the state to expand the reach of home visiting in Texas and continue improving outcomes for children and families across the state.

b. Continued efforts to support breastfeeding and increase continuity of care by increasing access to education, resources, and services for breastfeeding moms

Policies that support moms who choose to breastfeed can help Texas achieve healthier outcomes. Breastfeeding fulfills critical health needs for babies, helping protect against child obesity, diabetes, respiratory infections, and other illnesses. Texas provides a number of resources to moms seeking to breastfeed, including the Every Ounce Counts campaign, recognition of Baby Friendly hospitals, and assistance through local WIC clinics. However, despite these resources and the many benefits of breastfeeding, less than half of Texas babies are being breastfed at six months.[7] Policies that ensure moms have the information and support they need to start breastfeeding and sustain their breastfeeding goals are important, low-cost health policy solutions.

5. Increase access to comprehensive, quality health care for moms and other uninsured women by closing the Coverage Gap for Texas women who make too much to qualify for Medicaid and too little to qualify for premium tax credits in the Health Insurance Marketplace.

A primary tool for reducing health care costs and improving birth outcomes is ensuring that low-income women receive adequate preventive and primary care before, during, and between pregnancies. For the 687,000 Texas women who do not currently qualify for affordable comprehensive health coverage, the best solution for ensuring continuity of care is to eliminate the Coverage Gap (See Improve Texas Children's Health and Well-Being by Connecting Entire Families with Affordable Health Coverage for more details). Currently, moms must be at or below 19% of the Federal Poverty Level (FPL), or $3,760 for a family of three, to receive Medicaid, and above the poverty level to receive subsidy assistance for private coverage in the Marketplace. Those who fall in between do not have access to affordable comprehensive care options. With the elimination of the Coverage Gap, women below the poverty level would no longer experience a sudden termination of their health care after receiving postpartum care, but could instead continue to receive basic comprehensive coverage through Medicaid.

[7] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, ""Breastfeeding Report Card: United States/2014," July 2014.

Principle 6: Improve the health and well-being of Texas children by maximizing opportunities to connect entire families with affordable health care

1. **Take timely advantage of the flexible options available under federal law for Texas to close the Coverage Gap.**

New coverage opportunities today are helping to connect more of Texas' 1.2 million uninsured children with medical homes, and to improve children's well-being. Private coverage with sliding-scale premium assistance through the health insurance Marketplace now offers families with incomes just above the CHIP income limit new access to comprehensive coverage, so fewer children lose coverage when a parent's income rises. Marketplace prices are the same no matter what the child's health status or history is, and dental and vision benefits are now a standard part of all children's Marketplace coverage.

Standing between children and these benefits is a Texas Coverage Gap. Parents in a family at 110% of the FPL can get Marketplace private coverage with generous premium assistance and reduced co-payments and deductibles, but parents in a family at 99% of the FPL are left with no help. In fact, the Coverage Gap works against parents; for example, a single adult earning $14,000 is "above poverty" and gets subsidies, but a single parent with one child earning the same $14,000 is "below poverty" and gets no coverage.

The Kaiser Family Foundation estimates that 1.05 million uninsured Texas adults (U.S. citizens) are below the poverty line and in the Coverage Gap, and that one-third of these (over 345,000) are parents with dependent children. Texas HHSC estimates that as many as 45% of the uninsured adults who could be covered are parents, putting the number of uninsured parents in the Coverage Gap over 470,000.

This Coverage Gap can be closed by expanding traditional Medicaid or by negotiating with the federal government to develop a custom-built, private-coverage solution for our state. The evidence is clear that other conservative states have negotiated innovative models for closing the Coverage Gap that incorporate cost-sharing, wellness programs, and other personal responsibility measures. Our state should take steps to close this Coverage Gap for parents, and in doing so increase parents' and children's access to preventive care, and improve child and family well-being.

2. **Consider the positive impact on child and family well-being if low-income parents of children in Texas Medicaid could also access care.**

Today, while 2.8 million Texas children benefit from Medicaid, only about 145,000 of their parents qualify for Medicaid[8]. And, over half of Texas' uninsured children and teens—about 600,000—are estimated to be eligible for Medicaid or CHIP but not enrolled today, according to U.S. Census data.

Studies find multiple benefits for children when parents themselves have health coverage**:** children already enrolled in Medicaid are more likely to receive care, and a higher percentage of children eligible for Medicaid or CHIP also will be signed up and keep their coverage.[9]

3. **Assess the economic impacts of closing the Coverage Gap for state and local government budgets, including job creation, local and state revenue gains, reduced employer tax penalties, and offsets to current local and state health, mental health, and criminal justice costs.**

Former state demographer Billy Hamilton and leading economist Ray Perryman have modeled that closing the Coverage Gap will pay for itself due to the significant federal match, offsetting the cost of current health care programs that would no longer be needed, and through the increased revenue generated from taxes on health care premiums. Additional benefits to closing the coverage gap include the creation of 200,000 - 300,000 jobs over the next the next 10 years; reducing property tax pressure and lowering insurance premiums for businesses and taxpayers. Because of the Coverage Gap, an estimated 9,000 Texans are expected to die prematurely each year; more employers will pay a federal penalty for failure to provide insurance to their employees, which could reach $399 million per year; and Texas cities and counties will pay over $4 billion in annual costs for uncompensated care. These impacts and potential reductions in spending for local and state health, mental health, and criminal justice services should be further studied to fully define the economic effects of closing the coverage gap.

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[8] Texas Health and Human Services Commission, June 2014.

[9] Georgetown University Health Policy Institute Center for Children and Families, *Expanding Coverage for Parents Helps Children: Children's Groups Have a Key Role in Urging States to Move Forward and Expand Medicaid*; July 2012, http://ccf.georgetown.edu/wp-content/uploads/2012/07/Expanding-Coverage-for-Parents.pdf