SELLERS FEINBERG

A Vision for Texas Health Care Reform

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Submitted to Texas Health and Human Services Commission

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Executive Summary

The health care system in Texas is facing significant challenges. The State's health care costs are increasing, its rate of uninsured is the highest in the nation, and its insurance premiums are costly and often out of reach for individuals and small business owners. In addition, proposed federal changes place hundreds of millions of dollars in funding for hospital payments at risk.

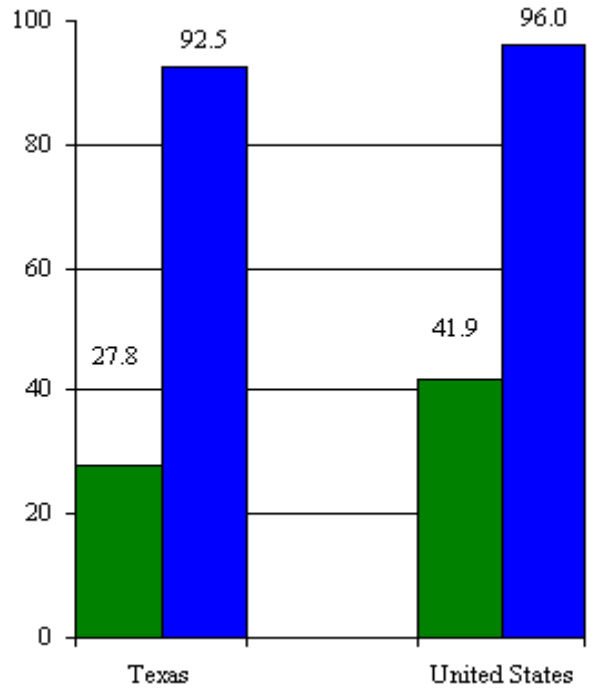
At 24.6%, Texas has the highest rate of uninsured in the nation. In reviewing data on the 5.5 million uninsured, several characteristics highlight opportunities for reform. The vision for reform outlined in this paper addresses the specific challenges and opportunities of insuring the uninsured in Texas. Texas Department of Insurance data on uninsured Texans indicates:

- Over 50% of the uninsured are poor with incomes under 200% of the federal poverty level (FPL).
- Most uninsured adult Texans work. Almost 80% of the uninsured have a family member who is employed, but insurance is either not available or not affordable.
- Of the uninsured, almost 60% are under age 34. Young adults are generally healthy.
- Statewide uninsured rates are highest among minorities in Texas; almost 60% of Texas' uninsured are Hispanic.
- At 74%, the majority of uninsured Texans are U.S. citizens or legal permanent residents.
- More than three-quarters of all part-time employees in Texas work in firms that offer insurance, but only 23.4% of these workers qualify for coverage.
- Of the 426,803 private-sector businesses in Texas, 72% have 50 or fewer employees. These firms account for 27.8% of the total population employed by private sector establishments – almost 2.2 million individuals.[1]
- Only 28% of small businesses offer insurance and employees working for small businesses are more likely to be uninsured. Many small employers cite unaffordable coverage and insurance market complexities as barriers in extending coverage to their workers.

[1] Agency for Healthcare Research and Quality. 2004 (Revised July 2006). Medical Expenditure Panel Survey Insurance Component Tables.

Figure 1[1]

Percentage of Private Sector Establishments That Offer Health Insurance by Firm



Texas' health care system relies heavily on public hospital settings as the main delivery point of care for the uninsured. Despite a significant investment in funding to support care for the uninsured, the care provided is unnecessarily costly, largely unmanaged, and does not systematically ensure access to primary and preventive care. This system is not efficient.

At the federal level, proposed rules would place new limits on hospital and uncompensated care payments, placing the state at risk of losing nearly $500 million annually in federal Medicaid funding for Texas.

Fortunately, new opportunities have emerged to help Texas address these pressing issues. Recent changes in federal law and policy and innovative Medicaid-funded state health care reform initiatives across the country offer new strategies to help meet Texas' specific health care system and financing needs. A Texas-based initiative can be designed with specific goals and cornerstones to create the platform for broad-based, comprehensive health care reform.

This paper presents a vision for health care reform and provides an approach that addresses the challenges and opportunities in Texas. The vision for Texas leverages a Medicaid waiver and state plan amendments to protect federal funding and provide new mechanisms to expand insurance coverage to uninsured, low-income populations and small businesses to support access to affordable coverage. While the proposed approach establishes the building blocks for reform, implementation can be phased in to ensure a gradual transition to a more cost-effective delivery system with continued support for Texas' critical hospital safety net providers.

With federal approval under a Medicaid Section 1115 waiver and related state plan amendments leveraging new flexibility under the federal Deficit Reduction Act of 2005, the state can create a platform for broad-based, comprehensive reform.

The proposed plan for Texas is based on four cornerstones:

1) Protect and optimize Medicaid funding.
2) Reduce the number of uninsured Texans.
3) Focus on keeping Texans healthy.
4) Establish an infrastructure to facilitate the accomplishment of reform goals.

The following are goals for Texas health care reform.

- Develop a more efficient and cost-effective system to provide care to the uninsured that focuses on individuals by emphasizing care management, primary care, and prevention with a non-entitlement, non-traditional Medicaid-funded subsidy.
- Promote access, affordability, and choice in extending health insurance and coverage to more uninsured Texans.
- Protect and support the stability of the health care safety net infrastructure.
- Protect at-risk federal funding of nearly $500 million in payments to Texas health care providers.
- Maximize federal funds for health care services to the uninsured now funded solely with state and local public funding.
- Build on existing strengths of public-private partnerships, including employer-sponsored insurance (ESI), individual and small group market insurance, and other Texas programs, including the state's high risk pool and other coverage.
- Increase personal responsibility by providing incentives to improve health and health care outcomes.
- Help support a culture of insurance as part of the system transformation.

Ultimately, the solution for Texas is a partnership between local entities, the state, the private sector, and the federal government. Other states have forged such relationships, and their

experiences have demonstrated that Texas is at a distinct advantage with the policy objectives of the state and the federal government well aligned, including increased sustainability in a system-wide approach by reducing the number of uninsured, improving the coordination of care for Medicaid recipients, and supporting better health and lower costs for the overall population. By unifying these goals through a comprehensive policy, Texas has an opportunity to negotiate a program with the federal government that provides mutual benefit and sustains critical funding for the Texas Medicaid program.

Additional information on the program and financing reforms is provided in:

- Appendix A – Texas Data on Insurance and the Uninsured
- Appendix B – A Vision for Texas Health Care Reform

I. Background

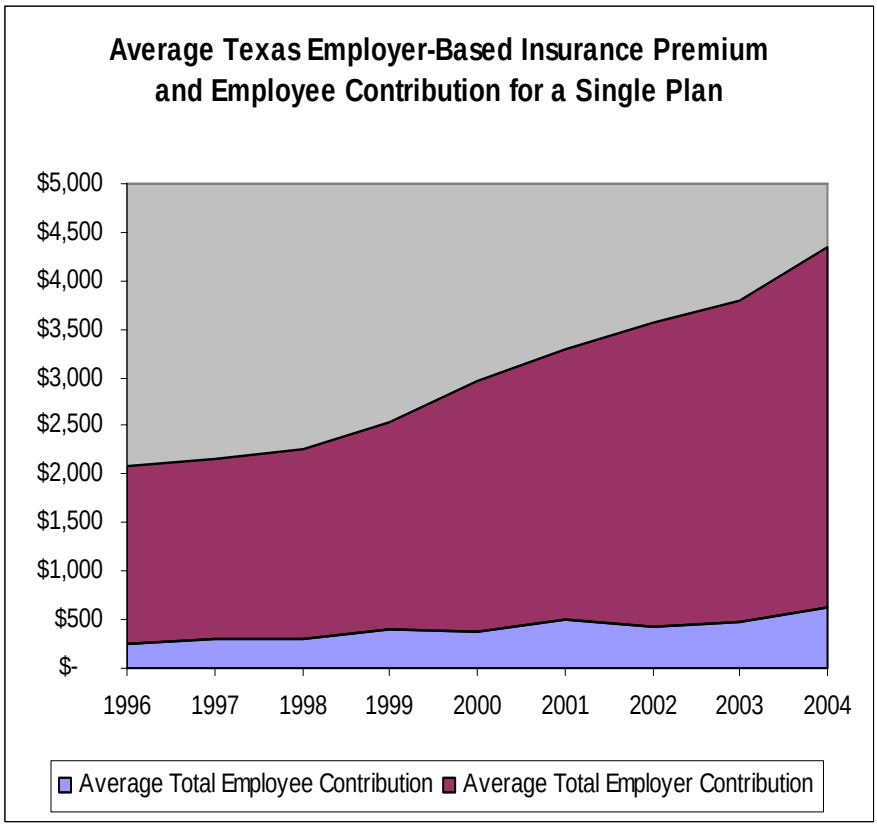
The health care system in Texas is facing significant challenges. The state's health care costs are increasing, its uninsured rate is the highest in the nation, and insurance premiums are costly and often out of reach for individuals and small businesses. In addition, proposed changes at the federal level place hundreds of millions of dollars in funding for the current system at risk. This collection of factors, described more fully below, highlights the importance of reforming the Texas health care system.

With total annual health care expenditures of $107 billion in 2004, Texas ranks 3rd nationally in total spending for health care. Of this, the state and federal governments spent approximately $25 billion for Medicaid, the uninsured, the State Children's Health Insurance Program (SCHIP), and other publicly funded health care.[2] Despite this significant investment, Texas has 5.5 million people without insurance, and costs continue to outpace the rate of growth in income and state revenues.

Texas' health care system relies heavily on public hospital settings as the main delivery point of care for the uninsured. This approach offers insufficient access to "front-end" primary and preventive care, resulting in uninsured individuals seeking care after their health conditions have worsened. This delay often leads to unnecessary hospitalizations, higher costs, and a sicker population. Problems with this system of care not only impact public health care and the state budget but also affect Texas' health insurance marketplace and its economy. Given the high numbers and costs of the uninsured, Texas employers pay higher insurance premiums to support the cost of care for the uninsured (Figure 2). These high premiums, in turn, make it increasingly difficult for small businesses to provide health insurance to their employees, contributing to the high rate of uninsured and creating a greater challenge for Texas businesses to compete economically.

[2] Milbank Memorial Fund, National Association of State Budget Officers, and The Reforming States Group. 2002-2003 State Health Care Expenditure Report, Table 14, Milbank Memorial Fund, Copyright 2005. Available at http://www.milbank.org/reports/05NASBO/nasbotable14.pdf.

Figure 2[3]



In addition, recent shifts in federal policy place hundreds of millions of dollars in funding for the current system at risk. This system relies heavily on public hospital intergovernmental transfers and upper payment limit programs to help fund care for Medicaid and the uninsured. The federal government wants to restrict the use of these mechanisms. Proposed federal rules would place new limits on hospital and uncompensated care payments, making Texas at risk of losing nearly $500 million annually in federal funding. Loss of these funds would significantly diminish Texas' ability to meet the needs of individuals covered by Medicaid and the uninsured.

Fortunately, new opportunities exist to help Texas address these pressing issues. Recent changes in federal law, policy, and innovative Medicaid-funded state health care reform initiatives across the country offer strategies to craft a new plan for health care in Texas that incorporates the health care needs, existing delivery system, and culture of the state. A state-based reform in Texas can be developed to promote access, affordability, and choice in extending health insurance coverage to more Texans, protect at-risk federal funding, maximize federal funds to cover the uninsured, and build on the strength of the state's existing public-

[3] Medical Expenditure Panel Survey Insurance Component Tables (MEPS/IC) 1996-2004. Generated using MEPSnet/IC, February 28, 2007.

private partnerships. Taken together, these new initiatives would create the platform for broad-based, comprehensive health care reform.

II. New Federal Policies

Over the past several years, the Centers for Medicare and Medicaid Services (CMS), which administers the federal Medicaid program, has proposed regulations and implemented policies to restrict states' opportunities to claim federal funds and provide Medicaid reimbursement for hospital services. While Texas has demonstrated all of its hospital financing transactions to be fully compliant with federal law during the course of the most recent federal review, CMS continues to press states for further limitations.

Most recently, CMS proposed a new regulation to establish even more restrictive criteria for intergovernmental transfer payments (IGTs)[4] and certified public expenditures (CPEs)[5]. Among other changes, the proposed rule would limit payments to public providers to the cost of services provided. This rule would severely restrict Medicaid payments to governmentally-owned health care facilities and providers, reducing federal Medicaid funding for Texas hospitals and health care providers by nearly $500 million per year.

States across the country are expressing considerable opposition to this rule because it significantly reduces the amount of federal support for Medicaid and uncompensated care programs. The rule, if adopted, would become effective September 2007. Regardless of the adoption of this particular rule, federal direction since 1992 has been to move away from state

[4] Intergovernmental transfers (IGTs) are transfers of public funds between governmental entities. The transfer may take place from one level of government to another (i.e., counties to states) or within the same level of government (i.e., from a state university hospital to the state Medicaid agency). IGTs are used as a financing mechanism to fund the non-federal share of state Medicaid expenditures. IGTs are permitted as a financing source for Medicaid expenditures under Section 1903(w) (6) (A) of the Social Security Act. Texas Medicaid uses IGTs to fund Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments.

[5] A certified public expenditure (CPE) is a mechanism through which funds spent by a public entity (city, county, state agency, or other public entities within a state) for the provision of covered services to Medicaid recipients are certified through a cost reporting process. CPEs are permitted under federal Medicaid law and regulations as the non-federal share for matching federal Medicaid funds for Medicaid provider payments.

program dependency on IGTs and upper payment limit (UPL)[6] programs that exceed cost; it is unlikely that this direction will change.

In response to the potential loss of federal funds from these types of funding mechanisms, some states have developed plans to preserve current federal funding levels through Medicaid waivers. In the latest round of agreements with the federal government, several states have restructured their Medicaid programs and financing in ways that have permitted the states to preserve their current level of federal funding while improving access to affordable health insurance coverage for uninsured individuals and small businesses. In addition, the Deficit Reduction Act of 2005 (DRA) provides increased flexibility and additional opportunities to modify Medicaid cost sharing, benefit coverage, and program integrity within the Medicaid program. The innovation and creativity of states within this new environment has been responsible, in large part, for this new era of health care reform.

To leverage federal Medicaid funding for state-based reforms, states must align with federal policy objectives. The Bush Administration's "Affordable Choices" program and recent federal approvals of state health care reform initiatives incorporate several key principles including:

- Supporting and building upon the commercial insurance market;
- Diverting the uninsured from a traditional, more costly Medicaid entitlement to a more limited package of benefits with higher cost sharing;
- Providing premium subsidies for low-income uninsured children, parents and childless adults, typically those under 200% of the federal poverty level (FPL);
- Enhancing and reinforcing the employer-sponsored insurance (ESI) and the individual and small group markets;

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[6] States have broad flexibility in setting Medicaid rates paid to hospitals, nursing homes, and other providers. Federal Medicaid rules, however, specify that state Medicaid payments to groups of facilities and providers (e.g., state-owned facilities, non-state publicly owned or operated, and privately owned hospital providers) cannot exceed the amount Medicare would have reasonably paid for the same services. Federal Medicaid rules also specify that states cannot pay individual hospitals more than the amount of their aggregate charges for providing services to Medicaid beneficiaries. These rules collectively are known as the upper payment limit (UPL). As approved by CMS, Texas makes enhanced UPL payments to certain publicly-owned and privately-owned hospitals using IGTs as the required state match.

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and they receive payments to help cover the cost of uncompensated care provided to indigent or low-income patients under the Texas Medicaid Disproportionate Share Hospital (DSH) program.

- Encouraging personal responsibility through cost sharing and incentives for preserving and maintaining individual health;
- Including cost-sharing and benefits similar to ESI;
- Improving the management and coordination of care for Medicaid and the uninsured; and
- Redeploying federal payments for uncompensated care from public subsidies for institutions to insurance coverage for uninsured individuals.

III. Examples of Innovative State-Based Reforms

Within the last two years, CMS has approved state-based health care reform initiatives under the authority of Section 1115 of the federal Medicaid statute providing for research and demonstration projects. These waivers typically include both program and financing elements. Generally, waivers secure more state flexibility, increase access to primary and preventive care, and promote individual choice and responsibility. Waivers also seek to stabilize Medicaid expenditures and gain more predictability in federal funding. Specific examples of the types of reforms either proposed or enacted by states include the following.

Examples of State-Based Reforms	
Reform Component	**States Where Proposed or Enacted**
Preserve at-risk federal Medicaid funding, while securing flexibility to restructure health care delivery systems.	**California, Florida, Massachusetts, New York**
Create low-income pools to extend health care coverage to the uninsured.	**California, Indiana, Massachusetts, Michigan,**
Use private insurance approaches.	**Florida, Indiana, Kentucky, Massachusetts, Michigan**
Increase consumer choice and personal responsibility.	**Florida, Indiana, Iowa, Kentucky, Massachusetts, Michigan, South Carolina**
Pursue strategies to cover all children, through buy-in to Medicaid and state pools for uninsured children.	**Illinois, Oregon, Pennsylvania, Tennessee, Washington**
Expand use of managed care.	**California, Florida, Hawaii, Indiana, Iowa, Massachusetts, Michigan, New York, Vermont**
Establish a statewide, consumer-driven marketplace through a Health Insurance Exchange model to coordinate and facilitate insurance market activities to support choice, market competition, and portability.	**California, Massachusetts, Michigan, Washington**
Enhance access to more affordable insurance products for small businesses.	**Arkansas, Massachusetts, Michigan, Oklahoma**
Improve quality and promote use of evidence-based medicine and purchasing for value.	**California, Florida, Indiana, Massachusetts, Michigan, New York, Vermont, Washington, Wisconsin**
Incorporate cost containment, quality, and health information technology initiatives.	**California, Indiana, Massachusetts, Michigan, New York, Pennsylvania, Washington**
Coordinate with or provide a Medicaid program opt-out option for ESI.	**Arkansas, Florida, Massachusetts, Michigan, Oklahoma, Wisconsin**

IV. Challenges and Opportunities in Texas

Texas is poised to develop a state-based reform that builds on the strengths of its existing system and takes advantage of new federal policy options. While there is value in assessing the paths taken by other states, Texas must develop an approach that best addresses its own challenges and opportunities. As with other states, Texas could seek federal approval through a combination of Medicaid state plan amendments and a Section 1115 Medicaid waiver to reduce the number of uninsured and improve the Medicaid program.

The following section identifies challenges for Texas and potential opportunities.

1. Insuring the uninsured

Challenge: With 5.5 million uninsured, Texas has the highest rate of uninsured in the nation. Of the uninsured, over 50% are poor with incomes under 200% of the FPL. Roughly 75% of the uninsured are U.S. citizens. Almost 80% of the uninsured have a family member who is employed, but insurance is either not available or not affordable. Of the uninsured, almost 60% are under age 34. Small businesses compose 72% of all private-sector establishments in the state, but only 24% of these businesses offer insurance. Appendix A provides an overview of data on insurance coverage and the uninsured in Texas.

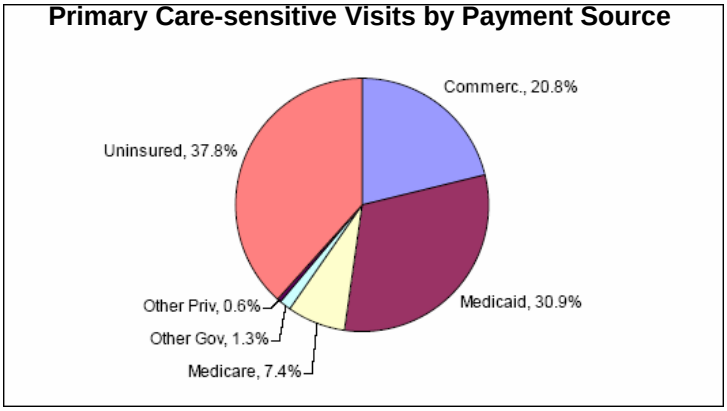
Opportunity: Extend access to health care to more uninsured individuals through non-entitlement, Medicaid-funded subsidies and to more small businesses through access to more affordable insurance products. Approximately 2.1 million low-income uninsured persons in Texas are U.S. residents who could potentially qualify for a non-entitlement Medicaid-funded subsidy. Many of these uninsured persons are young and have a connection to work. A cost-effective, integrated approach to extend primary and preventive health care coverage to more uninsured could be designed using state, local, and federal Medicaid funds.

2. Restraining the rate of growth in health care costs

Challenge: The high rate of growth of health care costs in Texas is well documented. According to National Health Expenditure Data published by CMS, personal health care spending in Texas has increased an average of 9% annually since 1984. With 50% of individuals accessing care through publicly funded programs, including those who receive care through Medicaid-funded payments for uncompensated care for the uninsured, opportunities can be explored to improve access to more affordable care. Without a change in direction, the cost of care for the uninsured will continue to increase, along with the pressure on safety net providers to provide that care. In addition, dependence on hospital-based emergency care is an inefficient and costly way to provide care for the uninsured. New programs offer the potential to control the growth in Medicaid costs fueled by caseload and the increasing cost of uncompensated care.

Without access to front-end primary and preventive care, uninsured individuals often delay seeking care until health conditions have worsened. A University of Texas School of Public Health study demonstrated this case through an analysis of 11 hospitals in Harris County. Through a review of emergency room data for 2004, researchers discovered that nearly one-quarter of all emergency room visits are non-emergent in nature and that the uninsured accounted for 41% of these non-emergent episodes.

Figure 3[7]
Primary Care-sensitive Visits by Payment Source



Furthermore, the study indicated that the uninsured also account for nearly 38% of all primary care-sensitive visits (i.e., those that were either non-emergent or emergent though could have been preventable/avoidable had proper primary care been provided - Figure 3). These statistics suggest that the lack of access to effective primary care for the uninsured results in both preventable

[7] Begley, Charles et al. "Houston Hospitals Emergency Department Use Study January 1, 2004 through December 31, 2004," Final Report prepared for Gateway to Care, January 2006.

hospitalizations and more costly standard levels of care that are provided in high cost, high acuity care settings, such as hospitals.

Opportunity: Increase access to primary and preventive care in place of more expensive emergency room and hospital care. In addition, reform could divert uninsured individuals both from traditional Medicaid enrollment and from uncompensated care in hospitals to coverage that supports higher quality and cost-effective outcomes for primary and preventive care services than are available in most settings providing care to the uninsured.

3. Reduce cost shifting to other payers

Challenge: When public funds are not sufficient to support the entire cost of uncompensated care, employers and individuals who have insurance pay higher premiums. Cost shifts from uncompensated care increase premium costs that are already too high for many working individuals. Families USA, a non-profit group that studies health care and the uninsured, estimated that in 2005 this cost-shift in Texas amounted to 13% higher premiums - $550 for an individual policy and $1,551 for a family policy. As health care premium costs become less affordable, businesses drop coverage and individuals are less able to take advantage of coverage that is offered.

Opportunity: Reduce cost shifting to employer plans and Texas taxpayers by ensuring more cost-effective care for the low-income uninsured. To the extent a reform initiative extends coverage to more uninsured, working Texans by providing subsidies, workers could also opt to buy into employer-sponsored insurance.

4. Extend access to affordable health coverage without an entitlement

Challenge: Like many other states, in order to control costs and live within budgetary constraints, Texas is reticent to expand entitlement programs. In place of an entitlement with traditional Medicaid benefits, recent federal waiver approvals have highlighted a range

of opportunities to cover more uninsured at a lower cost. Federal waivers have allowed states to cover the uninsured without an entitlement, increase accountability for consumers and providers, and improve health outcomes while controlling costs. States have adopted reforms to leverage private sector products, with market competition, managed care, increased choice, and incentives for wellness and healthy behaviors.

Opportunity: Make insurance more affordable to preserve the state's ability to remain competitive and foster job growth. By extending coverage to the uninsured, a platform could be created to extend access to affordable health insurance to all uninsured in small businesses, providing choice, portability, and pre-tax treatment of employer and employee contributions.

5. Preserve current federal funding and protect UPL under capitation

Challenge: Under the proposed CMS rule limiting public providers to cost**,** Texas is at risk of losing nearly $500 million annually in federal funding that now supports payments to hospitals for Medicaid services. Furthermore, because of CMS regulations prohibiting supplemental payments to providers paid by capitation, Texas was unable to implement a fully capitated STAR+PLUS expansion without losing hospital funds.

Opportunity: Advance a health care reform proposal that protects at-risk federal funding and that allows Texas to protect existing supplemental payments under capitated programs. The federal government has approved initiatives to preserve at-risk funding for other states as part of comprehensive health care reform.

6. Leverage new federal funding

Challenge: Currently, hundreds of millions of dollars spent by the state and local governments on care for the uninsured are not matched with federal Medicaid funding. In order to operate a more efficient system, Texas must seek to maximize federal Medicaid revenues for all state and local government spending for health care services for Medicaid

enrollees and low-income uninsured to the greatest extent possible. CMS has approved waivers for other states recently that have utilized a number of strategies, including:

- Certified public expenditures (CPEs) for state and local government health programs that are currently authorized by Medicaid; and
- Federal match on existing state/local government health programs for the uninsured that are not currently authorized by Medicaid, i.e., unmatched state and local funding.

Opportunity: Pursue CPEs that would offer Texas an alternative to the use of IGTs. Qualifying costs of public providers would be certified as Medicaid expenditures, and the resulting federal revenue could be used for waiver financing. The certified costs could be those of a government-owned hospital or those of a community-based public provider that are not currently matched with federal dollars but are authorized for match under the current Medicaid program or under the authority of a waiver. For example, some states have used CPEs for primary and preventive health care provided to Medicaid populations, including immunizations, care management, outpatient mental health and substance abuse treatment, home health and personal care, and prenatal care coordination.

Alternatively, through a waiver, Texas could pursue matching the costs of state and local programs that provide health services to the uninsured. For example, some states have matched community mental health spending, community support services, and community-based health care services, including state-funded pharmacy benefits, and public health prevention and treatment (cancer, diabetes, dental, substance abuse, HIV/AIDS) on the basis that such expenditures support services to an uninsured population that would receive health care coverage under the waiver. Texas could seek authority to utilize these mechanisms to maximize federal funding for indigent health care services now funded solely with state and local dollars. CMS is receptive to this approach as long as states can show that including state health care expenditures for the uninsured covered under the waiver generates savings through better care coordination and improved outcomes.

7. Protect safety net providers

Challenge: Safety net providers serve a disproportionate number of low-income Medicaid-eligible or uninsured patients. To preserve at-risk federal funding, other states have dedicated a portion of funding from varying sources (DSH, UPL and other funds) to a low-income safety net care pool under a Medicaid waiver. Funds from a pool are utilized to increase health care coverage for the uninsured. Under this type of financing approach, hospitals continue to benefit from funding preserved in two ways:

- Low-income pool payments are dedicated to cover uncompensated care costs incurred by hospitals in the event insurance coverage does not successfully or immediately extend coverage or reduce uncompensated care; and

- Funds to cover the uninsured flow to hospitals as claims-based reimbursement for providing care to those patients that now have insurance or other health care coverage.

As new coverage arrangements are put into place, safety net providers have the opportunity to work in partnership with other local and state providers to provide care that is more managed, prevention-focused and primary care-oriented. These changes in delivery systems improve Texas' ability to negotiate for federal approval to protect funds currently in the system.

Opportunity: Structure a low-income or safety net care pool to allow for a gradual transition and phase-in of insurance and coverage in place of public subsidies to hospitals to cover the uninsured. This approach acknowledges some ongoing uncompensated care costs for public hospitals that continue to provide care to the uninsured, including undocumented immigrants ineligible for coverage under a Medicaid waiver.

8. Leverage existing or proposed public - private partnerships

Challenge: Texas has a number of programs that currently provide health care for the uninsured, including county indigent programs, DSH payments to hospitals and the state's high risk pool. Many of Texas' large hospital districts currently provide access to care networks as care is needed rather than through a prepaid insurance premium. Other proposed three-share/multi-share programs would offer small businesses the ability to provide health insurance to their employees with financial responsibility shared by the employer, employee, and public funding.

Opportunity: Complement and build upon existing and proposed public-private programs to ensure a Texas-specific solution that supports the needs and preferences of Texas citizens, providers, and employers to move towards a more coordinated and efficient system of primary health care services for all Texans.

9. Enhance and strengthen health coverage and insurance

Challenge: Subsidies alone cannot provide a complete solution for Texas' uninsured. In order to expand coverage to more of the uninsured, small business and individual insurance options have to be more affordable and available than they are today. Changes to increase portability and choice of health care insurance and coverage, facilitate work site enrollment and payroll withholding, allow pooled contributions from multiple employers and jobs, increase affordability by pooling risk, streamline administration, and ensure pre-tax contributions for health care by employers and employees will help more people purchase insurance.

Opportunity: Collaborate with health insurance market experts and the insurance industry to develop a solution that works for the Texas insurance market, including the development of products and coverage options that could be offered through a health insurance exchange.

V. A Plan for Texas

In designing a plan to transform the financing, access, affordability, and delivery of health care in Texas, it is important to frame the reality of health care today and the vision for health care tomorrow.

TEXAS HEALTH CARE

TODAY	Vision for TOMORROW
5.5 Million Uninsured ✓ Highest percentage of residents without health insurance of any state in the country.	**Reduce the Uninsured** ✓ Provide access to affordable health care coverage for as many uninsured Texans as possible with available funding.
Insured Pay for the Uninsured ✓ Families with insurance pay over $1,500 per year to subsidize people without insurance.	**Reduced Cost Shifting to the Insured** ✓ Reducing the ranks of the uninsured would minimize the financial burden on those currently insured and should reduce this component of insurance premiums.
Expensive, Unmanaged Care ✓ Health care for the uninsured is largely unmanaged, resulting in higher costs and a sicker population.	**Primary/Preventive Care for the Uninsured** ✓ More preventive and primary care services with care management for the currently uninsured population would reduce costs and lead to a healthier population.
At - Risk Federal Funding ✓ System is heavily dependent on a federal funding source that the federal government is proposing to significantly reduce.	**More Secure State/Federal Partnership** ✓ System would preserve at risk funding and be aligned with federal policy goals.
Difficult for Small Businesses and Individuals to Afford Insurance ✓ Participating in health insurance is too costly for most small businesses and individuals in the state.	**Affordable Products for Small Businesses and Individuals** ✓ Small businesses and individuals would have the opportunity to participate voluntarily in the health insurance marketplace because they would have affordable products and administrative assistance.
Entitlement to Medicaid and Hospital Care ✓ Uninsured access care through Medicaid entitlement, indigent care programs, or hospital emergency rooms.	**Culture of Insurance** ✓ Care would be provided through insurance and coverage programs providing medical homes and primary and preventive care.

A. The Texas Reform Plan

Overview. Other states faced with similar challenges of the potential loss of substantial federal Medicaid funding and high rates of uninsured have worked to develop comprehensive health care reform proposals. These usually include Medicaid waivers and state plan amendments that protect federal funding and provide new mechanisms to expand insurance coverage to uninsured, low-income populations and small businesses.

The proposed plan for Texas is based on four cornerstones:

1) Protect and optimize Medicaid funding.
2) Reduce the number of uninsured Texans.
3) Focus on keeping Texans healthy.
4) Establish an infrastructure to facilitate the accomplishment of reform goals.

Key Features. The Texas Reform Plan would create the framework for comprehensive reform of the financing and delivery of health care to the uninsured in Texas and would subsidize coverage for a significant number of the state's low-income uninsured.

- ***Target Population*.** Texas could extend access to health coverage, with state-federal subsidies, to uninsured populations not currently eligible for Medicaid or other government programs, including:
  - Uninsured parents with income up to 200% of the federal poverty level (FPL);
  - Uninsured childless adults with income up to 200% of the FPL; and
  - Uninsured children who do not qualify for Medicaid or the State's SCHIP program.

  Children up to 200% of the FPL and who meet the state's asset test are currently covered under the state's Medicaid and SCHIP programs; however, it is anticipated that additional uninsured children would be enrolled as a result of the reform.

Crowd-out provisions, including waiting periods, requirements to take ESI, if available, income and asset limits, and employer contributions could be implemented to limit enrollment to those who are uninsured and without access to coverage.

Enrollment in the subsidized insurance and coverage programs would be voluntary.

- ***Benefits.*** The state would specify minimum benefit coverage for the subsidized population to cover basic benefits that are the core of most health insurance plans. The benefit design would be largely tailored to the needs of low-income children, parents and childless adults. Tiered benefits, with minimum coverage for certain populations, could be specified. Plans offered to the non-subsidized population would be targeted to the needs of uninsured employees of small businesses in Texas.

- ***Delivery System*.** Texas would promote care management approaches in the delivery of health care, including utilization of medical homes with care management, defined networks, higher cost sharing than Medicaid, and wellness and healthy behavior incentives. Plans would compete for enrollees based on price, provider networks, quality, access, and efficiency. In addition, plans would compete on benefit design and cost sharing for non-subsidized enrollees.

- ***Personal Responsibility and Cost Containment.*** Texas would create a "culture of insurance" with personal responsibility for enrollees, providers, and purchasers.

  - ***Enrollees***. Choose a plan that best meets the enrollee's needs, comply with enrollment, cost sharing, and managed care requirements, including incentives for wellness and healthy behaviors.

  - ***Providers.*** Use appropriate, effective care coordination, and focus on quality and prevention in the delivery of care including disease management, patient safety, and improved outcomes.

  - ***Purchasers.*** Leverage choice, market competition, and portability to increase access to affordable health insurance coverage for small businesses.

- ***Employer-Sponsored Insurance (ESI).*** Individuals would be allowed to voluntarily opt-out of the Health Opportunity Pool subsidy plan to enroll in ESI, using their state-federal subsidies to pay for any required employee contribution.

- ***Cost Sharing.*** The Texas Reform Plan would provide premium and cost sharing subsidies for the purchase of health insurance or health coverage on a sliding scale based on income, with enforceable cost sharing.

    - For persons with income under 100% of the FPL, minimal cost sharing could be required through targeted co-payments at the point of service to ensure appropriate utilization and cost-effective access to care.
    - For persons with income between 100% and 200% of the FPL, co-payments would not exceed 5% of income (to adhere to CMS policy).
    - The use of deductibles would be prohibited to ensure access to preventive and primary care and to facilitate the enrollment and use of the health care system by program participants.

- ***Plan Operation.*** Operations could be phased in using the existing infrastructure. The proposal could begin implementation by building on Medicaid systems and operations for uninsured children and very low-income parents, and could expand capabilities to link with insurers, providers, employers and other entities as additional populations are covered. To address broader system issues such as insurance affordability and portability, an additional option for plan operations is to provide insurance and coverage models through insurance products and coverage models offered through a newly created Health Insurance Exchange (Exchange).

  The Exchange would serve as a new administrative distribution mechanism that would provide added value by enhancing choice, coordinating health care financing from multiple sources, and engaging consumers in a centralized “marketplace” where they can become informed and empowered purchasers. The Exchange could be created as an independent, quasi-public agency, similar to the Texas Guaranteed Student Loan Corporation.

  The Exchange could:

    - Offer products to the subsidized expansion population as well as to employers and employees of small businesses who are not eligible for a subsidy;
    - Facilitate enrollment, certify plans, administer premium subsidies, coordinate with employers to collect premiums, assure portability, and leverage pre-tax contributions to reduce cost;

- Create an environment, similar to the commercial marketplace, where providers would compete on price, quality, and provider networks and efficiency; and
- Provide a choice of insurance and coverage options including:
  - A basic benefit health plan with first dollar coverage and an annual benefit limit of $25,000 to $35,000;
  - High deductible health plan (catastrophic) with a health savings account;
  - A pre-paid and/or point of service plan;
  - A benchmark plan with more comprehensive coverage and higher participant cost sharing, such as the State Employee Health Insurance Plan;
  - Texas-specific, locally-based coverage options, such as three-share/multi-share and hospital-based coverage plans; and
  - If eligible, the Texas high risk pool.

Appendix B provides an overview of *A Vision for Texas Health Care Reform,* including a summary of the reform goals and reform plan.

B. Approaches to Financing Health Care Reform

Designing a financing structure to support a health care reform initiative is one of the most crucial elements to ensuring success. In recent negotiations with several states, the federal government has demonstrated some flexibility in designing financing mechanisms to meet state reform goals. Texas can take advantage of lessons learned from other state reform plans and willingness demonstrated by the federal government to design a financing structure that is right for Texas.

Many recent state reform efforts have established low-income or safety net care pools as part of their health care reform initiatives. The purpose of these pools is to provide premium subsidies to a portion of the uninsured population for the purchase of private insurance products. States have opted to dedicate funding from varying sources (DSH, UPL and other funding) and at varying levels to fund their pools. Reform initiatives in California, Indiana, Massachusetts, and Michigan have utilized low-income pools to increase health care coverage for the uninsured.

The key goals in reforming Medicaid financing for current Medicaid recipients and the uninsured are improved efficiency and increased system stability.

Efficiency. Reallocating a portion of state and federal funding for the uninsured to also support a low-income pool would allow Texas to target spending on the uninsured at an earlier stage in the continuum of care. By providing access to primary and preventive care and other low-acuity services, the state can prevent the need for higher cost health care services that often result when primary and preventive care is unavailable. In short, the goal of the reform would be to cover more people at a lower cost per person.

Stability. A low-income pool can preserve and protect at-risk federal Medicaid funding and ensure the continuation of funds for critical safety net providers that play a crucial role for Medicaid and the uninsured. Even if the proposed federal rule is delayed or withdrawn, CMS policy is moving in a new direction. A low-income pool that aligns with CMS policy could provide flexibility to convert a portion of federal funds to premium subsidies for health care coverage, while retaining provisions to reimburse hospitals for UPL and DSH.

Key Features. Several features could be incorporated in the reform of hospital financing, including:

- The level of funding dedicated to a low-income pool would determine the scale of the reform.

- Texas could explore increased funding for hospital rates to align Medicaid reimbursement more accurately with the costs of serving the Medicaid population. Funding for current DSH payments previously dedicated to the Medicaid shortfall could then be redirected to support health care coverage for the uninsured.

- In incorporating better care management, a critical goal would be to ensure financial support for hospital safety net providers as an integral part of the reform initiative. The pool could be structured to continue UPL and DSH payments with a gradual transition to insurance coverage to support the existing health care safety net and ensure that the proper infrastructure is in place to provide a smooth and effective transition to a more cost-effective delivery system.

- By providing a subsidy to make coverage more affordable and choice to make coverage more attractive and accessible, the goal is to create a culture of insurance that pays providers adequately for services delivered.

- The low-income pool could potentially maintain existing UPL funding while allowing the conversion to more comprehensive, risk-based managed care for STAR+PLUS.

Texas Health Opportunity Pool. In addition to the key features outlined above, creation of a health opportunity pool under a Medicaid waiver would provide greater flexibility to identify new and existing state and federal funding to support uninsured populations with greater flexibility to define benefits and populations served.

Potential options to fund the Texas Health Opportunity Pool include using existing DSH and/or UPL funds; negotiating for new federal funds; and using unmatched state and local funds as match. Texas could also explore opportunities to use its unexpended federal SCHIP allocation under the reform.

With a gradual increase in funding dedicated to the pool, the state could extend health coverage to more uninsured individuals. Where funding is at-risk, the pool could serve as a vehicle to maintain that funding.

As other states have done, Texas could explore strategies to leverage unmatched state and local funding as the non-federal share of Medicaid payments. The state could seek new sources for funding the non-federal share of any DSH or UPL payment reallocated to the low-income pool and could identify CPE opportunities to maximize state and federal funding to cover the uninsured.

VI. Conclusion

Texas is facing significant challenges to its health care system. The increasing costs of health care in Texas and the growing ranks of the uninsured are pressing problems, but perhaps even more urgent is the potential loss of federal funding that would result if CMS implements the proposed rule limiting Medicaid reimbursement for public health care providers.

The solution to this problem must include collaboration between Texas' state, local, and private partners and the federal government. Other states have forged such relationships and their experiences have demonstrated that Texas is at a distinct advantage with the policy objectives of the state and the federal government well aligned: increase sustainability in health care by reducing the number of uninsured, improving the coordination of care for Medicaid recipients, and promoting better health and lower costs for the overall population. By unifying these goals through a comprehensive policy, Texas has an opportunity to negotiate a program with CMS that provides mutual benefit and sustains critical funding for the Texas Medicaid program.

To implement the vision for Texas health care reform, the state would need to engage CMS in preliminary discussions to build an initial case for reform. This interaction would aim to establish the baseline principles for reform and could commence immediately. With legislative guidance and input from health care providers and other stakeholders, the state could work cooperatively to develop and negotiate a Medicaid waiver and related state plan amendments that can serve as the basis for reform.

Throughout this process, it is recommended that stakeholder input be solicited to incorporate the expertise and perspectives of the uninsured, providers, business, insurers, and other stakeholders in developing the vision for Texas health care reform.

As described above, exploring a transition of large provider subsidies to individual subsidies for the purchase of private health care coverage offers an immense opportunity to begin changing how Texans access health care and the cost structure of that care. Should Texas choose to move in this direction, it is critical that the state mitigate the potential impact on the health care safety net. As other states have undertaken similar reforms, they have worked with the federal government to preserve the authority to use some low-income pool or safety net care pool funds

to reimburse hospitals and other critical providers for uncompensated care. Such provisions not only protect the state against potentially low rates of enrollment by uninsured individuals but also create the platform from which these providers can be transitioned into a reimbursement model that, in the end, works to benefit the entire health care economy.

At the same time, the proposed funding arrangement would also ensure that hospital costs for providing care to uninsured Texas residents, including undocumented immigrants, would continue to be reimbursed using federally matched funds. The safety net serves a necessary public function in providing this care, which should continue to be recognized through the policies of this plan.

A plan for Texas health care reform must be bold in its goals but responsible and measured in its implementation. By creating a plan for health care financing reform, a framework is created through which Texas health care can be transformed while protecting and supporting critical safety net providers throughout the process.

Appendix A – Options to Address Access to Health Care for the Uninsured

At 24.6%, Texas has the highest rate of uninsured in the nation. In reviewing data on the 5.5 million uninsured, several characteristics emerge that highlight opportunities for reform.

- **Low-Income Uninsured.** Over 50% of the uninsured are poor with incomes under 200% of the federal poverty level (FPL). Over 70% of uninsured children, or 892,000 children, live in families with income below 200% of the FPL.

  Through reform, low-income parents and childless adults could qualify for subsidized coverage to make health care more affordable. Moreover, additional children who are now eligible for Medicaid or SCHIP could be enrolled through family-based coverage and insurance.

- **Working Adults.** Almost 80% of the uninsured have a family member who is employed, but insurance is either not available or not affordable.

  Reform could provide incentives to increase employer-sponsored coverage to promote voluntary contributions from employers, and to enroll subsidized workers in existing employer-sponsored insurance.

- **Young and Healthy.** Of the uninsured, almost 60% are under age 34, and many are in good health.

  Reform could create benefit packages appropriate to the needs of covered populations.

- **Minorities.** Statewide uninsured rates are highest among minorities in Texas; almost 60% of Texas' uninsured are Hispanic.

  Reform could offer health care choices to address different cultural needs and preferences.

- **Part-time Workers.** More than three-quarters of all part-time employees in Texas work in firms that offer insurance, but only 23.4 % of these workers qualify for coverage.

Reform could provide the framework to extend coverage to part-time, seasonal and contract workers, leveraging subsidies, voluntary contributions from multiple employers, and portability of coverage.

- **Citizens.** Roughly 75% of the uninsured are U.S. citizens.

  Under reform, a majority of low-income uninsured would be eligible for federally-funded subsidies*.*

- **Small Business**. Only 24% or about 86,000 of the approximately 360,000 small businesses offer insurance. Many small employers cite unaffordable coverage and insurance market complexities as barriers in extending coverage to their workers.

  Reform could create an opportunity to extend more affordable, accessible insurance products to uninsured small businesses.

Appendix B – A Vision for Texas Health Care Reform

Reform Goals

With federal approval under a Medicaid Section 1115 waiver and state plan amendments leveraging new flexibility under the federal Deficit Reduction Act, create a platform for broad-based, comprehensive health care reform to:

- Develop a more efficient & cost-effective system to provide care to the uninsured that focuses on individuals by emphasizing care management, primary care and prevention with a non-entitlement, non-traditional Medicaid-funded subsidy.
- Promote access, affordability and choice in extending health insurance and coverage to more uninsured Texans.
- Protect and support the stability of the health care infrastructure.
- Protect at-risk federal funding of over $500 million in payments to Texas health care providers.
- Maximize federal funds for health care services to the uninsured now funded solely with state & local public funding.
- Build on existing strengths of public-private partnerships, including employer-sponsored insurance (ESI), individual & small group market insurance and Texas programs, including the state's high risk pool and other coverage.
- Increase personal responsibility and provide incentives to improve health and health care outcomes; and
- Help support a culture of insurance as part of the system transformation.

Reform Plan

Framework for Reform, Financing & Partnership

Cornerstones for Reform

- Protect and optimize Medicaid funding.
- Reduce the number of uninsured Texans
- Focus on keeping Texas healthy.
- Establish infrastructure to facilitate the accomplishment of reform.

Framework for Reform

- **New State-federal subsidy** for low-income uninsured to purchase primary care health coverage and insurance.
- **Texas Health Opportunity Pool** to support subsidies to low-income uninsured funded by a reallocation of part of disproportionate share hospital (DSH) funds, efficiencies in the current Medicaid program, and other revenues approved under an agreement with the federal government.
- **New agreement with the federal government** to protect at-risk funds and to maximize federal claiming on state and local spending for the uninsured as part of a Medicaid s. 1115 waiver and related Medicaid State Plan Amendments.
- **Reformed system to purchase health insurance and coverage** that focuses on primary and preventive care in settings that offer care coordination and cost-effective care. Access could be facilitated through a Health Insurance Exchange with a choice of options for uninsured individuals and small businesses.

Texas Health Opportunity Pool

Establish a **Texas Health Opportunity Pool** to fund subsidies for the purchase of insurance by the uninsured.

- Dedicate funding for the pool from monies now used to cover the uninsured and from at-risk health care provider payments:
  - Reallocate part of Texas DSH payments already spent on health care for the uninsured.
  - Protect at-risk health care provider funds of $500 million or more.
  - Leverage financing options approved in comprehensive reform waivers to match current state & local spending for uninsured.
  - Maximize unexpended SCHIP allocations.
  - Leverage efficiencies in current Medicaid spending.
- Explore opportunities to increase hospital rates to:
  - Align Medicaid payments more closely with Medicaid costs.
  - Free up DSH for subsidies to uninsured.
- Ensure financial support for critical safety net providers with a gradual transition to a more cost-effective delivery system.

New Federal Medicaid Agreement

Seek a federal Medicaid 1115 waiver to protect at risk funding, reallocate a portion of DSH payments for insurance/coverage subsidies to the uninsured & reform financing & delivery of health care for the uninsured.

Subsidies and Access to Health Care

New State-Federal Subsidies

- Provide **new subsidies** to purchase health care under a reformed system to deliver primary and preventive care to the uninsured.
  - ***Target Population*.** Extend access to Medicaid-funded subsidies to purchase health coverage and insurance to:
    - Uninsured parents with income up to 200% of the federal poverty level (FPL); and
    - Uninsured childless adults up to 200% FPL.
    - Voluntary program with crowd-out protections.
  - ***Benefits*.** Specify a minimum benefit tailored to the subsidized uninsured, with core benefits like ESI.
  - ***Delivery System.*** Require care delivery through managed care approaches.
    - Use care management, defined networks, higher cost sharing & wellness and healthy behavior incentives.
    - Assure plans compete on access, price, provider networks, quality, and efficiency.
  - ***Personal Responsibility*.** Create a "culture of insurance" with care coordination, incentives for consumers and providers, and market competition.
  - ***Employer-Sponsored Insurance*.** Allow ESI opt-out.
  - ***Cost Sharing*.** Provide subsidies on a sliding scale based on income with targeted cost sharing to support Texas' policy objectives.
    - No deductibles to ensure primary/preventive care.

Reformed System to Purchase Insurance/Coverage

- Ensure **access to health care** through the Health Insurance Exchange, a new, quasi-public entity to provide insurance and coverage tailored to the target populations.

  To increase access and choice, the Exchange would:
  - Certify and offer plans, facilitate enrollment, administer premium subsidies, coordinate payroll withholding, assure portability & leverage pre-tax contributions to reduce cost
  - Provide a choice of insurance and coverage options, including Texas-specific programs, including:
    - Basic benefit health plan with first dollar coverage and annual benefit limit of $25,000 to $35,000;
    - High deductible health plan (catastrophic) with a health savings account, or HSA (preventive);
    - A pre-paid and/or point of service plan;
    - A benchmark plan with more comprehensive coverage and higher participant cost sharing; and
    - If eligible, the Texas high risk pool.
- Create a platform to offer more accessible, affordable insurance products to unsubsidized small businesses & uninsured.