



LA FE POLICY RESEARCH AND EDUCATION CENTER

Promoviendo Bienestar para Familias y Comunidad con Conocimiento, Confianza y Poder
Promoting Family and Community Well-Being through Knowledge, Trust and Empowerment

Texas Medicaid Waiver: Implications for Health Care Reform

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EXECUTIVE SUMMARY

Texas started a process of health care reform having recognized that it retains the highest uninsured rate in the country, uncontrolled health care costs, and questionable quality in the level of available and accessible health care. The Medicaid program is a centerpiece of the reform effort. Senate Bill 10, passed by the Texas 80th Legislative Session (2007), permitted Medicaid Reform to serve as the driver for addressing the State's health care crisis.

In response to Senate Bill 10, the Texas Health and Human Services Commission (HHSC) submitted (December 12, 2007) the required State Medicaid Reform Waiver 1115 proposal to the Center for Medical Services (CMS) – the federal oversight agency for the Medicaid entitlement program. The State is in on-going negotiations with CMS, and a revised Waiver 1115 proposal was submitted in April 2008 for further review and additional negotiations.

Given the rigorous approval process (2-4 years) and influence by CMS during its course of review, as well as on-going State-level changes in the health care environment it is likely that revisions will occur. The key reform elements of the submitted goals include: a) keeping Texans healthy by providing access to high quality health care, reinforcing consumer choice and consumer personal responsibility for health care and healthy behavior; b) restructuring federal Medicaid funding for the purpose of gaining flexibility, enabling greater optimizing of investments in health care, and reducing the number of uninsured; and c) establishing infrastructure to enhance the quality and value of health care through better care management and performance improvement incentives.

The focus of this policy analysis is to evaluate the components of the HHSC Medicaid Reform Waiver 1115 proposal as of 2008 and identify its challenges while gaining greater understanding of how the reform proposal will or will not address health disparities¹ among low-income, and race/ethnic population groups—all of whom represent the largest number of uninsured and are most heavily impacted by multiple health disparities.

Highlights of components of the HHSCs Medicaid Reform Waiver:

The central components of the proposed Medicaid Reform Waiver (MRW) have been designed with consideration to: a) the State's current health care crisis environment, b) Texas Legislative and HHSC hospital and uncompensated care studies, and c) policy research on reform strategies and experiences of other states.

MRW's framework is largely influenced by the Deficit Reduction Act (DRA) passed by Congress in 2005. The DRA's carrots and sticks policies allow for a state flexibility option while mandating restricted funding and new enrollment requirement. The DRA places many challenges before State Medicaid Programs--financially and programmatically through increased service expectation, reduced funding, and added emphasis on decreasing the number of uninsured. The current Medicaid Reform Waiver proposal by Texas' HHSC emphasizes restructuring the financing and delivery of indigent health care. The State proposes to rebase Medicaid financing to better achieve optimal federal matching funds to support the creation of a Health Opportunity Pool (HOP), which will provide expanded subsidy opportunities for employer sponsored health insurance.

The State has embraced the DRA's policy support for public-private sector collaboration to address the problems of the uninsured. The States' MRW proposal targets the uninsured by providing affordable private health insurance options through employer-sponsored and/or individually purchased private health insurance. A concurrent policy strategy is that the health insurance options emphasize primary preventive care.

The States' emphasis on a public-private market approach is not yet clearly defined or developed in the proposed reform policy components. Nonetheless, Texas focused on utilizing the public-private market model to expand coverage and healthcare cost-sharing as the strategies for implementation. These approaches intend to create an environment that will grow a "culture of insurance" among the uninsured.

Key components of the Texas MRW 1115 include:

- **Eligibility and Target Population:** The HOP long-term goal is to subsidize private health insurance premiums for 3.6 million uninsured individuals at 200% or less of the Federal Poverty Level (FPL) through a "phase-in" approach – dependent on available financing, experience, and infrastructure ready timelines. Other factors include first-come-first-served basis and applying for and accepting Employer Sponsored Insurance (ESI) plans. The Phase 1 priority target population is the current 482,822 parents with children on Medicaid and CHIP and siblings over age 21.
- **Benefits:** The proposed HHSC Medicaid Reform's policies would target service tailored benefit packages, subsidies, and financing that emphasizes primary and preventive care. The proposed benefit package represents service limits below those provided under Medicaid or CHIP, or most employer sponsored insurance plans.
- **Financing:** The proposed HOP financing mechanism-referenced as the Medicaid Reform Finance Transformation Model would restructure State funding and financing for health insurance coverage to the uninsured. A central component of the HOP financing mechanism is the "Diagnosis Related Group- Disproportionate Share Hospital Reimbursement Swap" that would reroute traditional and available uncompensated care dollars (\$150 million in general revenue) to create HOP. After rebasing, HOP's initial funding is estimated at \$304 million inclusive of federal matching funds.

Key Challenges of Texas' MRW:

Current Medicaid Reform policies lack empirical support raising questions about the State's approach. A comparative review of other state public-private market approaches and respective reform policies illustrate limited evidence of success in reducing the number of uninsured, improving the quality of care, or reducing health care costs. Often, they have been less cost-effective or sustainable. Ironically, policy research suggests that, even with its financial challenges, Medicaid still provides more cost-effective care than the private health insurance sector.

Excluding key stakeholders in concept design and policy development creates a challenge for gaining public support. Stakeholders are too often asked to “react to” a proposal and subsequent policy strategies as opposed to being asked to be a part of the reform development process. The Texas Hospital Association did not support the State’s proposed waiver nor has the insurance industry expressed a public stance. Furthermore, Hispanics, Blacks, and/or low-income uninsured groups were not invited or engaged through targeted venues such as front-line community health and human service organizations, civic or faith-based groups to consider their perspective, ideas or recommendations. As a result, HHSC’s proposal lacks stakeholders support.

MRW fails to address the implications that these reform efforts will have on the health disparities in the targeted populations most affected. It is estimated that Texas has 1.4 million uninsured adult citizens with incomes below 200% of the FPL. Of these adults, minorities have higher uninsured rates than Whites even when the level of education is the same. For instance, college educated Hispanics and Blacks are still three times more likely to be uninsured. The demographic, education, income, health and insurance disparities among most uninsured-Hispanics have large implications for real change in reducing the number of uninsured in Texas.

The complex state of Texas’ diverse geographic characteristics, urban/rural differences, racial and ethnic population composition exacerbates health care disparities. The proposed waiver did not explicitly address these issues nor provide research data to promote dialogue and policy approaches that increases opportunities for reform success.

In summary, Texas is taking a minimalist approach to expanding health insurance coverage. The national trends to make changes to state Medicaid programs are driven by the DRA. The policy research indicates limited success with many of the reform efforts. Successes for substantive health care changes appear to have more promise when states take the lead in supporting comprehensive reforms, demonstrate increase revenue investments, and both challenge and truly partner with stakeholders to find solutions. The Texas reform plan, thus far, is limited in scope and vision and will have little impact on strengthening and expanding health care safety nets.

Health care reform in Texas has really just begun and there is ample opportunity to revise and improve the underlying approach and policy strategies to reduce the number of uninsured, improve quality, and reduce costs. With the Obama administration’s new health reform effort, Texas finds itself in a favorable position, able to take advantage of stimulus dollars and maximize opportunities for its uninsured citizens, with the added benefit and hindsight of having constructed the 1115 Waiver in 2007, and having received feedback on that MRW over the past year.

I. INTRODUCTION

The U.S. and Texas are facing uncontrolled health care costs, a high number of uninsured and under-insured, and questionable quality in the level of available and accessible health care.² Currently the U.S. and state governments, including Texas, are attempting to alleviate the crisis through multi-prong approaches including reforming major entitlement programs like Medicaid. The following health care issues and reform trends are impacting states across the nation.

The impetus of these latest reform efforts is the passage of the National Deficit Reduction Act (DRA) of 2005, which was signed into law in 2006. The DRA gives states greater flexibility and less oversight to make more wholesale changes to their Medicaid program.³ The Act promotes market-driven and competitive type approaches to solve the nation's health care access, costs, and quality problems. Of note, the DRA law strongly reinforces that any proposed Medicaid changes to be "budget neutral" i.e., federal funding without the waiver is no more than federal funding with the waiver. Several state governors, Medicaid state agency heads, and consumer advocates opposed the DRA because it created barriers to health care, specifically, Medicaid reform.⁴ Examples of the mandates range from new proof of citizenship/legal residency requirements, to funding reductions targeting provider reimbursement, school-based outreach and enrollment support.

With the DRA in place, nearly every state in the country is engaging in some level of health care reform, either conceptually from a **comprehensive** (holistic multi-tiered/multi-strategy approach), **incremental** (building reforms one step at a time) or **minimalist** (restrictive eligibility requirements, revamping service delivery, and no additional funds to increase insurance coverage) approach. States are using their respective Medicaid program as the foundation and starting point from which reform efforts are being initiated. The primary issues Medicaid reform is supposed to address include:

- Rising health care costs impacting state budgets
- Rising number of uninsured and increasing reliance for Medicaid as the "safety net"
- Service benefits and quality concerns
- Service delivery fragmentation and cost-inefficiency

Invariably the levels of reform efforts are impacted by economic and fiscal conditions, the influence of stakeholders, and the political environment. Within these environments is one or more of the following central reform efforts:

- **Expanding Health Insurance Coverage** utilizing public and private mechanisms.
- **Market Reforms** that support coverage expansions in the private health insurance market.
- **Reimbursement Mechanisms** targeting primary and preventive health care; provider quality improvement and compensation requirements; and innovative use of computer technology to stimulate more integrated cost-effective care.

What is Texas proposing through its Medicaid Reform strategy and how will it potentially impact identified problems in the State's health care delivery system(s) relating to access, costs and quality of health care? In particular, what impact will the reform have on addressing health disparities among low-income, race/ethnic population groups, and/or immigrants—all of whom represent the largest number of uninsured and are impacted by multiple health disparities?⁵

In 2007, the Texas 80th Legislature passed Senate Bill (SB) 10, a Medicaid Reform bill that would serve as the driver for addressing the State's health care crisis. Responding to SB 10, the Texas Health and Human Services Commission (HHSC) submitted a Medicaid Reform Waiver (MRW) 1115 proposal in December 2007. The MRW proposal was submitted to the Center for Medical Services (CMS), the responsible federal oversight agency for the Medicare and Medicaid programs. The purpose is to "waive" Medicaid requirements to implement major changes and test new ideas to improve the Medicaid program.

The language in SB 10 and the recent submission of its Medicaid Reform proposal reflects a market-driven approach as the State's chosen central reform strategy. The proposal refers to the DRA guiding reform principles and requests permission to take advantage of the DRA afforded flexibility to redesign its Medicaid program with a private insurance market emphasis, and use the Waiver process as the tool to implement the proposed changes.

Texas has historically taken a minimalist approach to the health and human services care needs of its citizens compared to other states. Texas remains the lowest state per capita expenditure (ranks 49th in health and human services), has the highest uninsured population in the country, and retains one of the most restrictive Medicaid eligibility requirements (a person must earn less than \$2,184 annually to qualify for adult Medicaid).⁶ Texas and Texans must realize that there are much greater challenges in designing and implementing health care reforms, and SB 10 is only a beginning along with other approaches to comprehensive reform.⁷

There is a growing convergence trend in the U.S. and Texas in which individual health consumers are being required to assume more responsibility for more aspects of their health. The responsibilities include personal/family health behaviors, more cost-efficient use of health care providers and facilities, and increased out-of-pocket cost-sharing for their health care. Unfortunately, most people have few financial resources and protections or tools to realistically and effectively respond to these new responsibilities.⁸ This is particularly true in many low-income and racial/ethnic groups where health disparities are prevalent and acute.⁹

These issues require Texas policy-makers to develop innovative Medicaid reforms that will result in meaningful programs that reduce health insurance and health care disparities. Texas is engaged in a process of negotiations with CMS regarding its MRW proposal and final approval. Concurrently, MRW details are being developed and numerous design and implementation decisions are still to be made. In addition, stakeholders want to participate in the proposed reform change process.

This report is an analysis of Texas' MRW proposal and the implications and potential to increase health care access by reducing the number of uninsured with a special focus on minority populations. As new developments unfold in the MRW process, we expect this document to be instructive as a review of the past effort, while providing useful insights for future reform. This policy paper references information up to March 2008. At the time of editing, new developments are occurring in the State's MRW process. However, this document is relevant because the DRA and the State's efforts in Medicaid reform will move forward, and the information can be utilized as other reform efforts are attempted.

II. MEDICAID REFORM STRATEGIES AND EXPERIENCE

A. Overview: Deficit Reduction Act and Medicaid Reform Waivers

Medicaid and the State Children's Health Insurance Program (SCHIP) are both a shared financing program structure of federal and state funds targeting low-income uninsured populations. Medicaid is an entitlement program whereas CHIP is not. Any modification to the Medicaid Program requires an Amendment to the State's Medicaid Plan or submission of a Medicaid Waiver.

Medicaid is the largest health care program in the nation covering over 42.1 million individuals, spending \$304 billion in 2006.¹⁰ Unquestionably, Medicaid is among the largest expense for states. It is not surprising that major change to the health care system is often initiated through the Medicaid Program. The Texas Medicaid program is \$60 billion in combined state and federal funds; it comprises 26% of the State's biennial budget.¹¹

Under the Medicaid Program, two types of waivers provide states with the flexibility to apply for and implement Medicaid Program changes and/or Demonstration Projects.

- A Section 1915 Waiver provides States flexibility to make program changes to Medicaid.
- A Section 1115 Waiver allows States to apply for Research and Demonstrative Projects.

An initiative under the 1115 Waiver is the Health Insurance Flexibility Accountability (HIFA). This allows states to utilize current available or unspent state Medicaid and SCHIP funding. All 50 states have applied for and implemented at least one Medicaid Waiver. Approval by the CMS for a State Medicaid Waiver request may take years.¹²

With the DRA, states were confronted with opposing concepts and policies that on one hand primarily sought to reduce government spending over ten years by a 10% cut-containment mechanism. While on the other hand, the DRA allows states to balance the cost-containment challenge with more flexibility and less oversight to make comprehensive changes to their Medicaid program. It included strong support for private-public partnership and permits increased cost-sharing provisions for enrollees.

Under DRA law, any proposed Medicaid changes are required to be budget neutral and incorporate new mandates that were established. These new mandates include proof of citizenship / legal residency requirements, funding reductions targeting provider reimbursement, school-based outreach and enrollment support, targeted case management, asset transferring rules targeting long-term care eligibility, and rules that will change Medicaid hospital funding and programs (i.e., Graduate Medical Education funding support).

While there are concerns about the new mandates by governors, hospitals, and advocates, states are using the DRA's flexibility to help them design health care reforms that best fit their state, thereby using the applicable Section 1115 Waivers in Medicaid as central to their reform strategies. The DRA flexibility options include the following:¹³

Increased Premium and Cost Sharing-

Eligible Group	Rule/ Option
Above 150% FPL	Unlimited Charge on Premium
	Max 20% on Co-payments on medical cost
100%- 150% FPL	No premium charge
	Max 10% on Co-payment on medical cost of income
All Eligible	Cost Sharing and Premiums not exceed 5% family's income per mo./qtr
	Denial of Service due to failure to pay "Enforceable" Co-pay and Premium.
	Permits increased co-pay for non-emergencies and higher cost sharing for non-preferred drugs.
Exemptions	Prohibited imposing cost-sharing and premium on pregnant women and mandatory children.

Benchmark Benefits-

Eligible Group	Rule/ Option
Children & other certain groups	Permits state to replace exiting Medicaid benefit package with benchmarks
	Max 20% on Co-payments on medical cost of income
Children	Required to provide wrap-around or comprehensives benefits for EPSDT and access to rural health clinic and FQHC
All Eligible	Opt-out and know-your-rights notifications of benchmarks plans.
	Benchmarks benefits apply only to groups covered under Medicaid prior to enactment of DRA
	State must provide multiple health plans and can vary by region.
Exemptions	Pregnant, women and parents, disabled or special needs individuals, dual eligible and individuals with long-term care.

Competitive Waiver Demonstration-

Projects	Rule/ Option
HEALTH OPPORTUNITY ACCOUNTS Low-Income Children & Parents	Target for up to ten states demonstrations
	Budget Neutrality not required and enrollment must be voluntary
	State contribution for individuals to utilize for high deductible and other health care cost.
MONEY FOLLOWS the PERSON (MFP)	Rebalancing waiver to transition elderly, disabled out of hospitals, nursing homes and other institutions back into community.
	Match Federal dollars 75-90% of cost of community based long-term care for first 12 months after individual leaves institution.
	State cap at \$1.75 billion over five years.
HOME and COMMUNITY BASED SERVICES	Pregnant, women and parents, disabled or special needs individuals, dual eligible and individuals with long-term care.

The above tables are only a share of options provided to states under the DRA. It is the mandates that raise the most challenging reform questions for states.

Examples of states DRA/MRW reform efforts include:

- **Comprehensive Health Care Reforms (Comprehensive)** of state healthcare systems like Massachusetts or California;
- **Medicaid Program Reform Initiatives (Incremental/Minimalist)** like Florida's pilot reform efforts of the State's Medicaid Programs; and/ or
- **State Waiver Reforms (Incremental/Minimalist)** that utilize demonstration project approaches that seek reforms among segmented populations.

The Texas experience, as it relates to the waiver reform process, is defined by the 80th Texas Legislature's passage of the SB10 Medicaid Reform law. Senator Jane Nelson, the bill's lead author, is quoted as stating after the passage of SB 10: "This legislation lays the foundation for a new approach to health care for the poor, the fragile and the uninsured" and "helps contain our acute care costs over the long term and, more importantly, help Texans maintain good health."¹⁴

B. Design Considerations: Texas HHSC Research and Development

Preceding the development of the Texas MRW proposal, HHSC researched other states' Medicaid Waiver strategies and experiences in response to the DRA. The research papers detailed states' reform strategy goals, program implementation, affected populations and stakeholders, fiscal issues, and implementation considerations and timelines. HHSC's research does not provide a comprehensive examination because many of the MRW projects are in infancy. But some of the initial reports found:

1. There are growing concerns for financing coverage expansions of the uninsured and increased Medicaid expenditures.
2. No one strategy is the same.
3. There is minimal empirical information to support state successes.

Where relevant, HHSC outlined other Texas health care reforms and/or CMS Waiver requests targeted for coordination/incorporation with the MRW implementation activities.¹⁵ HHSC policy research focuses on the strategic reform options summarized in Table 1.¹⁶

The DRA set the tone for health care reform in the United States. Yet within the DRA framework, states face challenges, financially and programmatically, and have high expectations, reducing costs and decreasing the uninsured. The DRA paradigm is similar to other U.S. carrot and stick policies. The federal policy allows flexibility and expansion options (carrots) and at the same time mandates funding restrictions and new enrollment requirements (sticks).¹⁷

Table 1: State-Level Health Care and Medicaid Reform Strategies

Strategic Reform Options	Description	Reform Goal	Other States
Health Insurance Market Exchange (Connector)	Individuals and businesses purchase insurance from competing health plans	Reduce uninsured, improve access and quality, benefit options, support private market coverage, consumer choice and responsibility, improves sustainability, maximize federal funds	1- MA
CHIP Premium Assistance (CHIP – PA)	Federal and State CHIP funds to pay a portion of the enrollee costs into private employer or group insurance coverage	Reduce uninsured, support private market coverage	10- (IL,MA, NJ,OR,V A,WI, ID,OK, UT,ME)
Three-Share/Multi-Share Programs	Premium costs split among employer, employee and 3 rd share which can be either private or public dollars - focus on small business less than 50 employees	Reduce uninsured, supports private market coverage, costs reduction or avoidance, maximize federal funds, improve leveraging dollars available from employer and employee	7- (MI,IL,N M,OR, AR,CA, MA)
Low-Income Pools	Medicaid waivers - lump sums of federal funds states receive in exchange for restructuring their Disproportionate Share Hospital (DSH) and/or Upper Payment Limit (UPL) programs. Can be used for payment to hospitals to help with Medicaid shortfalls, and uncompensated care, expand coverage, and infrastructure improvements	Reduce uninsured, supports private market coverage	3- (FL, MA, CA)
Medicaid Opt-Out	Allows Medicaid eligible and potential eligible family members to opt-out and opt-in to their employers insurance plan	Reduce uninsured, supports private market coverage, cost reduction or avoidance	1- FL
DRA Benchmark Plans	Alternative benefits plans to beneficiaries allowed through State Plan Amendment process	Consumer choice and responsibility, benefit options	7 - (ID, KY, WV FL, MD, UT,VT)
Enhanced Benefit Accounts	Consumer-directed reforms – incentives to increase use of preventive services and promote personal responsibility, i.e., health saving and health opportunity accounts	Consumer choice and responsibility	4-(ID, KY, WV, KY)
Pay-for-Performance	Strategy to facilitate quality improvements and better health outcomes by rewarding providers who have met a specified set of performance expectations	Improve access and quality, cost reduction or avoidance	4- (CA, MA, MI, NY)

In summary, HHSC’s research on other states sheds light on variation and complexity as it relates to funding and enrollment. How will states manage the policy mandates and flexibility options for their state? More importantly, do the DRA and MRWs hinder or enhance a state’s ability to address the growing health care cost and uninsured crisis?

III. TEXAS MEDICAID REFORM WAIVER PROPOSAL

In designing its MRW 1115 proposal, Texas considered the following: a) the State's current health care crisis environment surrounding the uninsured, quality, and costs issues; b) Texas Legislative and HHSC hospital and uncompensated care studies; and c) preceding policy research on reform strategies and experience of other states across the country. This entire section is based on what HHSC provided in hearings, at community forums, on their web site, and in interviews.

The MRW 1115 proposal places substantial emphasis on "restructuring" how it pays for Medicaid services to enrollees and indigent uncompensated care. The restructuring is anticipated to reallocate state and local (e.g. including local public hospital tax dollars as part of State/federal match) funding and financing for health insurance coverage to the uninsured.

The Texas MRW proposal was submitted on December 5, 2007. The proposal identified the following goals:¹⁸

1. Keep Texans healthy by a) providing access to high quality health care, b) reinforcing consumer choice, and c) personal responsibility for health care and healthy behavior.
2. Restructure federal Medicaid funding for the purpose of a) gaining flexibility, b) enabling greater optimizing of investments in health care, and c) reduce the number of uninsured.
3. Establish an infrastructure to enhance quality and value of health care through better care management and performance improvement incentives.

HHSC underscored the importance of these goals with the declaration that they will help address the underlying reasons for indigent health care costs—Medicaid funded indigent care focuses on hospital-based care and not preventive primary health care, thereby driving how uninsured Texans access more expensive healthcare. The MRW proposal asserts that the uninsured go without primary and preventive care until a high-acuity and high-cost health event occurs. In effect, reimbursing hospital providers at the most expensive end of the care continuum, as opposed to improving access to primary and preventive care which can moderate costs and growth of indigent care.

The **expected results** from the implementation of the Medicaid Waiver goals and policy strategies include:

1. Improved access to both basic health services and the health status of low-income uninsured.
2. Strengthened access to and use of employer sponsored health insurance (ESI).
3. Improve the pricing and quality of care delivered through performance-based purchasing and market-base competition.
4. Increased consumer choice.
5. Improved health investments by focusing on primary and preventive care, and not on more costly and unmanaged episodic care.
6. Promotion of healthy lifestyles, chronic disease management, and personal responsibility for health care costs such as cost-sharing.
7. Reductions in long-term care growth-rate of health care costs for low-income people, and reduction in the related increases in private sector health care premiums.

HHSC has chosen to recommend implementation of several key MRW policy strategies to guide *Phase 1* of its reform proposal. Numerous details and/or final decisions regarding major *Phase 1* components of the policy strategies are still in development, e.g., benefit package and cost sharing, subsidy amounts, enrollment caps, financing, etc. Concurrently, HHSC is in on-going negotiations with CMS regarding both the various MRW components and its planned financing, aspects of which also require CMS approval.

The policy strategies along with corresponding description of their implementation approach, guiding administrative and operational considerations, and proposed financing are described below.

A. Health Opportunity Pool (HOP):

The HOP will be established as a “Trust Fund” outside the State Treasury to be held by the State Comptroller and administered by a “Commission”. The establishment and oversight of the HOP will be under HHSC for a start-up period (timeline undecided). The HOP will subsidize private health insurance premiums for uninsured individuals at 200% or less of FPL through a “phase-in” approach and a “doable” (available financing, experience, and infrastructure ready) timeline.

200% FPL: 2007 HHS Poverty Guidelines
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For 1 \$20,420/annual \$1,701.67/month
--

For 2 \$27,380/annual \$2,281.67/month
--

For 3 \$34,340/annual \$2,861.67/month
--

For 4 \$41,300/annual \$3,431.67/month
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HOP Target Population

- Approximately 3.6 million uninsured adult citizens and legal residents of which 2.1 million (60%) are at 200% or less of FPL.
- **Priority Target Population:** the 482,822 parents and siblings over 21 with children on Medicaid and CHIP
- **Secondary Target Population:** those not in system that include uninsured children, other uninsured parents and childless adults over 25 (1.3 million), and childless adults 19-25 (365,000).

HOP Eligibility

- At or below 200% FPL
- Texas resident, U.S. citizen or qualified legal resident
- Apply for Employer Sponsored Insurance (ESI) and accept coverage if eligible and affordable.
- Not eligible for Medicare, Medicaid, or CHIP, including eligible or enrolled in CHIP – Premium Assistance (PA).
- Did not have health insurance in past six months unless lost for good cause.

HOP Enrollment Considerations

- Based on available financing.
- Subsidy available on first-come first served basis.
- Requires application for ESI coverage as eligibility requirements and subsidy to offset employee share of the cost.

- Those without access to ESI coverage apply for HOP subsidy to private health insurance product. State will certify a select but as yet undefined number of plans.
- Failure to pay any assigned portion of cost share by enrollee will result in a six month eligibility suspension.

HOP Benefit Design

As previously noted, the DRA allows benchmark with prior approval “tailored benefit” plans. Coverage options can include 1) standard Blue Shield Blue Cross offered under Federal Employee Health Benefit Plans provided State employees, 2) coverage offered by the largest commercial HMO in State, or 3) other benchmark plan(s) approved by CMS. The State MRW proposal outlined the following:

- *Basic Criteria:* will offer a choice of plans and benefits at an affordable cost by providing:
 - Eligible individuals with a manageable selection of healthcare services and benefits among insurance plans.
 - Healthcare coverage will begin the 1st month after eligibility is determined and plan enrollment is complete.
 - Once enrolled, enrollee will be locked-in for a 12 month period except for external cause (move, lack of access, no co-payment).
- *Phase I - Benefit Design Principles:*
 - Emphasis on primary and preventive care, and enhanced care management.
 - A robust primary and preventive care package.
 - Encourage access to qualifying, affordable ESI if available.
 - Minimize crowd-out from employers with benefit design not more robust or attractive than private health insurance.
 - Broad range of services that meet the basic healthcare needs of most enrollees.
 - Include behavioral health services.
 - Leverage market “benefit package” competition to reduce cost.

Since submittal of the State’s MRW proposal, HHSC has acquired and is using a consultant designed Interactive Benefit Model. The Model estimates the cost implications of different benefit designs and benefits limitations for the targeted adult uninsured expansion population. Based on benefits, population, and year the Model is purported to have the capacity to adjust for health status, take-up rate, and anti-selection. Data for the Model is organized into nine service categories (Table 2) from which to choose for the benefit design:

Table 2: Medicaid Reform Benefit Service Categories

Primary and Specialty Care	Acute/Outpatient Care	Other Services
Primary Care Physician - Preventive Visits	Inpatient Facility	Pharmacy
Primary Care Physician – Other Visits	Outpatient Surgery Other Outpatient Facility	Mental Health and Substance Abuse
Specialty Care Physician – Visits	Outpatient Emergency Room	Other Ancillary Health Professionals

In turn, the benefit design can be varied in any service category based on:

- Dollar and utilization limits
- Co-payments, deductibles, and member premiums
- Out-of-pocket maximum (member premium and deductible)
- Annual benefit maximum
- Supports use of subsidy for ESI
- Allows option to include/exclude physician claims that occurred during an inpatient stay

State Uninsured and Phase 1 Priority Impact

In Texas, 5.6 million individuals are uninsured, of that, 4.1 million are adults. Within the uninsured adult population, approximately 2.3 million have incomes at or below 200% FPL. This adult population’s income prevents them from qualifying for Medicaid and Medicare (they earn too much) and most are unable to afford private insurance (they earn too little). The following two tables examine the demographic make up of the uninsured in Texas who earn at or less than 200% FPL (\$20,477 a year for 1) and the characteristics of the priority target population for the State’s MRW program. Some of the findings are common knowledge, but some of the findings are unique and require further examination.

- Of the estimated 2.3 million uninsured adults who earn at or less than 200% FPL, 1.4 million are qualified for the MRW.
- Of the 1.4 million 47% are Hispanic, 19% Black, 31% are White
- 74% of uninsured below 200% FPL are under 150% FPL

Table 3: Uninsured Adult (19-64) Population by Race/Ethnicity and FPL

Population	<150% FPL	150 - 200% FPL	Total's
Hispanic	500,522	178,346	678,868 (47%)
Black: Non-Hispanic	220,325	61,001	281,326 (19%)
White: Non-Hispanic	317,408	128,390	445,798 (31%)
Other	32,508	10,259	42,767 (3%)
Total	1,070,760	377,996	1,448,756 (100%)

Source: Census Bureau – Current Population Survey 2007

Note: This table does not include uninsured Non-citizens

As stated earlier, HHSC identified 482,822 uninsured adults (parents and siblings) of Medicaid/CHIP children for potential enrollment in *Phase I* of the HOP.¹⁹ This target population represents approximately 21% of the total number of the State uninsured adults at <200% FPL.

- Almost 2/3 of the priority population is female.
- The older age bracket, 35-64, has a higher uninsured percentage.
- Hispanics make up 73% of the priority population.
- 83% of the priority population earns less than 150% FPL.

Table 4: Uninsured Parents of Medicaid/CHIP Children

Population	<150% FPL	150 - 200% FPL	Total's
Female	257,711	47,803	305,514 (63%)
Male	147,072	30,237	177,309 (37%)
		Total:	482,822
Age 19 – 34	173,677	36,895	210,572 (44%)
Age 35 – 64	231,105	41,145	272,250 (56%)
		Total:	482,822
Hispanic	303,118	47,588	350,706 (73%)
Black: Non-Hispanic	34,524	10,581	45,105 (9%)
White: Non-Hispanic	61,985	16,758	78,743 (16%)
Other	5,156	3,113	8,269 (2%)
		Total:	482,822
Source: HHSC Selected Data on the Uninsured Table, 2006 Current Population Survey			

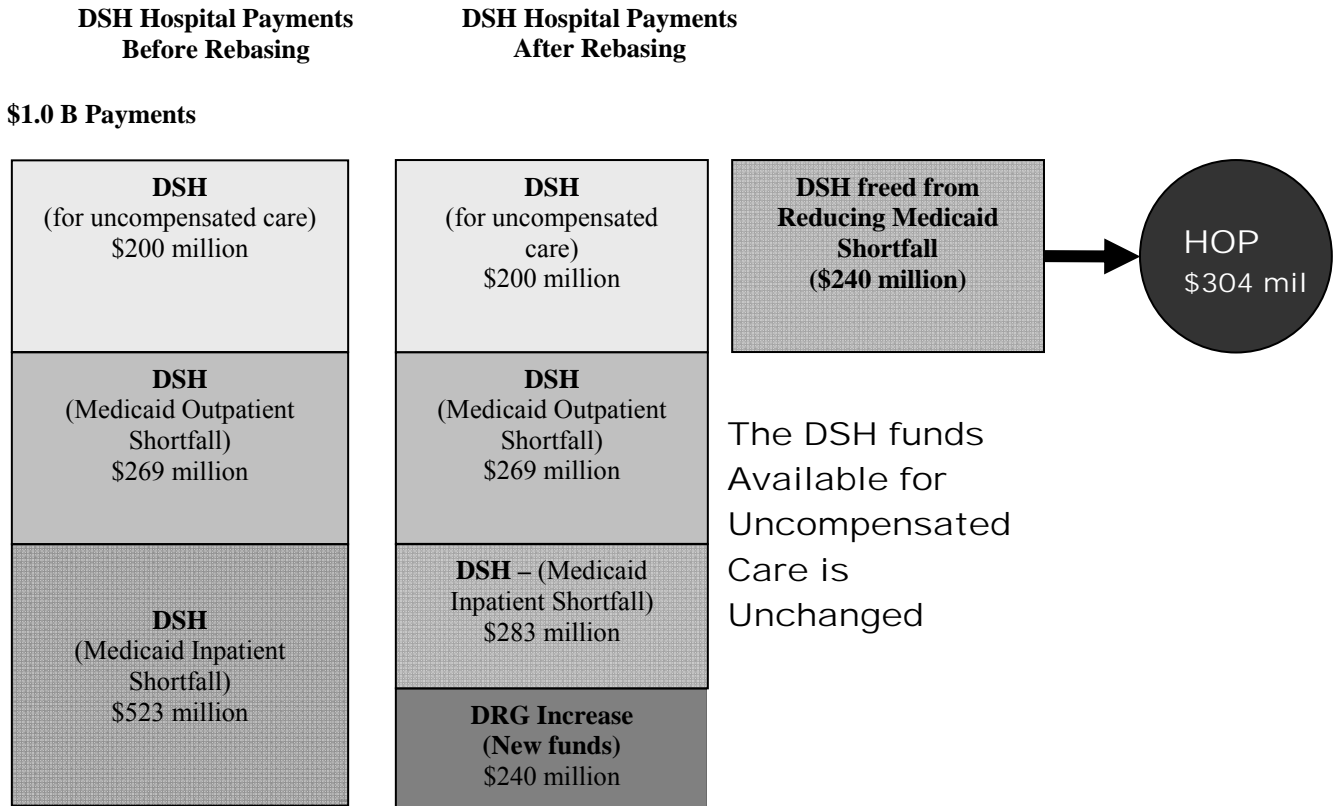
B. Medicaid Reform Waiver Financing:

The MRW is dependent on the proposed state financing mechanism in which Texas will transform its methodology for funding Medicaid and indigent care to hospitals. HHSC refers to the central component of the transformation as the “Diagnosis Related Group (DRG) - Disproportionate Share Hospital (DSH) reimbursement Swap.”²⁰ HHSC staff presented the following: (see Appendix A for hospital Medicaid financing terminology):

- Hospitals receive DSH based on the care they provide to Medicaid and uninsured clients.
- Medicaid payments to hospitals for Medicaid clients are currently less than the cost of care.
- “Medicaid shortfall” is the difference between the costs and payments.
- Increasing Medicaid payments (rebasing), HHSC anticipates a reduction in the Medicaid shortfall therefore reducing the DSH funding needed by hospitals to make up for that shortfall.
- The funds for rebasing are General Revenues (\$150 million) included in the SB10 Medicaid Reform legislation.
- Hospitals will see no change in the amount of funds allocated to provide care for the uninsured.
- The DSH funds that would have been used for Medicaid shortfall can now be used for the proposed Health Opportunity Pool (HOP) strategy targeting uninsured adults.

The MRW finance transformation model is illustrated by Chart 1.

Chart 1: Medicaid Reform Finance Transformation Model



The result would mean \$240 million from the DRG – DSH Swap plus \$62 million in available general revenue funds for a total of \$304 million for the HOP.

The financing strategy and mechanism above are an integral part of HHSC and CMS negotiations which also will require approval. As part of these on-going negotiations HHSC is investigating other possible matching revenue opportunities to leverage as part of the HOP to draw down federal dollars. With all the State matching sources, the amount Texas could potentially receive from the federal government is \$240 million. Paralleling these efforts are the concurrent series of related policy decisions regarding the benefit package(s) design, eligibility, cost-sharing, etc.

Phase 1 was scheduled for implementation in September 2008. The current stage of MRW efforts in Texas demonstrates some uncertainty about what final decisions will be made in the myriad HOP areas enabling expansion of health insurance coverage to uninsured adults. Further, the MRW also contains other proposed and complementary programs addressing the issues of the uninsured, costs, and quality of care for Texans²¹; and identifies other expansion groups for subsequent years’ coverage expansion, dependent on *Phase 1* outcomes and available financing. (See Appendix B for a brief explanation of these initiatives).

The Texas MRW proposal should be viewed as 1) a part of national trends to reduce the increasing number of individuals without health insurance; 2) a trend calling for more “consumer responsibility” in cost-sharing and healthier behaviors to prevent serious and costly illnesses; 3) expanding healthcare access by increasing coverage through the private health insurance market; and 4) focused on improving the cost-effectiveness of the care delivered with available federal and State funds.

It would be constructive to review the experience of other states with MRWs similar to Texas. Section IV of this report provides a comparative review of the MRWs experience in six states exemplifying similar strategies and policy options. The comparisons can provide some insight regarding the identified MRWs policy options and successes to date—reductions in the number of uninsured, minimizing or reducing health care cost, and improving healthcare quality. Additionally, the comparison can serve to assess their potential impact on population groups with the most severe health care access disparities such as low-income, Hispanics, Blacks, and immigrants.

IV. MEDICAID REFORM: A COMPARATIVE REVIEW OF SIX STATES

HHSC researched other state Medicaid reform activity before embarking on SB 10. While their research examined multiple states, this section examines six other states' MRW efforts with similar characteristics to Texas. Table 5 provides information on the characteristics of Texas and the six other states, all which are at different stages of the MRW effort.

Examining the Medicaid data across the states, Texas has the highest percentage among all the states for children enrolled on Medicaid, yet it has the lowest enrollment rate for adults. This is because in order for working parents to qualify for Medicaid they must earn less than 21% of the FPL, that is \$3,605 a year for a family of three. If states are addressing the uninsured issue through the MRW, it is incumbent upon all states to address their current Medicaid rules and eligibility; one cannot be done without the other.

Table 5
State Characteristics: Residents, Uninsured, and Medicaid Eligible's

Characteristics	TX	CA	FL	OR	AZ	NM	ID
Total Residents	23 million	36 mil	18 mil	3.6mil	6.1mil	1.9mil	1.4mil
% Near Poor: 100-199% FPL	22%	20%	20%	20%	21%	22%	23%
Age: Kids (0-18)	30%	28%	24%	25%	28%	28%	29%
Age: Adults (nonelderly)	59%	61%	60%	62%	60%	59%	60%
White	48%	44%	61%	81%	57%	44%	87%
Black	11%	6%	15%	2%	3%	2%	0%
Hispanic	36%	36%	21%	9%	32%	42%	9%
Other	4%	14%	3%	8%	7%	12%	4%
Non-Citizen	11%	16%	11%	6%	11%	7%	3%
Total %of Uninsured	24%	19%	21%	17%	20%	22%	15%
% of Uninsured Children and Adults of all the uninsured population							
% Children Uninsured	26%	21%	22%	19%	24%	25%	24%
% Adults Uninsured	74%	79%	78%	81%	76%	75%	76%
% Uninsured Near Poor: 100-199% FPL	32%	31%	31%	31%	33%	35%	39%
% of Insured by source of insurance coverage							
Insured: ESI	54%	53%	56%	60%	53%	50%	61%
Insured: Direct Purchase	8%	5%	6%	6%	4%	5%	7%
% of Insured on Medicaid	13%	13%	11%	12%	17%	18%	13%
% of Medicaid Children and Adults of all Medicaid Enrollees							
Kids on Medicaid	72%	58%	62%	57%	55%	65%	62%
Adults on Medicaid	28%	42%	38%	43%	45%	35%	38%
Medicaid Eligibility levels and Federal Poverty Level (FPL)							
Working Parents	21%	107%	58%	100%	200%	65%	43%
Pregnant Women	185%	200%	185%	185%	133%	185%	133%
Infants	185%	200%	200%	133%	140%	235%	133%
Kids: 1-5	133%	133%	133%	133%	133%	235%	133%
Kids: 6-19	100%	100%	100%	100%	100%	235%	100%

Other States' MRW Efforts:

We examine Arizona, California, Florida, New Mexico, Idaho, and Oregon MRW policy strategies and approaches. This is a snapshot of their efforts (Appendix C provides more analysis):

- **AZ:** Expanding coverage to childless adults and parents of SCHIP and Medicaid clients.
- **CA:** Expanded coverage of parents, caregivers, legal guardians to SCHIP clients.
- **FL:** Cornerstone of the reform initiative is to change the Medicaid Benefit Package.
- **NM:** Expanded coverage to SCHIP parents and childless adults through employers.
- **ID:** Increased affordable private health insurance to low-income individuals.
- **OR:** Expanded coverage to all below 185% FPL.

Table 6 is a State 1115 Waiver Comparison Matrix which summarizes the MRW policy options in the six States and Texas.

Table 6: State 1115 Waiver Comparison Matrix

Medicaid Reform Waiver Policy Strategies	TX Health Care Reform (pending)	CA Parental Coverage Expansion 1115 Waiver HIFA (7/2002)	FL Medicaid Reform (7/2006)	AZ Health Care Containment System 1115 Waiver (10/2006)	OR Heath Plan (11/2002)	NM 1115 HIFA (7/2005)	ID Children's Access Card Program 1115 HIFA Waiver (11/2004)
Proposal Years Projected Cost	5 Years @ \$304 million (1 st Yr)	6 Years @ \$1.36 billion	5 Years @ \$20.6 billion	5 Years @ \$189 million	5 Years @ \$166 million	5 Years @ \$48 million	5 Years @ \$2 million
Eligibility: Below 100% FPL At or Below 100-200% FPL	Uninsured Parents of SCHIP & older sibling up to 21, Childless Adults (≤200% FPL)	Uninsured Parents, Caregivers, Legal Guardian of SCHIP - (≤200% FPL)	TANF related groups (1931Eligible's)	Uninsured Parents of SCHIP - (≤200% FPL) Childless Adults (≤100% FPL)	Low-income family Eligible for Medicaid, Low-income Adults (≤ 100% FPL) SCHIP/ Medicaid eligible children	Uninsured Parents of SCHIP, Childless Adults (≤200% FPL)	Children - (≤ 150% FPL) Children Expansion - CHIP plan B for PA (≤ 151-185% FPL) Adults - Small business workers (≤ 185% FPL)
Benefits Packages: Coverage Programs	<i>Limited Benefit Services</i> -Basic Primary & Preventive services. <i>Premium Assistance</i> -Determined by private coverage.	<i>Same Benefits Service:</i> SCHIP package with limited hearing & dental and higher premiums.	<i>Customized Benefit Packages (CBP)</i> - Covers mandatory services but amount, duration and scope based on population; <i>Over Standards for CBP</i> -Preapproved services by the state; <i>Risk Adjusted Premium Development for CBP</i> -Separate Medicaid premium into comprehensive care and catastrophic care	<i>Benefits Coverage includes</i> - Inpatient/ Outpatient hospital services, ER Care, Physician Services, Outpatient health Services, Lab, X-rays, Pharmacy, behavioral health and acute care	<i>OHP Plus</i> - comprehensive services for Medicaid/SCHIP (low-income elderly, disabled, TANF eligible) <i>OHP Standards</i> - Reduced Benefits Package to Adults <i>Family Health Insurance Assistance Program (FHIA)</i> - Determined by private coverage plan	<i>Premium Assistance:</i> Determined by private coverage and market	<i>Same Benefits Service:</i> Medicaid Services <i>Premium Assistance</i> - Determined by private coverage & includes comprehensive coverage, Doctor's visits and inpatient hospital services
Premium Assistance (PA) Programs	<i>SCHIP HOP Pool</i> - provide PA for parents and kids to purchase ESI. <i>HIPP HOP Pool</i> - provides PA for parents and kids to purchase ESI. Local/regional health coverage programs to be eligible for HOP funding – PA for certain employees of small employers less than 50		<i>Employer Sponsored Insurance (ESI)</i> -Opt-Out mechanism of Medicaid to purchase ESI with their premium	<i>Limited PA Subsidy</i> – Reliance on employer and employees to pay premium.	<i>Family Health Insurance Assistance Prog. (FHIAP)</i> - Assist low-income families pay for premium and cost-related expenses	<i>NM State Coverage Insurance</i> - Enables low-wage worker to purchase ESI with <i>Public-Private Partnership</i> .	Children - Medicaid Opt-Out (≤ 150% FPL) Children -Expansion-CHIP B (≤ 151-185% FPL) Adults - Small business workers (≤ 185% FPL)
Healthcare Pools			<i>Low Income Pool (LIP)</i> - Established and maintained for the allocation of resources to safety net providers who provide coverage				

Table 6: State 1115 Waiver Comparison Matrix

Medicaid Reform Waiver Policy Strategies	TX Health Care Reform (pending)	CA Prenatal Coverage Expansion 1115 Waiver HIFA (7/2002)	FL Medicaid Reform (7/2006)	AZ Health Care Containment System 1115 Waiver (10/2006)	OR Heath Plan (11/2002)	NM 1115 HIFA (7/2005)	ID Children's Access Card Program 1115 HIFA Waiver (11/2004)
Health Incentives	<i>Promoting Healthy Lifestyles Incentive Pilot</i> - Utilizing health-related programs to improve health outcomes.		<i>Enhanced Benefits Accounts (EBA)</i> Program- health incentive program to promote healthy behaviors and accrued funds for meds.				
Health Opportunity Accounts	<i>Health Saving Account Pilot</i>		<i>Enhanced Benefits Accounts (EBA)</i> Program				
Cost- Sharing	≤ 150% of FPL: Sliding Scale	Premium -\$10mo (≥ 150%FPL) Co-Pay - Same as State Employee Scale (Family cap-\$250)	Pre-approval sliding scale of co-pays expect for ESI option which is determined by ESI plan	<i>Arizona Acute Care Program (AACP)</i> – Not exceed nominal cost limits but co-pay (\$4-\$30). <i>Arizona Long Term Care System (ALTCS)</i> – Monthly premiums for ≤ 400% FPL that can not exceed 2% of annual adjusted gross income of household for families 400-500% FPL. <i>Arizona HIFA</i> - Childless Adult required to pay premium not exceed 5% of net household income.	<i>OHP Plus</i> - No Premium and Co-pay- (\$2-3) for dental, outpatient & meds	Premium - None (≥ 100% FPL) Co-Pay: Required for all (\$5-\$20) <i>Out-of-Pocket Cost</i> : Not exceed 5% of family income	<i>Premium Assistance</i> - Determined by private coverage
At or Above 100% FPL	Not determined yet	Premium - \$20 mo. (≤ 150%FPL) Co-Pay - Same as above			<i>OHP Standards</i> - Premium (\$9-20) <i>FHIA</i> - Determined by private coverage plan	Premium - \$20-35mo (≤ 100% of FPL) Co-Pay - Required for all (\$5-\$20) <i>Out-of-Pocket Cost</i> - Not exceed 5% of family income	
Provisions: mandates, market reforms	All participants required, if applicable, to apply for ESI.	Continuous Coverage - Up to 2 mo. of transitional coverage from Medicaid to SCHIP. Purchase 3 months premium in advance and get 4 months free for families.		Budget Neutrality, IMD phase down, Premium for parents of long term care, eliminating rate setting waiver, ESI for children and childless adults, fraud recover, family planning re-determination and spouse as paid care giver.			

Summary: Comparative States

What are some preliminary findings from these comparative states which Texas might find useful as it proceeds with its Medicaid Reform strategy? The preceding MRW reviews of the six states illustrate insufficient evidence of verifiable success in reducing the number of uninsured, minimizing or reducing health care costs, or improving the quality of health care. Appendices C and D provides added information to preliminary findings summarized here.

California's MRWs approaches are the most comprehensive in scope of the comparison states, and clearly part of the State's overarching goal to achieve a form of universal coverage. Recent legislation to move to universal coverage failed by a slim margin, and CMS denied its most recent MRW proposal to expand eligibility for Medicaid and SCHIP. Nonetheless, the State appears to have some promising health care safety-net practices for those on Medicaid, SCHIP, and those who are ineligible for public health insurance coverage. Also, its cost sharing components support expanded wrap-around services to more individuals. The State also proportionately contributes more financially to Medicaid than other states reviewed.

Florida's pilot-focused MRW initiative in 2006 experienced policy and programmatic challenges. During the rollout process, the State lost provider support and enrollees voiced dissatisfaction. In the fall of 2007, the project came to a halt.

Arizona appears to have had some success in expanding health care coverage to adults employed in small businesses through a tri-share program. The State's approach has been incremental and tends to limit the health benefits it will support with any subsidy. In the beginning Arizona provided a limited amount of financial subsidies while relying on the employer and employee to pay most of the premium cost. Today employers and employees pay into the benefit package without State funding.

Among the comparison states, Oregon appears to have the most extensive experience with health care reform initiatives dating back to the early 1980's. In 2002, the Oregon Health Plan (OHP) expanded coverage to 185% FPL and developed benefit packages based on population need. In 2003, the state experienced a budget shortfall and cutback on the Plan. This resulted in a reduction in enrollment numbers (by 46%), and a decrease in continuity of care; the poorer enrollees were hit hardest, medical debt was incurred for previous enrollees, and former enrollees experienced declining health. Oregon's rollercoaster ride from comprehensive to limited funding for the OHP highlights unintended consequences that can occur when a system's funding is dramatically changed. Oregon now finds itself having to conduct a lottery in which over 80,000 of the State's 600,000 uninsured individuals applies to win only 1 of 3,000 OHPs expansion slots available.

New Mexico's efforts are similar to Arizona's. The State is focusing on increasing health care coverage for individuals employed in small businesses. They are implementing a 3-tier benefit program to coincide with different eligibility and cost-sharing options.

Idaho is targeting the Medicaid and SCHIP population, but also offering different benefit packages for different target populations: low income, special needs, and the elderly. Both New Mexico and Idaho are implementing their respective MRW initiatives, and plan for yearly increases in coverage expansion.

Unquestionably, each of the comparison states have much more detailed history regarding their effort to cost-effectively operate their Medicaid and SCHIP programs by the “best-fit” (financial resources and political/policy environment) and approaches possible. The use of the Medicaid Waiver process and the DRA will continue to provide both opportunities and barriers to address the health issues in their states.

After reviewing these six states, we conclude undoubtedly that external factors influence the ability to decrease the number of uninsured while also decreasing the impact of health care costs on state budgets. The MRW experience is only one piece of a much bigger puzzle in health care reform, and the insight provided in this document is not exhaustive. Because many of these state reform efforts are in their infancy, there is limited evidence at this time in measuring the outcomes and goals of these MRW efforts. We can, however, glean the following from some of the states’ efforts:

- Efforts are diverse in programming and funding schemes—no two states are alike.
- There are complex internal and external factors to consider when a state is implementing an MRW program.

Some examples of issues arising in the states we reviewed that Texas should examine are:

- Raising premiums for enrollees negatively impacts enrollment (Oregon)
- Stakeholders like providers and health plans should be at the table (Florida)
- Tri-shares show promise (Arizona and New Mexico)
- A state can maintain a strong safety net while implementing an MRW (California)

True health care reform may be an untenable position without stronger national health policy reform leadership and action. The continued rise in health care costs is often outside the control of individual states.²²

As such, Texas, like all other states, must communicate to the larger community that the State cannot by itself reform health care. Federal and local level collaboration and resources are necessary, particularly in any realistic reduction or long-term goal to ameliorate the number of uninsured individuals and families. The State must be realistic in its goals for reform, and it must be willing to invest resources and address regulations of costs.

V. EXAMINATION OF MEDICAID REFORM

One of the main goals for Medicaid reform should be that the final benefit package(s) decisions lead to beneficiaries truly having a regular medical home where quality preventive and cost-effective chronic care management is the norm. At the same time, several critical questions arise regarding what possible impact or success will result from the Texas MRW proposed program in *Phase I*. Questions include:

1. Will the benefits reflect the needs of the target population and will there be choices for enrollees?
2. Does the State's financing mechanism support the proposed HOP model?
3. What amount of premium and cost-sharing responsibility will be required of enrollees?
4. Is the Texas employer climate ready to invest in health care benefits?
5. Will uncompensated care be reduced?

A. Benefit Package(s)

The anticipated take-up rate under the above scenario is projected at 41%. The Interactive Benefit Model (IBM) is intended to show effects of benefit, cost-sharing, and other input adjustments (see Appendix D). Below you will see the differences in the proposed benefits and current Medicaid benefits:

Benefit	Proposed Benefit	Current Medicaid Package
Inpatient Hospital Days	3 days	30 days
Prescriptions (service Limit)	30	36
Mental Health and Substance Abuse Visits	18	No limit under clinic services: mental health clinic
Preventive Visits and Other Visits	14	unlimited
Psychologist	No information	30

The proposed package, which was developed by an outside consultant for HHSC, represents a benefit package with service limits below those provided under the current Medicaid program or most large employer-sponsored health insurance plans. Arguably, benefits may be considered robust for a healthy population but not if a sizeable portion of the target population has one or more chronic illness conditions.

While HHSC proposed that enrollees will have a choice among benefit plans, what precise benefits or number of plans offered is decided. Also, it is not known what benefit packages the private insurance carriers will be interested in supporting whether through an employer or on the individual market. The insurance industry has not expressed a public stance.

In addition, caution is warranted regarding whether enrollees will have real choice. According to recent MRW incidences in other states regarding choice, enrollees were required, or at best misled, into accepting a benefit plan not suited to their needs.²³

B. Available Financing

HHSC presented several example scenarios using the Interactive Benefit Model referenced in Section III.B. The HHSC scenario (Appendix E) indicates that 199,687 parents could enroll in the program at a cost of \$429 million which is well above the \$304 million investment described in the State's MRW financing model. The proposed scenario indicates a subsidy of \$140.00 Premium Member Per Month (PMPM). Physicians, hospitals, and other health providers will be reimbursed at Medicaid rates that are well below the national average. Health providers generally agree this expansion of Medicaid, without fixing reimbursement rates, impedes physicians, particularly specialists from accepting patients or joining provider networks.

At this juncture, available financing for the HOP is not known. Negotiations are on-going with Continuing Medical Education and other opportunities for Certified Public Expenditures for increasing the State match are being explored. While the State continues to move on with the proposed MRW, critical stakeholders are missing. The Texas Hospital Association (THA) and Texas Medical Association (TMA) do not support the proposed financing strategy in HHSCs proposal dated Dec 5, 2007.²⁴ They noted that "HHSCs current annual Medicaid payments to hospitals are some \$1.2 billion less than the cost to provide those services."²⁵ Therefore, while the proposed MRW financing model creates some monies (\$304 million) it is far from sufficient to curb the huge dollar shortfall and uncompensated care demand in Texas.

Providers and health care organizations are concerned about the financing for Texas' proposed MRW, but more importantly, the small investment of \$150 million by the State will have a small impact on increasing eligible enrollees under the MRW project. HHSCs strategy for the determination of financing available will be a decision that will either provide affordable benefits that cover more individuals or provide a more expansive benefit available to a fewer individuals.

C. Cost-Sharing

A major pillar of the DRA is to reduce federal spending. States increase or implement co-payments and premiums to decrease government expenditures in Medicaid and at the same time expect to be able to provide an affordable benefit and create a sense of consumer responsibility.

There is no doubt that there will be premiums and cost-sharing requirements by enrollees in the Texas Medicaid Waiver. The premium amount will be based on the family's income. The Texas co-pays for "point of service" illustrated in the benefits model are not large but they will add-up depending on the frequency of service use. The maximum allowable annual healthcare expenditures are capped at \$25,000. A central argument of SB10 and the MRW proposal on these points is to "create a culture of insurance."²⁶

D. Employer Sponsored Insurance

A cornerstone of the Texas MRW proposal is focused on increasing ESI through the HOP particularly, addressing the issue through the small business employer. According to the Texas Department of Insurance, Texas has:²⁷

- A large proportion of workers employed by small businesses. Almost 400,000 small businesses employ nearly 3 million Texans, but only about one in four of these companies offer health insurance to their employees.
- Many workers are in industries that have traditionally not offered health benefits, such as construction, agriculture, retail sales and service positions.
- Relatively little union activity in comparison to those states where unions have driven the issue of health insurance.
- The number of small businesses offering ESI has slowly been declining, from 1.4 million individuals covered in 2000 to 1.1 million in 2005 among an approximate 22% (86,106) of all small businesses.
- In general, a lower rate of participation in public programs such as Medicaid and CHIP.

The average group health insurance premiums for Texas employers rose from \$2,193 for single coverage in 1997 to \$4,138 in 2004; and average family premiums have increased from \$5,693 to \$11,196. A TDI survey of small employers (2 to 50 employees) **in 2004 resulted in 69% of the employers indicating that the maximum monthly contribution they could afford was \$100 per-employee-per-month, and 14% said they could not afford any amount of contribution.** The Texas Legislature enacted some market-based initiatives intended to address the inability for ESI among small employers. Their review is outside the scope of this report. However, general information to date indicates a very small impact in helping to reduce the large number of uninsured in the State (some emanating from the Blue Ribbon Task Force on Uninsured Texans in 1999-2000).²⁸

Overall growing health benefit costs must be reviewed given the policy implications of State MRW efforts. Health insurance premiums increased 78% between 2001 and 2007, outpacing cumulative wage growth of 19% during the same period. The impact of these rising costs on different size business establishments and occupations is salient to HHSC/MRW projections for small businesses that provide ESI and it will influence their participation. After all, will businesses that offer ESI be able to afford it without some subsidy for their qualifying employees.

A recent analysis of health benefits among employers and employees found a wide range of cost exposure over time and by occupation and establishment size. A particularly important finding by the Kaiser Family Foundation in its publication, *Employer Health Insurance Cost and Worker Compensation* notes “Employer costs per hour for health insurance were higher for workers in higher wage occupations than for workers in lower wage occupations, but overall employer cost represented a lower percentage of payrolls for workers in high wage occupations than for workers in low wage occupations.”²⁹ This finding is complementary to other policy research findings regarding ESI offered, their benefit and affordability, and take-up rates among different size establishments.³⁰

E. Will SB 10 reduce uncompensated care in Texas?

One goal of the Texas Medicaid Waiver is to reduce the uninsured. That being stated, it is difficult to link a state's uninsured number to a waiver like this. The waiver alone cannot fix the uninsured problem – it is only one piece of a much bigger puzzle. As a matter of fact, two major Texas stakeholder organizations, the Texas Hospital Association (THA) and Texas Medical Association (TMA) stated that SB 10 will not reduce uncompensated care as outlined in the HHSC/MRW proposal. In a larger context, HHSC, TMA, THA, and the Texas Association of Public Hospitals disagree on the annual level and method for determining uncompensated care in Texas.³¹

The Texas Medicaid Waiver will be successful if it can enroll its priority population and increase its capacity with quality benefits and affordability. Persons become uninsured for multiple reasons and it is troublesome that a project this small (9% of 1.2 million under 200% FPL) would be called upon to reduce the uninsured in Texas.

In addition to the multiple factors of being uninsured, hospitals, particularly public hospitals, have statutory requirements to service low-income or indigent populations without health insurance. They are legally-bound to provide emergency care regardless of residency or legal citizenship status, so even with Texas Medicaid reform, hospitals are bound to provide care to the uninsured. Noteworthy among the issues of uncompensated care is the scarcity of research examining the demographics and geography of the uninsured and the type of hospitals where they receive care. With those two attributes, the State and the federal government would have information to develop objective policy responses that have a better chance of hitting the right target population.

VI. ISSUES OF DIVERSITY AND ACCESS

The uninsured population in Texas is a diverse population. There are many challenges Texas faces in reducing the uninsured, and it is important that social and environmental issues facing the uninsured and disparities of the uninsured are understood so that solutions are created in a realistic manner.

It is critically important to give attention to how best to understand the target population's perspectives and elasticity to afford health insurance given that there are individuals and families:

- with low-incomes;
- with education and literacy levels (English and Spanish) that challenge the appropriate navigation and use of an already bureaucratic and often uncoordinated health care delivery system (particularly if the individual has a chronic disease);
- without the informed capacity to make sensible choices about health benefits;
- who live in neighborhood environments that do not support healthy behaviors including safety; or
- who are on and off health care coverage, which results in poor health status.

The insecurity on this last point is more often the result of fluctuations in private/public health care coverage. Medicaid constantly changes eligibility, benefits, or financing; parallel to that are the rising cost-sharing requirements in employer sponsored insurance or individuals with non-group health insurance.³² Also, insecurity impacts some population groups more than others.³³

As stated before, 5.6 million people are uninsured in Texas and of that number, 4.1 million are adults (19-64).

- Of the estimated 2.3 million uninsured adults who earn at or less than 200% FPL, 1.4 million are qualified for the MRW.
- Of the 1.4 million, 47% are Hispanic, 19% Black, 31% are White
- 74% of the uninsured below 200% FPL are under 150% FPL

Table 7: Uninsured Adult (19-64) Population by Race/Ethnicity and FPL

Population	<150% FPL	150 - 200% FPL	Total's
Hispanic	500,522	178,346	678,868 (47%)
Black: Non-Hispanic	220,325	61,001	281,326 (19%)
White: Non-Hispanic	317,408	128,390	445,798 (31%)
Other	32,508	10,259	42,767 (3%)
Total	1,070,760	377,996	1,448,756 (100%)

Source: Census Bureau – Current Population Survey 2007

Note: This table does not reflect uninsured Non-citizens

The demographic breakdown of the *Phase 1* population, which is 21% of the total number of the State's uninsured adults at <200% FPL are:

- Almost 2/3 of the priority population is female.

- The older age bracket, 35-64, has a higher uninsured rate.
- Hispanics make up 73% of the priority population.
- 83% of the priority population earns less than 150% FPL.

Table 8: Uninsured Parents of Medicaid/CHIP Children*

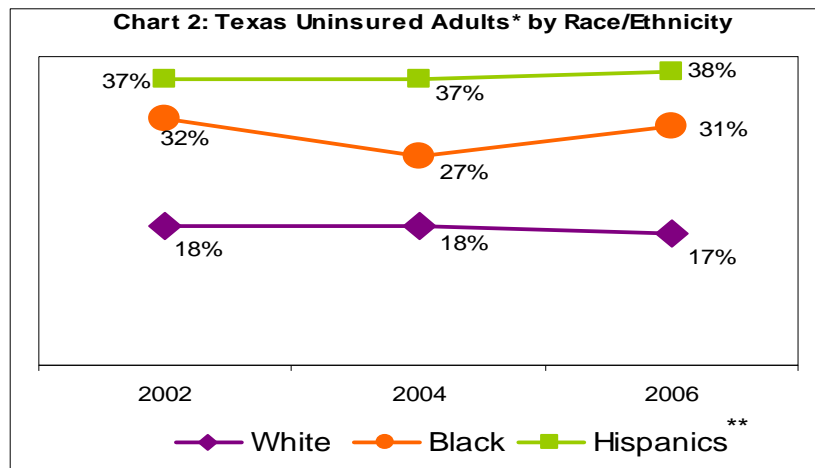
Population	<150% FPL	150 - 200% FPL	Total's
Female	257,711	47,803	305,514 (63%)
Male	147,072	30,237	177,309 (37%)
		Total:	482,822
Age 19 – 34	173,677	36,895	210,572 (44%)
Age 35 – 64	231,105	41,145	272,250 (56%)
		Total:	482,822
Hispanic	303,118	47,588	350,706 (73%)
Black: Non-Hispanic	34,524	10,581	45,105 (9%)
White: Non-Hispanic	61,985	16,758	78,743 (16%)
Other	5,156	3,113	8,269 (2%)
		Total:	482,822

The Uninsured

Blacks and Hispanics have a higher uninsured rate than their White counterparts. Hispanics represented 59% of the State’s total uninsured population in 2006 compared to their State population representation of 35%. Their uninsured rate is 38% and remains twice that of White Non-Hispanics after adjusting for Non-Citizenship. Chart 8 captures the ethnic breakdown of Texas uninsured adults by race/ethnicity. Also seen in this chart:

- The uninsured rate for Hispanics remains steady and high (38%);
- The uninsured rate for Blacks decreased in 2004 but increased in 2006 (31%); and
- The White uninsured rate has decreased (from 18% to 17%).

What is not seen in this chart, but has been researched and reported elsewhere, is that Hispanic and Black children uninsured numbers are increasing (27% and 23% respectively in 2006 compared to a decline to 11% for White Non-Hispanics).



Source: US Census Bureau: CPS 2003-2007, *Adults are individuals 19-64 ** Hispanic includes only native & naturalized citizens.

Table 9
Texas Uninsured Citizens by Race/Ethnicity and Educational Attainment

Education	White	Hispanic	Black
No high school diploma	22%	36%	28%
High school or equivalent	19%	41%	36%
Some college, less than 4-yr degree	13%	29%	23%
Bachelor's degree or higher	5%	16%	15%
All Educational Levels	13%	34%	28%

Note: Percentages reflect individual racial/ethnic and educational attainment sub groups and will not add to 100%

The table presents a glimpse into what the chart above illustrates. The table shows educational attainment and race/ethnicity for uninsured adults in Texas who are citizens.

- Blacks and Hispanics with a bachelor’s degree are uninsured at rates three times higher than Anglos (16% versus 5%)
- Those with higher education have lower uninsured rates

The chart and table presented in this section raise questions about the demographics of the uninsured and the insured. Being uninsured has linkages to race/ethnicity and educational attainment, but other factors that impact access to health insurance are job sector issues, employer size, health benefit costs, wages, and more.

The Insured

In 2006, 75% of the Texas population was insured either through private or public coverage yet, even for the insured, coverage problems are increasing. With health care costs in Texas being higher than the national average, businesses are offering less insurance and employees are not accepting or are not being offered health insurance. The rising number of uninsured among “middle-class” economic groups (because of cost) will further challenge State reform efforts.³⁴

The racial/ethnic breakdown of the Texas insured population in 2006 was:

- 87% of White Non-Hispanics had insurance coverage of which 65% had employment-based health insurance, 6% Medicaid, and 12% Medicare.
- 74% of Blacks had insurance coverage of which 47% had employment-based health insurance, 18% Medicaid, and 11% Medicare.
- 69% of Hispanics had insurance coverage of which 41% had employment-based health insurance, 23% Medicaid, and 8% Medicare.

The State and its legislators must keep in mind that health insurance should provide the opportunity to maintain good health and not add to the risk of financial health care debt, just as

the goal for Medicaid Reform should be to provide a medical home where prevention and management is the norm. Having health insurance coverage will increase the likelihood for Texans to have regular access to a medical home for preventive primary care or when an unanticipated health care need arises.

As the Nation and Texas move forward in Medicaid reform, it is clear that they must recognize the characteristics of the uninsured and their target populations and the insured, and understand and respect their environments. There are abundant literature and research regarding ‘health care determinants’ and their relationship to health and health care disparities. The determinants include income, education, employment patterns, language, neighborhood environments, etc. which can assist state health and human service systems to better understand and improve their effectiveness in addressing the disparities in the populations they are serving. The objective is to create equity and reduce disparities, not increase them.

VII. CONCLUSION:

This paper presented an overview of the efforts and challenges facing health care reform at the state and national level. There is consensus of a health care crisis and government is responding through multiple policy initiatives. Texas' current reform effort, through the Health Opportunity Pool (HOP), is the result of the 2005 federal Deficit Reduction Act and the State legislature's willingness to address the uninsured. Yet is that enough?

As the State continues to engage in health policy reform, it must address some important questions:

- a) How does Texas reform Medicaid without negatively impacting the State's Safety Net?
- b) Is Texas willing to invest significant resources in implementing reform?
- c) Does the State understand the characteristics of the population they are trying to insure?

Another important issue is community and stakeholder engagement; many key stakeholders and voices were left out of the SB 10 development process. As the State moves forward, it should consider the following:

- Collaborate with strategic partners and stakeholders like community health centers, public health offices, and private primary care practices.
- Explore a more accountable role for primary care collaboration with State academic health science centers; they can play a pivotal role in developmental design. These provider settings can have a significant role in strengthening and expanding primary preventive health care.
- Involve the countless experts and affected communities early in the policy development process. Not only does it reflect a stronger transparent investment, it also is simply good policy because it improves the opportunities to find solutions.
- Communicate with communities most impacted by health and health care disparities. Hispanic and Black communities should be engaged through targeted venues including front-line community organizations, and civic or faith-based groups. Linking/dialoguing with a reasonable sampling of businesses in which these community members are employed is another possibility; their engagement and involvement in this process has been minimal and/or non-existent.

Texas's attempt to reform Medicaid will not be successful if it takes minimal steps toward health care solutions. The federal DRA is somewhat responsible for that, because it has burdened states with a paradigm of cost savings and reducing the uninsured; the DRA is virtually forcing solutions to be rolled out incrementally. At the same time, Texas should be concerned about reducing the racial health disparities that will only get worse if not addressed.

Lastly, Texas should be mapping out a long term access to care vision so that more people are insured and those who are impacted by reform have a regular medical home where quality preventive and cost effective chronic care management are the norm without stressing our State's safety net. The opportunities presented by the new Obama administration's vision for change to our health care system luckily coincide with Texas' need to retool its previous effort to reform Medicaid.

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VIII. APPENDICES

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Appendix A: Texas Medicaid Reform Waiver – Hospital-Based Financing Terminology

- **Cost Based** – Reimbursement to hospitals based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rules which reimburses hospitals for their allowable costs. This is to be distinguished from DRG-based reimbursement, whose rates are prospectively determined.
- **Inter-Governmental Transfers (IGTs)** – Methodology employed by Texas to obtain state match for Federal funding and does not require General Revenue. IGT has limitations in that only public funds can be used (only transfers between governmental entities), the result is a limitation in the available non-General Revenue funding to match Federal funds and potential Federal revenue is lost.
- **Disproportionate Share Hospital Reimbursement (DSH)** – Federal law requires Medicaid make payments to hospitals serving a disproportionately large number of Medicaid and low-income patients. Federal funding to Texas is capped. Texas uses IGTs to fund the state match.
- **Upper Payment Limit (UPL)** – Financing mechanism used by Texas to provide supplemental payments to hospitals. The basis for this funding is the difference between what Medicare and Medicaid pays for essentially the same patient. The formula results in increased payments because Medicare’s aggregate payments are higher than Medicaid’s. Texas uses IGTs to fund the state match.
- **Graduate Medical Education (GME)** – Medicaid provides payments to hospitals to support its share of direct costs related to medical training programs and to support higher patient care costs associated with the training of residents.
- **Diagnosis Related Group (DRG)** – A method for grouping hospital patients using diagnoses.
- **Standard Dollar Amount (SDA)** – The value that determines the individual hospital’s Medicaid reimbursement payment. Each hospital has its own SDA which results from dividing its average cost per admission by its CMI. This calculation essentially “standardizes” the standard dollar amount.
- **Ratio of Costs to Charges (RCC)** – Providers claims for reimbursement are stated in terms of charges. Medicaid, which pays “allowable costs” converts charges to costs for the hospital. The RCC is the basis for making this conversion. The RCC is derived from an analysis of the providers Medicare cost report. The analysis determines allowable costs and then creates the RCC by dividing costs by charges.
- **Uncompensated Care** – Identifies the costs for a hospital resulting from the provision of treatment to patients who are unable to reimburse the hospital for their care. Formally defined as the sum of a hospital’s bad debt expense and its charity care.
- **Rebasing** – Updating to a more recent year the data used to calculate the hospitals’ SDA payment. The effect of rebasing is to capture changes in cost that impact the amount of Medicaid allowable reimbursement paid to a hospital.
- **Medicaid Hospital Shortfall** – Hospital costs for providing treatment to Medicaid patients which are allowable under Medicaid rules but are not reimbursed because the DRG-based payment does not fully reimburse the full amount of these costs. Shortfall costs that originate in the SDA reimbursement system are passed to the DSH system where they are reimbursed.

Appendix B: Texas Medicaid Reform Waiver HOP Expansion Groups

HOP Expansion Groups:

1. Health Insurance Premium Payment Program (HIPP): Intended to reinforce and support ESI private insurance market.

- *New Medicaid Eligible's Group* is required to enroll in available cost effective ESI plans.
- State reimburses Medicaid eligible's for premiums and pays providers for other cost sharing, co-pays, and co-insurance deductibles.
- State will not provide Medicaid covered wrap-around services not covered by ESI plans.
- If cost effective, State will subsidize premiums for related family members but not eligible for cost-sharing support.
- Medicaid eligible's with access to ESI which is not cost effective can "opt-out" of Medicaid and "opt-into" HOP- funded private coverage plan but are:
 - Limited to cost per month per member for Medicaid services.
 - Not provided Medicaid wrap-around services
 - Responsible for all other costs.
 - Individual has right to resume Medicaid coverage
- *HIPP HOP Group* will allow families to combine parents/other qualifying family members with subsidies with available children's HIPP premiums.
 - Provide subsidy to the parent(s)/other eligible family members for ESI coverage.
 - All cost sharing will be the responsibility of the individual(s).
 - No wrap-around services will be provided.
 - If ESI is unaffordable, individuals have option to use subsidy for approved basic HOP funded coverage through private health insurance carriers.

2. CHIP-Premium Assistance (CHIP-PA) Program Group: Option to allow families to combine parents/other qualifying family members subsidies with available CHIP children's premiums to subsidize ESI.

- All cost sharing will be the responsibility of the individual(s)
- No wrap-around services will be provided
- If ESI is unaffordable, individuals have option to use subsidy for approved basic HOP funded coverage through private health insurance carriers.

Appendix C: State MRW Comparison Reviews

Case Study: *California Parental Coverage Expansion 1115 Waiver HIFA (7/2002)*

Demographics-While larger than Texas, California’s demographic composition share similar traits.¹ The State has a history of steady growth in the number of uninsured, accounting for 21% of the population in 2006. The largest segment of the uninsured population is adults (79%) and “Uninsured Near-Poor” accounts for 31%. Californians with ESI represented 53% of the insured population, slightly less than Texas.

Waiver- The State is experiencing comprehensive health care reforms that seek to utilize a multifaceted strategy that includes waivers, expansion of safety nets and state mandates to achieve a universal health care approach. The legislative reforms included the Health Security and Cost Reduction Act,² which sought to mandated employers with 10 or more employees to provide health insurance coverage – the legislative was not approved by a narrow margin.³

The State has implemented multiple MRWs (4) which are currently active. One example, the California Parental Coverage Expansion Waiver expanded coverage to the uninsured population while providing a comprehensive benefit package used to leverage to support for the failed Health Security and Cost Reduction Act.⁴

California MRW Impact		
Reduce Uninsured	Reduce Cost	Improve Quality
<p style="text-align: center;">↑ Uninsured ↑ Medicaid</p> <p>Uninsured rate steadily increased 2002-2006, 17.7% to 18.8%. Medicaid enrollment steadily increased 1999-2004, 13.5% to 16.7%. Slight decrease in 2005 and 2006, 15.8% and 16% respectively.</p>	<p>The State’s average annual growth expenditures are 5.7% which is the lowest among the comparison states for the period 1991-2004.</p>	<p>Improvements in health care quality are unclear.</p>

Case Study: *Florida Medicaid Reform (7/2006)*

Demographics- Florida’s (FL) Medicaid Reform was a case study for the Bush Administration’s new overall approach to reform the Medicaid Program. In comparison to Texas, Florida’s pilot Medicaid Reform strategies are closer aligned with the strategies drafted in the Texas MRW proposal. Florida’s uninsured population is 21%, and ESI coverage is 56%. The State has less uninsured children and fewer children on Medicaid than Texas.

¹ State Health Facts- Demographic Profile 2005-2006 for TX, FL, CA, NM, AZ, OR, Kaiser Family Foundation

² Fixing Our Broken Health Care System- The Governor’s Health Care Plan, State of California, Jan 2007

³ California Senate Committee Rejects Health Care Reform bill. Silicon Valley/ San Jose Business Journal, January 29, 2008

⁴ California Demonstration Fact Sheet, Center for Medicare and Medicaid Services , October 3, 2005

Waiver- The State has had many policy and programmatic challenges. Their MRW “pilot” strategies targeted four, and TANF related populations to participate in reforms that encompass a comprehensive and catastrophic coverage financing support mechanism, Enhanced Benefit Accounts (EBAs), and Medicaid Opt-Out, and direct premiums for ESI.⁵

Recent evidence reveals that the State’s Medicaid Reform Program has resulted in a decline in Physician participation in the Medicaid program. A Georgetown survey found that of the 186 participating Physician in 2 counties more than 25% are no longer accepting Medicaid beneficiaries. Fifty-one percent stated that restrictions and requirement made it difficult to provide medically necessary services. Two-third of the physicians who no longer participate are specialists.⁶

Echoed in the St. Petersburg Times of Tampa Bay, the State’s health care agency announced that Florida “is not ready to make Medicaid more like private managed care statewide” and would not push lawmaker to expand the pilot program. The drastic move came on the heels of a report by the agency’s inspector general in October of 2007 which recommended moving slower to revamp the system and gather more information.⁷

Even though, the majority of State’s Medicaid Reform Initiative affects children and other TANF related groups, the policy relevance to Texas is telling as a cautionary note. Their policy strategies such as premium assistance, health incentives programs, health saving accounts, and cost-sharing are similar.

Florida MRW Impact		
Reduce Uninsured	Reduce Cost	Improve Quality
<p>↑ Uninsured ↓ Medicaid</p> <p>Uninsured rate steadily increased during 1999-2006, 17.8% to 21.2%. Medicaid had been steadily increasing up-to 2004, then dropped to 10.6 and 9.9 in 2005 and 2006 respectively.</p>	<p>The States average annual health care growth is 7.1% for the period 1991-2004.</p>	<p>It appears the State experienced a decrease in health care quality to the target pilot groups.</p>

Case Study: Arizona Health Care Cost Containment System 1115 Waiver (10/2006)

Demographics-The Arizona experience as a border state with Mexico is comparable to Texas. Hispanics also account for the largest racial/ethnic group (32%). The unique border challenges

⁵ Florida Statewide Health Reform Demonstration Fact Sheet, Center for Medicare and Medicaid Services, October 3, 2005

⁶ Florida Medicaid Reform Pilot Program ‘Appear To Be Reducing’ Number Of Participating Physicians Study Finds, Medical News Today, May 11, 2007

⁷ State not ready to begin Medicaid Reform, St. Petersburg Times, December 7, 2007

are often illustrated by its socio-economic conditions. In 2006, the State had 20% of residents' living-in-poverty while an additional 21% are Near-Poor. The uninsured population is 20%, and the "uninsured near-poor" is 33%. Only 53% of the insured are covered through ESI, which is similar to TX and CA.

Waiver- The State's Health Care Cost Containment System demonstration was initiated in 1982 and renews in October 2006. This demonstration has been in an evolving process: 1982- covered only acute care; 1990 phased in comprehensive behavioral health; 2000- expanded income limits to 100% FPL; 2001 submitted a HIFA waiver; and 2006- resubmitted but now with budget neutrality constraints.⁸

The longevity of the State's reform efforts have resulted in some successful outcomes. The State's Healthcare Group of Arizona (HCG) program targeting small employers and employees, and subsidized with 8 million dollars in 2000. After 2004, The State legislature was able to cut program spending from \$8 to \$4 million because of savings, followed by no funding in 2005 because the program became self-sufficient. Effective July 2005, employers and employees paid all cost of premiums, and as of December 2006 the program had enrolled 24,000 individuals and 8,500 small businesses. Over 90% of the businesses have less than three employees.

Arizona MRW Impact		
Reduce Uninsured	Reduce Cost	Improve Quality
<p>↑ Uninsured ↑ Medicaid</p> <p>In 1999, AZ uninsured was 19.6%, dropped/fluctuated in the 17 and 18% range between 2000 and 2004, and then increased to 19.6 and 20.0% in 2005 and 2006 respectively. Medicaid enrollment steadily increase between 1999 and 2006, 9.0 to 16.1% respectively.</p>	<p>The States average annual health care growth is 7.7% for the period 1991-2004.</p>	<p>Improvements in health care quality are unclear.</p>

Case Study: *New Mexico 1115 HIFA (7/2005)*

Demographics- A border state, NM residents living-in-poverty account for 22% while the "Near-Poor" parallel TX and AZ at 21%. The uninsured population represents 22% (Uninsured Adults: 75%) of the population. NM leads the six states in percentage of uninsured living "Near-Poor" at 35%. Individuals insured through ESI coverage is significantly lower compared to the other states at 50%. Hispanic once again, comprise of largest racial/ ethnic group (42%).

Waiver- New Mexico's three tier system mandates and require that employer agrees to contribute and cover two-third of their workforce to qualify for premium subsidies by the state. The initiative covers 5000 lives. This initiative may not be the most effective means to increasing insured population given high poverty and low ESI.⁹

⁸ Arizona Demonstration Fact Sheet, Center for Medicare and Medicaid Services, October 3, 2005,

⁹ Health Insurance Flexibility and Accountability (HIFA) Initiative New Mexico Fact Sheet, Center for Medicare and Medicaid Services, March 4, 2002

Impact of NM's 1115 Waiver to:		
Reduce Uninsured	Reduce Cost	Improve Quality
<p>↑ Uninsured ↓ Medicaid</p> <p>The NM uninsured rate has fluctuated considerably between 1999 and 2006. It was 24.1% in 1999, decreased and climbing to 22.9% in 2006. Medicaid steadily increased to 17% in 2005 but decreases in 2006 to 15.9%.</p>	<p>The States annual health care expenditure is 7.2% for the period 1991-2004.</p>	<p>Improvements in health care quality are unclear.</p>

Case Study: *Idaho Children's Access Card Program 1115 HIFA Waiver (11/2004)*

Demographics- Unlike Texas, Idaho (ID) is significantly smaller and has lower uninsured rate (15%). A fairly homogenous population as Whites composes 87% of state's population. But the "Uninsured Near-Poor" is the largest (39%) of all six states.

Waiver- ID was among the four states that have applied for and received approval after the passage of the DRA. Targeted primarily for children, *ID Access Card* is intended to increase access to private health insurance to low-income individuals through premium assistance programs.

In 2006, ID implemented a Medicaid Reform Initiative that divided Medicaid and SCHIP population into three categories: *Medicaid Basic Plan* - Low-income children and working age adults; *Medicaid Enhanced Plan*- individuals with disabilities and special needs; and *Medicaid Coordinated Plan*- dual eligible elderly. ID pays a capitation rate per enrollee with private carriers.¹⁰ As the program began in the spring of 2007 there is not enough substantial evidence on the waiver. Based on information of key demographic data, preliminary anecdotal analysis show interesting finding articulated in the adjacent table.

Idaho MRW Impact		
Reduce Uninsured	Reduce Cost	Improve Quality
<p>↑ Uninsured ↓ Medicaid</p> <p>The ID uninsured rate has fluctuated considerably between 1999 and 2006. It was 18% in 1999, decreased to 14.5% in 2004 and climbing to 15.4% in 2006. Medicaid enrollment has fluctuated in the 10 to 12% range.</p>	<p>The State has the highest annual health care experience growth among the comparison states (8.4%) for the period 1999-2004.</p>	<p>Improvements in health care quality are unclear.</p>

¹⁰ Health Insurance Flexibility and Accountability (HIFA) Initiative Idaho Fact Sheet, Center for Medicare and Medicaid Services , November 4, 2004; State Coverage Initiative-State Profile: Idaho, Robert Wood Johnson Foundation, <http://statecoverage.net/reportsearch/index.cfm> , Jan 2008

Case Study: *Oregon Health Plan 2 -1115 HIFA Waiver (11/2002)*

Demographics-Aside demographic population size and make up of Oregon (OR), the challenges to health care access parallel to TX. Among the uninsured population, adults in OR are more likely than Texans to be uninsured (81%). Like TX, Oregonians are on the cusp of poverty as the “uninsured near poor” comprise of 31%.

Waiver- In 1993, OR was approved by CMS to implement the *Oregon Health Plan* (OHP). The goal of OHP was to improve health status of Oregonians, reduce uninsured and strengthen the economy through overhaul health system by integrating key component - Medicaid Reform, Insurance for small business, High-risk medical insurance pool, and Employer mandates for health insurance¹¹

However, by 2002 the State had applied for joint 1115 waiver and HIFA waiver to expand coverage up to 185% FPL and develop the *OHP Plus* and *OHP Standard* benefit packages. The approval of CMS allowed the creation of a prioritized health care list of conditions and treatment based on benefits who it serves. With a budget shortfall in 2003, the state was forced to modify the OHP. The effort to retain eligibility levels of OHP Standard at 100% FPL concessions were made by redesigning the package to include reducing benefits, increasing premiums, implementing co-pays, eliminated premium exemptions and six month lock out for nonpayment.¹²

As a result of the economic circumstance of the State and the impending policy change the OHP under went a long-term study on the implications of program changes to OHP.¹³ The study concluded negative impacts in each of the following critical areas:

¹¹ Office of Oregon Health Policy and Research, *Profile of Oregon's Uninsured, 2006- Health Insurance Coverage: The Oregon Health Plan*, Chapter 2, Aug 2007; Oregon Health Plan Demonstration Fact Sheet, Center for Medicare and Medicaid Services, October 3, 2005

¹² State Coverage Initiative-State Profile: Oregon, Robert Wood Johnson Foundation, <http://statecoverage.net/reportsearch/index.cfm> , Jan 2008

¹³ Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adults Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan, The Common Wealth Fund, July 2005

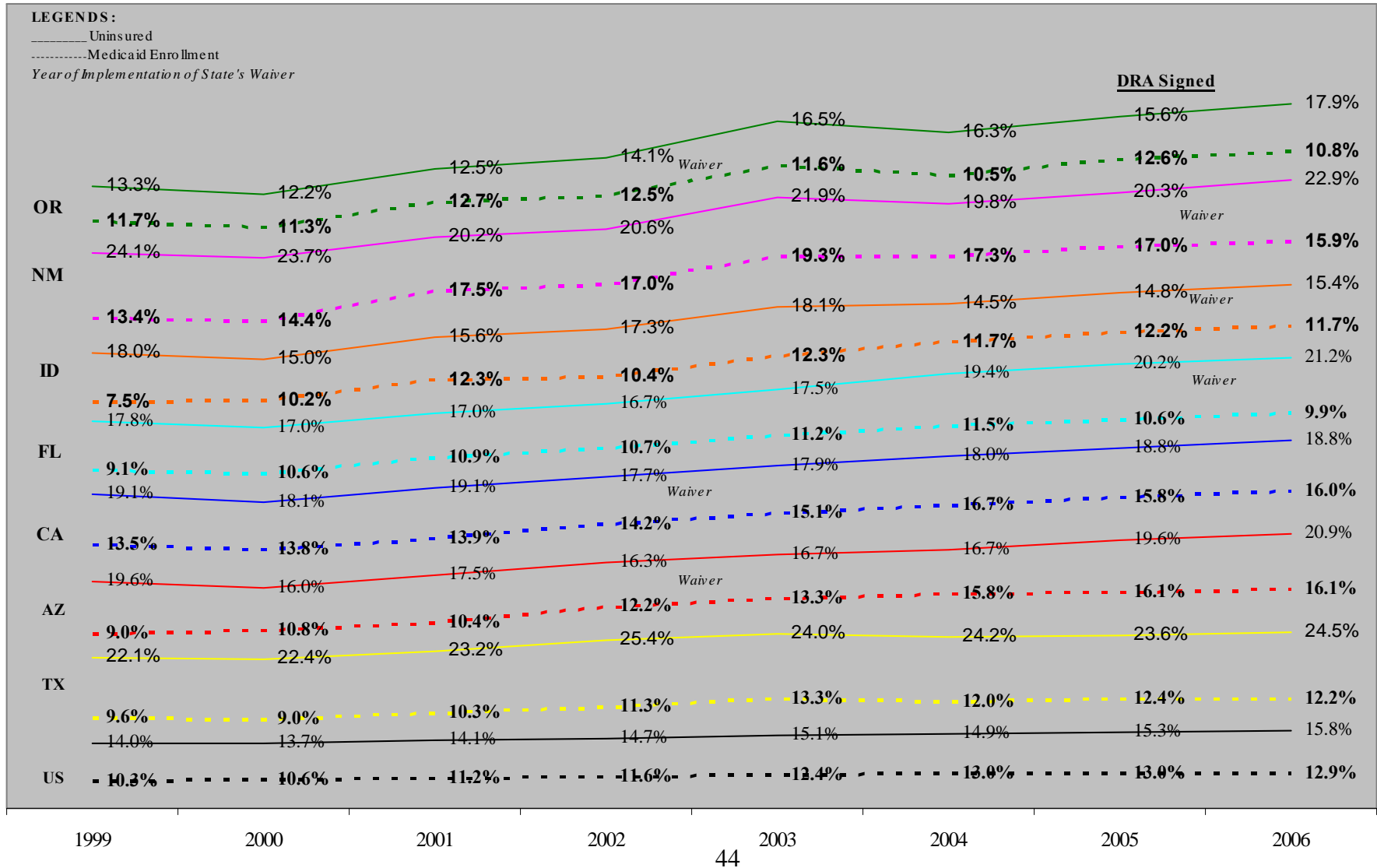
- **Impact to Health Care Coverage** - In the first six months of the policy changes, enrollment dropped by 46%. Among the dropped individuals, one-third were without health care coverage for more than 12 months. “Affordability” was the major reason for losing coverage – increases in premiums and cost sharing.
- **Impact to Access to Care** - The survey results reported “compelling evidence” regarding the importance of continuity in coverage as a means to maintaining access to care. Rapid policy changes to eliminate co-pay and restored benefits did improve access to care.
- **Impact to Utilization of Health Care Services** – The most vulnerable disproportionately lost coverage as a result of the policy changes. Thus, more likely to utilize the ER. Coverage continuity and length of coverage were not correlated to reduced primary care utilization. There was no clear evidence that eliminating co-pay and adding benefits will impact hospital utilization.
- **Impact to Personal Finance**- Individuals who lost coverage over three month had accumulated medical debt. Six-seven (67) percent who owed more than \$500 in medical bills accrued the debt while uninsured.
- **Impact on Health**- Overall, 68% of those who lost coverage and became uninsured for more than 12 months suggested that “time uninsured” play role in their declining health.

The report concludes that even small increases in premium and cost sharing results in individuals with the fewest resources to leave public coverage. Thus, creating a “highly unstable newly uninsured” population who will be dependent on public safety nets and charity.

Oregon MRW Impact		
Reduce Uninsured	Reduce Cost	Improve Quality
<p>↓ Uninsured ↓ Medicaid The States uninsured rate has steadily increase between 1999 and 2006, from 13.3 to 17.9%. Medicaid enrollment has had up/down fluctuations’ with 14.7% in 1999 and ultimately decreased to 10.8% in 2006.</p>	<p>The State’s annual health care expenditure growth is 7%. One study suggests that enrollment increases in the OHP have reduced uncompensated care, and that enrollment contractions led to large increases in uncompensated care costs.</p>	<p>The OHP approach to rationing and prioritizing health services did not result in negative health outcomes. Subsequent studies indicated that the OHP improved access to quality preventive and primary care.</p>

Appendix D:

**Trends: Uninsured and Medicaid Enrollment by States,
1999-2006**





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