

*Investing in Texas: Financing Health Coverage Expansion
Conference Proceedings*

Breakout Session: Transition to the Market

Although many Texans have been able to obtain health care through public programs such as Medicaid and CHIP, a significant number of individuals who do not qualify for these programs remain uninsured. In an effort to address this problem, a movement has developed to implement programs that help make private health insurance more affordable and accessible to this population. This breakout session focused on three programs that attempt to reach this population.

Premium Assistance Programs

Presentation Summary by Lisa Ewart

*Full report available at: <http://www.insuretexans.org> or
<http://www.utexas.edu/lbj/faculty/warner/uninsured/conf2002.html>.*

This presentation described premium assistance programs and several of the implementation questions faced by states when developing these types of programs. Premium assistance programs aim to encourage employer insurance by assisting Medicaid and SCHIP-eligible individuals in paying for this option instead of enrolling in the public plan.

Texas has a HIPP program that utilizes Medicaid funds to enroll Medicaid-eligible individuals into employer-sponsored coverage. The HIPP Program in Texas currently serves about 2,500 families and saves the state close to \$4 million per year. The most recent Texas Legislature passed House Bill 3038 directing the Health and Human Services Commission to implement a premium assistance program for SCHIP-eligible individuals using SCHIP funds.

The first question the presentation addressed concerned whether the state is implementing the premium assistance program as a part of a larger expansion or as an additional program within the current public insurance system. In times of budget constraint it seems more likely that the state may choose to enact an individual program by limiting premium assistance to those individuals enrolling or already enrolled in the public program.

However, in order to increase participation rates and help decrease the number of uninsured, states could consider premium assistance as a part of larger expansion. When programs expand to adults with higher incomes, individuals at these higher incomes are perhaps more likely to have access to employer sponsored coverage and the plan is more likely to be cost-effective.

The presentation also discussed cost-effectiveness determination. Under a program within the current public insurance structure, cost-effectiveness is determined by comparing the cost of covering the individual CHIP-eligible child in the public program with the cost of covering the child and the parent if necessary in the employer program. When considering the cost to the state of the employer program, the state should add in administrative costs of the premium assistance program and wrap-around services when employer plans don't provide all of the services of the public plan.

Expansion does have an effect on cost-effectiveness. If the public plan has expanded eligibility to adults, for example, then the cost-effectiveness test would compare the cost of covering both the adult and the children in the state public plan with the cost of covering the adult and the child in the employer-sponsored coverage. This increased cost to the state for the public plan makes it more likely that the employer plan would be cost-effective.

In addition, the presentation discussed how the program could be developed to prevent crowd-out. Crowd-out is the name given to the "substitution of public funds for private funds." States have implemented devices collectively known as firewalls to attempt to prevent this from happening. One particular firewall is the use of minimum employer contribution. Additionally, most states impose a period of being uninsured before the individual is eligible for the program.

Finally, this presentation tied premium assistance programs to the model where public assistance coverage was expanded to parents and childless adults through a HIFA waiver.

The HIFA waiver encourages premium assistance programs by allowing for flexibility of benefits, cost-sharing and the cost-effectiveness test for the expansion populations. The HIFA waiver also relaxes the crowd-out requirement. This flexibility might allow for more plans to become cost-effective and eligible, and therefore more people will be enrolled in the private coverage option with the help of public assistance.

SCHIP Full-Cost Buy-In

Presentation Summary by Jie Zhou

Full report available at: <http://www.insuretexans.org> or <http://www.utexas.edu/lbj/faculty/warner/uninsured/conf2002.html>.

The presentation described the definition of the SCHIP full-cost buy-in program, its advantage as a moderate vehicle for states to expand health insurance coverage, and some of the potential risks of the program. The presentation also laid out a rough frame for Texas SCHIP full-cost buy-in option.

Unlike subsidized public programs, SCHIP full-cost buy-in programs give states an opportunity to expand coverage without using public funds. Their role is to increase access to insurance to children with family incomes too high to qualify for subsidized

public programs, but who may not have access to employer-based coverage and who cannot afford the premiums charged in the individual market.

Since states do not receive federal funding to operate SCHIP full-cost buy-in programs, they have greater flexibility in designing these programs than they do for SCHIP. They can take advantage of administrative efficiencies and purchasing power of the existing SCHIP program.

With regard to the implementation of the SCHIP full cost buy-in, several critical issues are addressed in the presentation, including eligibility criteria, benefit package, and estimated premium rates.

Texas Health Insurance Risk Pool

Presentation Summary by Jed Perry

Full report available at: <http://www.insuretexans.org> or <http://www.utexas.edu/lbj/faculty/warner/uninsured/conf2002.html>.

This presentation discussed how the Texas Health Insurance Risk Pool (THIRP) could be altered to provide more health insurance to the uninsured. These policy options include altering cost-sharing requirement, using more restrictive managed care, subsidizing those with lower incomes, and increasing the level of financing for the pool.

THIRP was started in the late 1980s to provide coverage to those with preexisting conditions precluding them from buying health insurance, but the program was not funded at that time. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) mandating that states provide some sort of mechanism for guaranteeing access to health insurance coverage. To comply with HIPAA, the Texas Legislature chose to use THIRP and proceeded to provide sufficient funding. THIRP currently covers those eligible under the provisions of HIPAA, people with pre-existing conditions, and individuals with premiums higher than those found with THIRP.

Since implementation of THIRP following passage of HIPAA, enrollment has increased steadily. The program has more than 17,000 enrollees, making it the second-largest pool in the country behind Minnesota.

Premium rates are currently set at 185 percent of the “standard rate” generally charged by insurance carriers on the individual market. These rates can be very high, particularly for older participants.

The first option for increasing health insurance coverage through THIRP is to increase cost-sharing levels. The program currently offers three plans that decrease in premiums as they increase in cost-sharing. One method to lower the premiums would be to offer new plans with even higher cost-sharing, particularly deductibles.

Another option would be to offer a more restrictive plan. THIRP uses a PPO model plan that provides generous benefits with significant flexibility. However, the flexibility comes at a higher cost. Other states, such as California, have used more restrictive managed care plans (such as HMOs) to lower costs. Texas could potentially find similar cost savings if a more restrictive model were used.

THIRP is funded both by premiums from participants and assessments on insurance carriers. These assessments make up for the loss in the program. In effect, the funding from the assessment acts as a subsidy. However, for many lower-income individuals the reduction is not enough. In these cases, a subsidy is needed. Providing a subsidy that could meet the needs of many of these people could be costly.

As was mentioned, THIRP is partially funded through assessment on health insurance carriers. However, the assessment exempts many sources of insurance premiums, such as disability, dental, and small business insurance. If these exemptions were lifted, THIRP could get additional revenue. Also, companies that self-insure their employees are exempt from the assessment. By using provider taxes or assessing stop-loss/reinsurance, these self-insured plans could participate in funding THIRP as well.

Participant Discussion

Following the presentations, participants engaged in a discussion that spanned a wide range of issues, including the adequacy of the provider network and the viability of the health system in Texas. Participants raised a variety of clarifying questions about the Texas Health Insurance Risk Pool. Some of these included how THIRP provides benefits, how the financing mechanism for THIRP works, and how other states operate their high-risk pools.

Participants also raised concerns over using THIRP as a mechanism to increase health insurance coverage. Some suggested that increasing THIRP enrollment could cause health insurance rates in the private insurance market to increase. Others raised the issue of whether the increase in time and money spent on increasing THIRP enrollment would be better used for other reforms.

Several participants questioned the feasibility of estimates of the full-cost buy-in premium rates for Texas. They felt that the estimate is too low to be accepted by the health insurance providers. However, one expert from a state agency in Texas said argued that even with the estimate of the premium rate, quite a number of Texas families could not afford it.

Following the discussion of the premium rate estimate, the issue of expanding to adult participants was raised. One expert felt that SCHIP full-cost buy-in could not simply be expanded to adult patients because the program was not structured to accommodate adult patients and that to bring them into the program would be to create a new program. Other participants argued that expanding SCHIP full-cost buy-in to adults rather than creating a new program for adults would save administrative and marketing costs. Several other participants expressed their concern about expanding the SCHIP program because they

believe the program reimburses providers inadequately. One participant suggested that instead of expanding the program to adults, the state should consider expanding the program to children in families up to 250 percent of the poverty level.

Another participant raised a concern on the balance of cost and benefits of SCHIP full-cost buy-in options. He felt that the program with low costs and a rich benefits package might price people out of the market. In this respect, other participants also raised the concern that the program would attract the sickest and costliest patients to care for, which would limit the potential for savings.

Participants were asked to consider in what state the Texas health system would be in five years and what would need to be done to improve on the current situation. Some participants argued that if no significant steps are taken immediately to address reimbursement issues and other basic problems, that the system will collapse within five years. Others argued that the system will most likely look as it does today with, perhaps, greater numbers of uninsured Texans. There was also discussion about whether the system has a breaking point—a level of uninsured that if it reaches, it will collapse.

Some participants believed that the best way to decrease the number of uninsured would be to focus on a Medicaid waiver, which has the potential to provide insurance to large numbers of the uninsured. One participant proposed that the best way to insure more people would be to make it easier for small businesses to provide insurance because a large percentage of the uninsured are employed by small businesses. There was agreement that in the past, purchasing alliances have not been successful, but that it is worth considering alternate methods of enabling small businesses to insure their employees. It was suggested that if the state attempts anything in this area, that it first launch a pilot program so that it can learn what works well and what does not before rolling out to the whole state.