Investing in Texas: Financing Health Coverage Expansion
Conference Proceedings

Public Expansion Options

Jacqueline Angel: Welcome back. My name is Jacqueline Angel, and I am a professor here at the LBJ School. I have several tasks for the session this morning. First of all, I wanted to remind you that our conference proceedings will be posted on our website soon. We will also post all of the draft papers that our project team has been working on.

Also, I have the task of introducing our next speaker, and I wanted to remind you that we will have time for questions and answers. To facilitate this process, I would like for you to open up your folders; in the pocket are some cards, and this will give you the opportunity to jot down a question or comment for our next speaker, who is Leah Kegler. It is my pleasure to introduce Leah. She is a second-year LBJ student and also a member of the policy research project on the uninsured. While at the LBJ School, she has been involved in academic work as well as practical experience in social policy, especially with respect to health care, welfare reform, and aging. This has been done at all levels of government including her internship last summer with the U.S. Senate Finance Committee in Washington, D.C. She brings a lot of analytic skills to her presentation today. There is also a very detailed paper to support the work that she will be discussing today. I also want to thank Ray Sheppach and Mark Gibson for providing such a nice backdrop for her presentation. The title of her talk is "An Option to Expand Medicaid in Texas."

Leah Kegler: Good morning. Thank you, Professor Angel. My presentation highlights an option to expand Medicaid to low-income, uninsured adults in Texas between the ages of 19 and 64. It uses a combination of approaches to provide health care to parents and childless adults.

This presentation will begin with a general overview of who is and who is not covered by Medicaid and CHIP in Texas. Next, I will explain how a Section 1931 state plan amendment will allow Texas to expand Medicaid to parents, followed by a brief explanation of Section 1115 waivers, and how 1931 and 1115 can be linked to expand health care in Texas. I will also explain the assumptions that are associated with the model and finally, highlight the cost and the benefits of such a proposal.

Who is covered under Medicaid and CHIP in Texas? Children 18 and under and families earning less than 200 percent of the federal poverty level are covered, as well as pregnant women with incomes below 185 percent of the federal poverty level who passed the Medicaid Assets test, TANF-eligibles (specifically referring to parents), SSI recipients, and medically needy parents who spend down to 24 percent of the federal poverty level each month. Who is not covered? Forty-seven percent of adults ages 19 to 64 with incomes less than 200 percent of the federal poverty level are not covered, and at least 50

percent of this low-income population in Texas work. Texas law requires that counties only provide care for their indigent population at or below 21 percent of the federal poverty level. Some counties offer more coverage to its adults, but regardless, there are lot of very low-income people in Texas not entitled to health care coverage.

As I mentioned, today we are going to look at a couple of ways to expand health insurance to the low-income population in Texas. The first is Section 1931 of the Social Security Act. This was enacted in 1996 as part of welfare reform. Texas can use this statute to insure low-income parents by including increased income and resource disregards in a Medicaid state plan amendment. Texas would receive federal matching funds for adding these low-income parents to Medicaid in Texas.

Another way to expand to low-income populations in Texas is through Section 1115 Medicaid waivers. This statute allows the Secretary of the Department of Health and Human Services to waive specific provisions of certain programs including Medicaid and CHIP. One population Texas could develop a waiver to cover is childless adults. They cannot be covered under the Section 1931 State Plan Amendment. Obtaining a Section 1115 waiver is a long and tedious process for states. Proposals must be deemed budget-neutral by the U.S. Department of Health and Human Services and the Office of Management and Budget. Budget neutrality means that operating the program with the waiver does not cost the federal government more than without the waiver.

States often take advantage of waivers to do three things. First, they are used to increase access to federal match for the categorically ineligible, such as the childless adult population. Second, to waive federal program requirements, for instance what services are offered; in the 1990s a lot was done with managed care but this is no longer necessary because of provisions in the Balanced Budget Act of 1997. The third way is to redirect federal funds using the Disproportionate Share Hospital funds (DSH). But this presentation does not address DSH allocations.

As we can tell from earlier presentations, the recent “buzz” around the waivers is a specialized Section 1115 waiver known as the HIFA waiver. It is the Health Insurance Flexibility and Accountability demonstration initiative, and it was introduced by the Bush administration in August 2001. HIFA is a new approach to Section 1115 research and demonstration waivers specifically for Medicaid and CHIP. It targets the uninsured under 200 percent of the federal poverty level and uses the current level of Medicaid and CHIP funding. Specifically, it defines three Medicaid populations: mandatory, optional, and expansion. The mandatory population are those categories of individuals that states must cover to be eligible to participate in Medicaid and receive the federal match, as specified in federal statute. The optional populations are those states can chose to cover and receive a federal Medicaid match if they do so.

The third population, the expansion population, are those individuals who are categorically ineligible for Medicaid but are made eligible through the waiver process. HIFA allows states to provide reduced benefit packages to the optional and expansion populations, but the mandatory population still receives the full benefit package offered by the state. HIFA allows states to impose more cost-sharing on these populations to

help obtain a budget-neutral waiver. Through our research, we have devised some options to expand Medicaid in Texas. We hope this presentation will start a discussion in this area.

The options we have identified combine Section 1931 expansion to parents and a Section 1115 waiver to cover both parents and childless adults. They take advantage of the HIFA initiative to provide more Texans with health care, and allow Texas to draw down federal matching funds. Now, slide number 1 is probably the most complicated to explain in my presentation [note: the slides appear at the end of this section]. I invite you all to read the paper that this presentation was based on, to help you fully understand the concept presented on this slide. Also, I will present this slide twice, once to help us become familiar with the concept and again later after I have listed some assumptions to review. This is just one approach that Texas could use to expand Medicaid.

The first step in this expansion is for Texas to apply for a Section 1931 State Plan Amendment. This will cost the state its share of Medicaid match, but it will also increase the federal cost of Medicaid in Texas without a waiver. It is called a hypothetical 1931 because if a waiver is not granted in the following two steps, Texas does not have to expand using Section 1931. The second step is to propose a HIFA Section 1115 waiver to reduce benefits and apply cost-sharing to the newly covered Section 1931 parents. This is an optional population, and the expansion will save federal money and allows Texas to pursue part three of this approach—a HIFA waiver to expand a reduced benefit package with cost-sharing to childless adults, the expansion population. I would like to note before I discuss the assumptions that this approach is giving benefits to those who are currently uninsured, so even if it is not a full Medicaid package, it is some health care coverage, which is a start.

To develop any model, one must understand the components of its cost. In this model, the costs for a single year are found using this equation shown. As shown in slide number 2, we have looked at the state match rate multiplied by the number of eligible people multiplied by the participation rate, by the phase-in factor for that specific year, and by the cost for participation in the base year, multiplied by an inflation factor. As was noted this morning, Section 1115 waivers are costed out over five years and budget neutrality must be proven over this five-year period.

The next set of slides presents some of the assumptions that we made to come up with this model. The first addresses the matching rate. The Texas matching rate for federal fiscal year 2003 is approximately 60 percent. In other words, Texas pays 40 percent and the federal government pays 60 percent of most Medicaid expenditures. We use this same rate over all five years in our models because it is hard to predict changes in matching rates. They are based on a comparison of all the state economies over the prior three years. To estimate the number of eligibles, we used March CPS and census data averaged over three years. This is the standard that is often used—it is not perfect, but we see it as the best available data. We also eliminated those not eligible for the federal match which includes 50 percent of the foreign-born population as they are assumed to be undocumented. We eliminated immigrants in the United States who have been here for

less than five years, but kept those who have met the five-year bar. Texas currently has not taken this option to cover these individuals, but we assumed that Texas will do so in the next legislative session.

As you can see here, just to take a quick look at numbers, approximately 286,000 of Texas parents under 100 percent of the federal poverty level are uninsured (see slide number 3). Among people 19 through 64 who do not live with children younger than 18, there are 330,000 uninsured that are below 100 percent of the federal poverty level. As far as the participation rate, we assumed, looking at data in a recent article in *Inquiry,* that with zero percent cost-sharing, there is a 67 percent take up. When cost-sharing equal to 2 percent of family income is implemented, the take-up rate drops to 45 percent, and at 5 percent of annual income the participation rate drops to 17 percent. We also did not apply an assets test to the population that we covered when determining the participation rate. Although there is a Medicaid assets test, we did not apply one because it would have greatly reduced the number of eligibles for the reduced benefit package that is being offered.

For our phase-in factor we used a three-year phase-in factor. This is our own estimate, and we believe that it takes into account startup time and dissemination of the information regarding the program. As far as the cost per participant, according to the Texas Health and Human Services Commission, the cost of providing Medicaid to non-pregnant, non-elderly, non-disabled adults in Texas will cost approximately $253 a month. This is about $3,036 per person for state fiscal year 2002. This is for average acute cost, which includes everything Medicaid covers including prescription drugs and transportation. The prescription drug cost is about 20 percent of the premium. For the inflation factor states are able to choose between two different options, the Medical Consumer Price index or the historical trends in the Medicaid program over the last five years. We took this option and estimated inflation at about 6 percent.

Now, to return to the proposed approach to expansion shown in slide number 1. To review, the first step is a hypothetical Section 1931 expansion to parents. This leverages budget neutrality. The second step in proposing a HIFA waiver reducing benefits and applying cost-sharing to the parent population is where our cost-saving comes into effect. And the third step is proposing a HIFA waiver to expand the reduced benefits and cost-sharing to the uninsured adults in our expansion population.

In slide number 5, you will see some of the numbers that I ran regarding the model of a potential HIFA Medicaid waiver in Texas. In the first column, you will find the federal poverty level of the parents that are to be covered, the federal poverty level of childless adults, and then the cost-sharing imposed in each specific proposal, and these lead across to estimated participation rates. In the second column, there is a percentage of benefit package in relation to the Texas TANF adult package. Now the percentage is found using an equation, and I will address that in the next slide, but we multiplied that percentage of benefit package by the $253 that was the cost per participant per month, and then used that to find the amount of state revenue needed over five years and amount of revenue needed in the next biennium. Now, I am lucky here because my classmates

are going to address the financing this afternoon in the presentation, so I have not had to deal with the difficult issue of how to pay for such a proposal. The final column looks at the number of uninsured Texans covered.

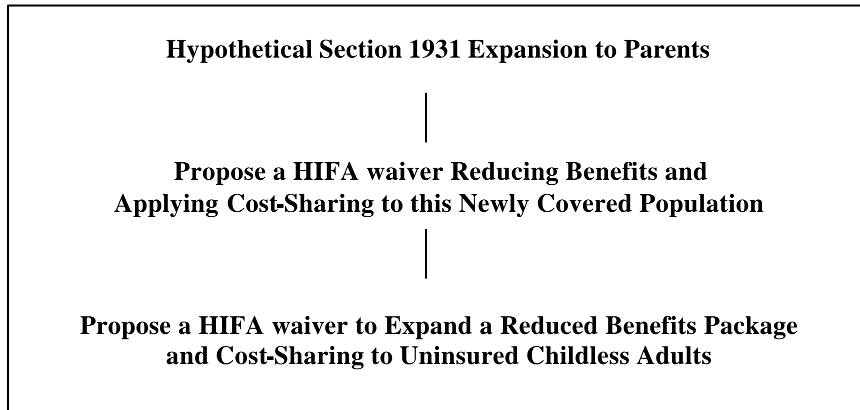
Now if you take a look at the different numbers, we can see that the best percentage benefit package can be found if Texas were to choose to cover parents up to 200 percent of the federal poverty level and childless adults up to 50 percent of the federal poverty level. This produces a 79.9 percent benefit package. Now, this of course requires the largest amount of state revenue if no cost-sharing is imposed, but it also can produce the most people if the similar benefit of 200 percent of the federal poverty level for parents, 100 percent of the federal poverty level for childless adults, and no cost-sharing is imposed, we are able to insure the largest number of additional people, approximately 560,000 Texans.

To find that percentage of the full benefit package per member that can be offered under the Section 1115 constraint of budget neutrality, we looked at the cost of offering the full Section 1931 benefit, which is basically how much money there is for a budget neutral waiver, and divided that by how much it will cost to give full TANF adult parent coverage to the new 1931 population and childless adults (see slide number 6). The percentage can also be increased based on cost-sharing requirements and how cost-sharing is implemented. The working paper gives a good overview of this concept.

We also heard this morning about Oregon looking into pursuing a HIFA waiver through CHIP. It is discussed in detail in the paper on expansion, and it is possible to apply for a waiver using excess federal CHIP allotment—Arizona and California have already been awarded this type of waiver. But it does not appear that Texas has enough remaining federal CHIP allotment to expand effectively using federal CHIP dollars. It would possibly limit the number of children who receive CHIP, and this is probably not the best option. To receive a CHIP waiver, Texas must also meet the CHIP waiver guidelines set by HHS. These were set in July 2000 by the Clinton administration. There are five different requirements and Texas would have to meet three of those requirements if those guidelines remain in place.

In conclusion, covering uninsured adults through a reduced benefit package does have tremendous potential. Decisions need to be made based on the number of people covered versus the wealth of the benefit package versus the cost to the state. Legislators, county officials, hospital administrators, providers, health care advocates, and health care consumers should all be a part of setting a clear expansion policy framework.
These individuals will need to look at state funds: how much can the state spend on an expansion? How many Texans should be covered? How extensive should the benefit package be? These are major issues that need to be addressed under any type of arrangement similar to the one that I have presented today. Finally, a strong commitment to financing health care in Texas is a fundamental component to reducing the number of uninsured in Texas. Again, possible financing options of this type of model will be presented this afternoon. Thank you.

Slide 1
Proposed Approach to Expansion



Adapted from: Charles Milligan, "Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage" (Washington, D.C.: State Coverage Initiatives of the Robert Wood Johnson Foundation, 2001), p. 4.

Slide 2
The Cost of a Medicaid Expansion

Cost in Year *X* = State match rate x Number of eligible people x Participation Rate x Phase-in Factor for Year *X* x Cost per participant in base year x Inflation factor

Adapted from: Leighton Ku and Matt Broaddus, *How to Review Cost Estimates for Family Coverage Expansions* (Washington, D.C.: The Center on Budget and Policy Priorities, 2001), p.1.

Slide 3
Total Number of Uninsured Parents under 65 by Income in Texas

Percent of the Federal Poverty Level	Number of Uninsured Parents
Under 50%	74,299
50 - 99%	211,814
100 - 149%	185,862
150 - 199%	152,252
200 - 249%	120,925
250% or higher	135,381
Total	880,532

Adapted from: U.S. Department of Labor, Bureau of Labor Statistics, *1999 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002; U.S. Department of Labor, Bureau of Labor Statistics, *2000 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002; and U.S. Department of Labor, Bureau of Labor Statistics, *2001 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002.

Slide 4
Total Number of Adults under 65 with no Children under Age 18 by Income in Texas

Percent of the Federal Poverty Level	Number of Childless Adults
Under 50%	243,428
50 - 99%	224,736
100 - 149%	322,016
150 - 199%	268,065
200 - 249%	262,369
250% or Higher	853,707
Total	2,174,320

Adapted from: U.S. Department of Labor, Bureau of Labor Statistics, *1999 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002; U.S. Department of Labor, Bureau of Labor Statistics, *2000 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002; and U.S. Department of Labor, Bureau of Labor Statistics, *2001 March Current Population Survey*. Online. Available: http://www.bls.census.gov/cps/cpsmain.htm. Accessed: April 8, 2002.

Slide 5
Selected Models of a HIFA Medicaid Waiver in Texas

FPL of Parents/ FPL of Childless Adults: Cost-sharing Imposed	Percent of Benefits Package in relation to Mandated TANF Adult	Per Member per Month Premium	Amount of State Revenue Needed over Five Years	Amount of State Revenue Needed for the Next Biennium	Number of Uninsured Texans Covered
100/50: 0%	54.05%	$136.75	$958,482,000	$360,197,000	290,419
150/50: 0%	65.87%	$166.64	$1,572,433,000	$590,920,000	390,966
200/50: 0%	71.90%	$181.90	$2,084,811,000	$783,472,000	474,879
200/100: 0%	60.83%	$153.89	$2,084,811,000	$783,472,000	561,325
100/50: 2%	54.05%	$136.75	$643,756,000	$241,924,000	195,058
150/50: 2%	65.87%	$166.64	$1,056,112,000	$369,887,000	262,589
200/50: 2%	71.90%	$181.90	$1,400,246,000	$526,212,000	318,948
200/100: 2%	60.83%	$153.89	$1,400,246,000	$526,212,000	377,010
100/50: 5%	54.05%	$136.75	$243,197,000	$91,393,000	73,688
150/50: 5 %	65.87%	$166.64	$398,976,000	$149,935,000	99,200
200/50: 5%	71.90%	$181.90	$528,982,000	$198,792,000	120,492
200/100: 5%	60.83%	$153.89	$528,982,000	$198,792,000	142,426

Source: Calculations based on 2000 Current Population Survey data; explanations for each column are explained previously and in the working paper entitled "Expansion through Waivers."

Slide 6
Percentage of Benefits Package in Relation to Mandated TANF Adults

$$\frac{\text{Cost of offering full Section 1931 benefits}}{\text{Cost of offering full Section 1931 Benefits + Cost of offering full benefits to Childless Adults}} = \text{Percentage of the full benefit package per member that can be offered under the Section 1115 constraint of budget neutrality}$$

Note: This is the equation used in Slide 5, second column.

Jacqueline Angel: The first question from the audience has to do with one of your conclusions. What benefits would be cut to create the reduced benefit package?

Leah Kegler: Well, actually, in the research we did not make any specific proposals on what benefits should be cut. It is a difficult question, and we believe that is something that needs to be addressed by the different stakeholders, so we did not really address which benefits to not offer to the expansion population. Definitely, there are some ideas out there which we heard this morning. Oregon has reduced some of its benefits, and they have specific reasoning behind those reductions. I think that it is an issue for stakeholders to take a look at.

Jacqueline Angel: Thank you. Could you talk a little bit how Section 1931 works?

Leah Kegler: Basically, what you are able to do using Section 1931 is to change the income level or the assets disregard levels of those who qualify for Medicaid, and so by increasing those, you are able to have more people eligible for the Medicaid program. To do this, the state has to apply for a state plan amendment, which needs to be approved by the Department of Health and Human Services. The only cost to the state is its portion of the Medicaid program. So, there is a cost but the state does receive the federal match, which is about 60 percent in Texas.

Jacqueline Angel: Did the model and assumptions that you are making take into account provider capacity at all?

Leah Kegler: No, it did not.

Jacqueline Angel: Thanks. Another related question is whether or not Texas would have to establish a system of rationing care, such as what Oregon has developed, to meet the budget neutrality requirement. Are there other options?

Leah Kegler: More cost sharing is an option. The reduced benefit package is not necessarily the best option, although in the presentation that I gave today, those reduced benefit packages are being offered to individuals who have no coverage right now, and so, we are taking the attitude in this presentation that something is better than nothing. This at least starts to allow the state to be able to cover some individuals, which is a good thing.

Jacqueline Angel: The next question has to do with how you are defining cost.

Leah Kegler: The definition of cost is in the six components that I went over in the assumptions. Although, I think there is a cost to the State of Texas if they do not expand health care coverage to low-income individuals, for example, not being able to access education or employment if they are not healthy. So I think that there is a real benefit to offering Medicaid to low-income individuals.

Jacqueline Angel: The next question deals with the take-up, specifically the participation rate that your research was based on, and was it the low-income population or all incomes?

Leah Kegler: The take-up rate was for the low-income population. The chart lays out the federal poverty level of the individual covered within each model.

Jacqueline Angel: Can you say a little bit more about what other states are doing with respect to the HIFA initiative and what sort of success that they have had?

Leah Kegler: As I mentioned, California and Arizona are the only two states who have had their HIFA waivers approved. There are other states, as we heard this morning, that are seriously looking into the HIFA initiative. Also, Utah, who did not have a HIFA waiver, received a Section 1115 waiver earlier this year that dealt with benefit reductions to specific populations.

Jacqueline Angel: Okay. This next question deals with different ways that the waiver can be used. Specifically, whether or not there is some way of using the HIFA waiver to subsidize employers covering their workers.

Leah Kegler: Yes, there definitely are and I'm going to give a plug to Lisa Ewart's and Jie Zhou's breakout group that will be held today over lunch. They are going to look at those and discuss how the premium assistance program plays into the HIFA waiver. So I am going to defer to Lisa on that question, and I encourage anyone who is interested in that to attend that breakout session.

Jacqueline Angel: Great. Will the expanded coverage include recommended prevention and early detection costs such as mammography and colon cancer screenings?

Leah Kegler: I cannot answer that question because, as I mentioned earlier, we did not look at what benefits would be taken out. That is a question that the stakeholders really will need to look at when designing a HIFA waiver.

Jacqueline Angel: With respect to the optional eligibility categories and benefits, what populations might use the coverage and what type of services may they be at risk for being without?

Leah Kegler: We did not really look at any of the optional populations covered by the State of Texas right now. In this presentation, a new optional population is created, those parents who are covered with the new Section 1931, so it is not affecting the coverage that any one in Medicaid in Texas has today. It is only affecting this new population who is currently uninsured.

Jacqueline Angel: We have some more time, and I would like to open it up.

Jim Walton: I would like to applaud you for the great presentation and your work today. I am very curious about going back to this issue of the provider network, and I suspect

that your model is outstanding. There are a couple of components that I am going to make recommendations and get your comments back.. There has got to be a factor in your model, especially in at the cost side, that tells you if the provider network does not play. If the provider network in a market is already full and you add another 500,000 people to the number of insured, what is the inflation factor of the cost of the state to pay for the same people that were uninsured that they were paying for before and now are paying for those costs somewhere else? These folks now have an insurance card, if you will, that is going to tell the state to pay a bill at an emergency room that they used to not have to pay for, and I think that you could probably model that pretty effectively by looking at what happened when the Medicaid Managed Care rolled out in different markets in the different regions, as well as when CHIP rolled out, and try to figure out what markets had trouble because their delivery system was unable to accommodate that great load. Then when we cut reimbursement rates to the provider network or when you make those adjustments, as we do by trying to balance the budget, what happens to the network then translates into how the cost transfers back to the state. I hope that I am making myself clear.

Leah Kegler: Yes, and you have an excellent suggestion. Thank you.

Jacqueline Angel: Any other smoldering questions?

David Warner: Just a clarification. When you are looking at the cost-sharing, you are assuming a constant percent of income. Alternatively, for example, you could have no cost-sharing below 100 percent of poverty and increased cost-sharing above.

Leah Kegler: Exactly, what was done here was just the same thing was applied to everyone. I actually did not even add the cost-sharing money back in because it depends on how that is implemented. If it is implemented as a straight premium then you are able to put that into the budget neutrality side of the equation, but if it is implemented as a co-payment, it is very difficult to track and very difficult to put it into the budget neutrality of the arrangement.

David Warner: The second question is just to clarify, for instance, if you did one of the most expensive models with 200 percent/50 percent with no cost-sharing, essentially, you are saying that it is going to cost $783 million more in state money and you would get an additional $1,174,000,000 in federal funds.

Leah Kegler: Right. There will definitely be more federal money being poured into the state, so that is a benefit of the state spending more money because for every dollar spent, there is a lot more coming back.

David Warner: And so to the extent that you could find money that is already being spent on indigent care in the state to use, it is possible to use this as the state match that could be drawing down pure federal money in some sense.

Leah Kegler: Right. I think that will be fully explained this afternoon. There are some inefficiencies in the financing of health care in Texas, and so I think if those were

addressed, the state may not be spending more money but be able to put some more money into the Texas economy.

Mark Gibson: I would like to congratulate you on a great presentation as well as nice work.

Leah Kegler: Thank you.

Mark Gibson: I would encourage folks, if you are looking at trying to match up federal matching funds with an employer subsidy program or an insurance subsidy program that has an employer component to it, to look at making the subsidy go to the individual as opposed to through the employer. We found that that is far simpler, and it reduces the resistance from the employer community, usually small business, and avoids another set of bookkeeping issues. In Oregon we do not have this complicating factor of the employer being involved. We just give the eligible enrollee the money and then they pay their shares of the premium at their workplaces if they have an employment-based coverage, so it's a simpler model.

I also want to ask one quick question: what is the assets test for Medicaid currently?

Leah Kegler: It is $2000 per household in countable income.

I will also be in the Hispanic issues breakout group, and other different expansion options, so if anyone would like to talk a bit more, I will be available. Also, I encourage you to take a look at the different papers on the website because I think they help explain a lot of what was presented today.

David Warner: One other thing I want to add is that the website address is printed at the bottom of the agenda (www.insuretexans.org), and we have posted all the papers on the website, and we will post these conference proceedings.

Jacqueline Angel: Leah, I want to thank you again for that excellent presentation, and it is now my pleasure to welcome the three breakout session leaders. Jen Eldridge will introduce Karla Buitrago and Lisa Ewart.

Jen Eldridge: Good morning. I am Jen Eldridge, and I would like to explain to you how our concurrent breakout sessions will work. As soon as we break here, we will be holding three concurrent breakout sessions during lunch upstairs on the first floor of this building. They are intended to be informal sessions and eating is quite welcome. You may have already signed up for a particular session, but we would like to invite you to join any one that you wish. Before I tell you about the session that I will be hosting, I would like to remind everybody that Senator Rodney Ellis will be speaking to us this afternoon in this room at 1 o'clock, and I know no one is going to want to miss that, so make sure you meet us back here at 1 o'clock.

I will be hosting a breakout session on expanding health care access to immigrants in Texas, which will focus primarily on community health centers and some opportunities

for expansion. I would like to invite you to join us for that. Leah will be joining me in that session, so as you think about what she said, if you have any questions for her, there will an opportunity in that session to continue our discussion of the Medicaid waiver option. Now I'd like to turn it over to Lisa Ewart.

Lisa Ewart: Thank you Jen, and welcome everyone. Thanks for joining us today. Another concurrent breakout session is entitled "Transition to the Market—Public Assistance for Private Insurance Coverage." The focus will be on implementation and policy options for programs that help make private health coverage more affordable and accessible. Three programs will be discussed. The first is the premium-assistance program, which uses public funds to assist eligible individuals enrolled in employer-sponsored coverage. The second is CHIP full-cost buy-in, which allows families with modest incomes to enroll their children in SCHIP, and finally, the Texas health insurance risk pool, which provides health insurance access to those denied private individual coverage. This breakout session will be hosted by me and my colleagues Jie and Jed Perry. Here is Karla Buitrago to talk about another breakout session. Thank you.

Karla Buitrago: On behalf of the education and outreach research team, I would like to invite you to the third breakout session, entitled "Consumer Education and Outreach—Making Private Insurance Work." Education and outreach programs can potentially serve as a cost-effective means of reducing the number of uninsured. The need for health insurance education is most critical in the small group market. In our breakout session, participants will be asked to discuss several policy options to help consumers, primarily small employers, to obtain health insurance that meets their needs. Policy options to be discussed include but are certainly not limited to a consumer health assistance program, otherwise known as an ombudsman program, a health insurance rate guide, and education for small employers about CHIP coverage for the children of their employees. We hope to see many of you there. Thank you.