

CONFERENCE BRIEF INVESTING IN TEXAS: FINANCING HEALTH COVERAGE EXPANSION

In 2000, there were approximately 4.6 million uninsured Texans. As part of a two-year Policy Research Project, graduate students and faculty at the Lyndon B. Johnson School of Public Affairs have been working to address this critical public policy issue by conducting strategic research and in-depth analysis on available policy options. Presented below are the options that will be discussed at the conference.

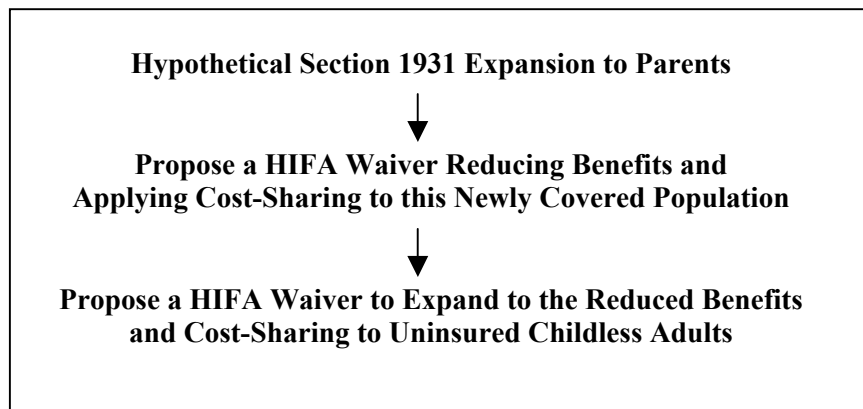
Options for Program Expansion

Almost 25 percent of all Texans below the age of 65 lack any type of health coverage. By reexamining program operations and requirements, Texas could expand current programs to increase coverage.

- **Using a Medicaid HIFA Waiver to Expand Coverage in Texas.** One proposed model for reducing the number of uninsured in Texas might take a three-part approach.
 - Texas could consider a state plan amendment that would entitle full Medicaid benefits to all parents of children under age 19 within a specific FPL. This hypothetical expansion would effectively serve as a “without the waiver” expenditure projection in a test for budget neutrality.
 - The next step involves proposing a HIFA Section 1115 waiver to cover the population referred to in the first step. This would allow the State to create a reduced package and impose higher levels of cost-sharing on recipients.
 - The final step entails utilizing the savings from the reduced benefit package and cost-sharing to offer Medicaid benefits to childless adults under a set percentage of the FPL.

Models using this approach cover between approximately 73,600-561,300 uninsured Texans. For the next biennium, the range of general revenue cost for our models is from approximately \$91,300,000 to \$783,472,000.

Proposed Approach to Expansion



- **Expanding Health Care Access to Immigrants in Texas.** Medicaid expansion would not cover undocumented persons and immigrants who entered the U.S. after August 1996 (“unqualified” immigrants). Community Health Centers (CHC) are a critical source of health care for these underserved populations. In December 2001, Congress approved the largest ever funding increase for CHCs – \$175 million for FY2002. The Texas Association of Community Health Centers (TACHC)'s Statewide Strategic Plan outlines a plan to expand access to approximately 573,000 new and current patients over the next five years by building new and expanding existing centers, and hiring new providers. Expanding CHC services could increase acute health care access for "unqualified" immigrants and other underserved populations who are ineligible for public benefits.
- **Premium Assistance Programs.** Premium Assistance programs have recently received national focus because they take advantage of private dollars in the form of employer contributions. These programs use Medicaid, CHIP, or state dollars to pay the eligible employee’s premium for the employer-sponsored health coverage when it is cost-effective and the employer benefit plan is comparable to the public health insurance plan. Premium assistance programs are a small part of an overall scheme to reduce the number of uninsured. House Bill 3038, enacted during the 77th Legislature, authorizes the implementation of a Premium Assistance program using CHIP funds. Texas already has a HIPP program that utilizes Medicaid funds. These programs encourage private insurance options and allow states to save money, but in states where they have been implemented, they often have low participation rates and are difficult to administer. If Texas decides to proceed with the Medicaid expansion modeled earlier in this brief, then most likely more individuals will be eligible for employer-sponsored coverage.
- **CHIP Full Cost Buy In.** CHIP full cost buy-in programs allow uninsured individuals an opportunity to pay the full premium associated with the state-run children’s insurance program. Full cost buy-in programs could target uninsured children with household gross income over 200 percent FPL. Based on the current CHIP premium rates, it is estimated that the monthly premium per child in Texas would be \$90 excluding dental coverage and state costs to administer. The challenge for Texas is to provide the maximum possible benefits to the enrollees of full cost buy-in programs without undermining the private insurance market.
- **High-Risk Pool.** There are four types of policy options to consider with regard to increasing coverage of the uninsured using the Texas Health Insurance Risk Pool (THIRP).
 - *Financing.* THIRP is subsidized by assessments made to health insurance carriers based on premiums. THIRP could increase its revenue through several mechanisms, including: imposing a tax on providers to reach health coverage that is currently not assessed because of an ERISA exemption; assessing reinsurance carriers; and allowing small employers to pay for employees to participate in THIRP.
 - *Cost-Sharing.* THIRP health plans currently require varying levels of cost sharing from participants. If a higher deductible was allowed, premiums could be reduced by approximately 25 - 30 percent if the current trend remains constant. Premiums could further be reduced by increasing co-payments and coinsurance levels.

- *Subsidies.* Texas could use additional financing sources cited above to provide a subsidy to ensure that premiums were no more than a certain percentage of a person's income.
- *Plan Construction.* In states with large managed care penetration, HMOs and other managed care organizations provide services for high-risk pool participants. By using a more restrictive model, THIRP could decrease costs.

Education and Outreach

Education is a cost-effective way to reduce the number of uninsured. In many cases, infrastructure is already in place at the state agencies to implement reform. By focusing education efforts in the private sector, Texas could reach relatively underserved audiences.

- **Health Care Consumer Assistance (Ombudsman) Program.** An Ombudsman program could serve all health care consumers regardless of type of health plan and create a central clearinghouse of health insurance information.
- **Health Insurance Rate Guide.** A rate guide would provide benchmark rates and a starting place for small employers, thereby reducing their research costs and time spent without insurance. However, provisions of a rate guide might require new legislation and several specific benefits packages for published rates would need to be established.
- **Information Distribution to Small Employers.** With cooperation from outside agencies, existing educational materials could be distributed to small employers, for example in mailings of tax statements by the Texas Workforce Commission. With the cooperation of the media, small businesses could be educated about recent insurance reforms, a critical gap in knowledge recently noted in the results of the Texas Department of Insurance State Planning Grant.
- **Small Business Education on CHIP Coverage for Employees' Children.** Employers often do not know children are eligible for public insurance. Establishing CHIP coverage for employees' children would eliminate the often high costs of family coverage through small employer plans. This effort would have to be coordinated with HB 3038, and TDI would need to design and produce new educational materials.

Provider Reimbursement for Medicaid and CHIP

Adequacy of the provider network in the Medicaid program has been a longstanding area of concern to policymakers, program administrators and providers. It is unclear what impact Medicaid and CHIP reimbursement rates in Texas have on the adequacy of the provider network.

- **Medicaid and CHIP Rates.** In general, Medicaid reimbursement rates in Texas appear to be average in comparison with other states. However, within the state, Medicaid and CHIP rates are significantly lower than those of Medicare and commercial payers. Surveys reveal provider dissatisfaction with rates, but the network of providers in Texas appears to be sufficient in most areas. Looking ahead, however, the expected growth of the Medicaid

population in the state may strain the existing network, especially if rates remain uncompetitive.

- **Border Issues.** Medicaid clients and providers alike face barriers that do not exist in other parts of Texas. Providers in the traditional Medicaid fee-for-service system along the Texas/Mexico border serve a disproportionate number of Medicaid clients while being reimbursed at the same rates as providers in the rest of the state. Because Medicaid is such a large part of their caseload, they are unable to offset Medicaid patients with other higher paying patients. Providers in the border counties that now have Medicaid managed care are reimbursed at capitation rates lower than the average for the rest of the state.

Financing Options

Expanding health coverage for the uninsured would require new sources of funding, much of which could come from current programs with some ingenuity and cooperation. For example, counties and hospital districts spend millions of dollars on programs that could qualify for federal Medicaid matching funds if eligibility were expanded. Alternatively, the state could pursue new revenue mechanisms for use as a match.

- **Hospital District and County Funds.** Hospital districts collect over a billion dollars a year, and only a fraction of these funds are used for drawing federal health care matching funds to Texas. Waiver developers could look for ways to use these funds to extend the reach of the Medicaid program. Preliminary information indicates that hospital districts and counties would be willing to consider such cooperative arrangements if their total revenue would increase significantly.
- **New Sources of State Revenue.** One natural place to look for these revenues is within health related spending, such as taxes on health services or excise taxes on goods with a health cost.
 - *Provider Tax.* Currently health care providers are spending enormous amounts of dollars on uncompensated care due to the large numbers of uninsured individuals in the state. A reallocation of these dollars through a tax would allow the state to bring down additional federal dollars through a Medicaid expansion program. This in return, would decrease the uncompensated care hospitals and physicians have to provide. It would also allow funds to be available for an increase in Medicaid reimbursement rates.
 - *Alternative Business Tax.* Replacing the franchise tax with an alternative business tax could generate additional revenue by applying a low-rate tax on a broad base of businesses, including those currently exempt from the franchise tax. Such taxes include the Business Activity Tax proposed by former Governor Bush in 1997 and a tax on free cash flow. Applying such a tax to health-related businesses could be used as a provider tax for expanding health coverage.
 - *Excise Taxes.* Excise taxes are usually imposed on goods that are considered luxuries or indulgences. Texas could follow the lead of Arkansas and West Virginia by implementing a *soda tax* to fund health services that would help offset obesity-related

health costs or follow the example of several states such as Connecticut and New York, in raising *cigarette taxes* to pay for health care.

- *State-Owned Hospitals and Medical Schools.* These institutions are provided substantial amounts of general revenue to pay for indigent care. To the extent that an expansion provided coverage to patients these entities serve, then it would seem reasonable that they contribute some of this General Revenue that would be offset by the match. Such funds could also possibly cover target rate and fee increases where warranted.