Chapter 4. Summary of Breakout Sessions and Closing Discussion

KENNETH APFEL: There have been very productive workshop discussions, and we're going to start the closing discussion now that we're all back together. There were five workshops, and we've asked five students to give short summaries of each of the workshops, followed by the moderators' comments. We're going to start with the Hispanic workshop issues in health insurance, and Sarah Lovering will go first.

SARAH LOVERING: I was in the Hispanic breakout group moderated by Pablo Schneider and student leaders Jeff Hamilton and myself. We began by talking about what we see as the problem—why so many Hispanics are without health insurance. We mostly talked about the public side, namely Medicaid and SCHIP. Among the things that we brainstormed were the problems people have in getting enrolled and staying enrolled in those programs. Remember, this is all particular to Hispanics, so there are other issues like cultural and language barriers that make it difficult for some Hispanics to understand what these programs do or how to go about staying enrolled. Another issue was that many individuals are in low-income, working families, and it's very difficult for them to take time off from work in order to go to their appointments to enroll or to reenroll.

We talked a lot about the administrative burdens of the programs. With CHIP in particular, we talked about marketing and outreach. This doesn't apply to Medicaid because Medicaid outreach only takes places when people are targeted through the SCHIP outreach and then are determined not to be eligible for SCHIP. They are referred to the Medicaid program, but that's where the help stops. They're kind of on their own from there to continue the enrollment process. At the end, we talked a little bit about private issues, but more about private-purchase insurance than employer-sponsored insurance. Pablo said that he had tried to convince private insurance companies to provide health insurance for the uninsured but that they were unwilling. We didn't really come to any conclusions. We don't have any new or innovative ideas about how to resolve that problem. We discussed the possibility of creating private-public partnerships, for example premium subsidies, like those we've heard have been implemented in other states.

Finally, we ended by going around the room and having everyone state their main thought or main point that they had taken from the breakout session. Some of these included increasing marketing and really focusing on outreach. One suggestion was to increase the reimbursement rate for Medicaid and SCHIP. Another one was to make sure we take care of providers—that they are reimbursed properly and that that there are enough providers to serve all the people who need health care. A few minutes were devoted to focusing on border issues. This included a discussion of rural issues, for example how can we make sure there are enough providers in certain areas, and emphasizing the importance of maintaining a strong public health insurance program on the border and in all rural areas, and getting people enrolled. Those were the main points of our breakout session. Thank you.

KENNETH APFEL: Thank you, Sarah. And Pablo Schneider will now supplement those comments.

PABLO SCHNEIDER: It occurs to me that a certain set of issues are common to people who are uninsured, and then we have a set of issues related to insurance for Hispanics. And there's an overlap there. I think the most valuable thing we got out of this was that we touched on something that was important to each person. And what made me think that there is an overlap and that there are some unique needs and issues for Hispanics is what Dean Clancy said about how Hispanics will benefit from a tax credit, especially in Texas, because there's such a low rate of work-based insurance for Hispanics in Texas. Having a tax credit would benefit them a lot, because they could use that credit outside of the work coverage.

So I'm just going to review briefly what was important. As Sarah said, we talked about public programs, mainly Medicaid and SCHIP, and we came up with what we thought were the main categories of Medicaid and SCHIP issues where progress could be made. One solution we identified was to create Hispanic initiatives to attract, serve, and retain Hispanic enrollees and employees, with those Hispanic initiatives possibly including on the attracting side "marketing" or outreach, on the serving side working with providers, working with materials, and working with Spanish language services, and on the retention side really looking at reenrollment, and at how to keep the people in the programs.

One initiative would be to enroll the people who are already eligible. That's huge. Another would be to restructure provider payment in some way. Another person said that provider sufficiency was extremely important—that you could enroll a few hundred thousand people in SCHIP, but if you don't have sufficient providers, then you can't serve them. You've attracted them, so how are you going to then serve them and retain them? Hispanic initiatives also should address U.S. Hispanics, legal immigrants, and undocumented immigrants, and each one of those groups has varying needs. On the private and public sides, one observation is that there has been historically very little marketing toward Hispanics, or enrollment outreach.

A key observation is that socioeconomic drivers are often as important or more important than cultural drivers or cultural issues. There's an intense oral health need among Hispanics, and there's not enough data on it. Better public and private insurance would lead to better provider infrastructure, which would lead to better access, better health, and so forth. Another interesting observation is that many of the barriers are not accidental. That fits in with my earlier statement that if there were the political will, and this country really wanted to solve the issue of lack of insurance, we would solve it. Now maybe we want to at least solve part of it.

In addition, there must be far more communication, conversation, dialogue, and sharing between the public and private sectors. The border is a third country and it needs unique solutions that are different from pure United States or pure Mexico. Finally, for anyone with any interest in premium subsidy programs, the Commonwealth Fund did a study of

several dozen initiatives, many of which involve premium subsidies, and those are available on the web. Thank you.

KENNETH APFEL: Thank you very much. We'll now hear from the workshop on private insurance options for small business. Katy Fallon will speak first.

KATY FALLON: We discussed a paper that two of us had written on small businesses, and how it seems so much harder for small businesses to provide health insurance, particularly in Texas. We started out by talking about the obstacles; the two big ones were availability and cost. Cost obviously was number one, but these two problems are very intertwined. The costs are high for both consumers and carriers. If I remember correctly, 30 percent of premiums go for administrative costs, and that's especially high for smaller groups, because there are fewer people to cover overhead costs. When I say "small groups," by the way, I'm referring to groups of 2 to 50 people, and as the groups get smaller, the prices generally get higher. I understand that the number of small group insurance carriers has dropped from 140 carriers a couple of years ago down to 40-something now. Thirty-nine dropped out of the small group market in just the past 12 months, and therefore there are fewer plans and less competition.

From there we tried to talk about solutions. The greatest potential is in product design. The carriers and consumers both feel a little bit boxed in about bells and whistles vs. affordability, and there doesn't seem to be a good balance between those two factors. The products need to be designed properly, including a good mix of educating the public that they need to take care of themselves. We discussed educating people about this in health class in elementary school, through just increasing general public awareness, either by agents or by teachers, carriers, whoever it might be. A few other solutions could come with deregulation. We fell on both sides of that issue, but certainly if you look at mandates these days, you can argue that deregulating will decrease the prices.

And finally, we discussed a couple of very concrete proposed solutions—House Bills 471 and 949 currently in the Texas Legislature, both sponsored by Kip Averitt. The Texas Association of Health Underwriters is specifically supporting them, and their purpose is to make sure with HB 471 that small-group agents are getting the same commission as larger-group agents, in order that commissions not be used as a disincentive to sell to small groups. HB 949 would restrict the use of group size in rating a potential group.

KENNETH APFEL: Thank you, Katy. And now we'll hear from Chuck Begley, our moderator for this workshop, for some supplemental comments.

CHUCK BEGLEY: I don't have much to add, except a little bit of color, which is that our group basically, as you might expect, was really good in coming up with the components of the problem, for which we focused on cost as one aspect, and, with some overlap but still separate, availability of a variety of innovative and optional plans. Our group was not shy about thinking that we would be happy with a variety of plans: partial coverage, full, comprehensive. This group was not into standardization, but rather into having a lot of choices out there. So that's a problem.

On the solution side, we had a harder time. When we did come up with possible solutions, the idea was that we need better products with more variety, some prevention and wellness aspects to them, real risks and consequences for people, and rewards for rational behavior and well-informed choices. But then we got down to how we might make this happen. What mechanisms would get us into that? And that's where we had a clear ideological split. We had some people in favor of a free market, saying that the market should be left alone to do that, and then others thought we should have more of a government encouragement or mandatory approach, and we used the Mandated Benefit Review Panel as one example of how the government could take more of a role in doing this.

We thought Dianne Longley's project, the Texas Department of Insurance project, could come up with a variety of ideas that reflected cooperation among consumers, providers, payers, and the government. And that was one of our conditions: everyone needs to be brought to the table. And it sounds as though this project is modeled along those lines.

KENNETH APFEL: Thank you. We will now move on to the workshop on improving outreach and simplification for SCHIP and Medicaid, and we'll hear from Andy Fouché.

ANDY FOUCHÉ: DeAnn Friedholm, our moderator, promised me that if I misinterpreted anything, I would be greatly chided afterwards, so I'm going to make this as quick and unspecific as I can. [Laughter] We started with SCHIP best practices, and the thing that everyone agreed on is that community-based organizations are a must for SCHIP outreach. They do programs such as Fiesta Days and Wal-Mart Days where they go to these companies with volunteers who are there to provide outreach—people who are actually connected to the community. The good thing about the CBOs is that their outreach practices are such that the people really can reach out to the community; people may even know the CBO volunteers in a personal context, so they feel more comfortable filling out the forms and applying.

In the improvement areas, there was more discussion on best practices. SCHIP in Texas is doing a great job, but there are some things that probably need to be worked on. One is dental vs. medical. The medical part of SCHIP is much more comprehensive than the dental side, especially in comparison with Medicaid. Medicaid has a very extensive dental program; SCHIP barely has any at all.

Also, one of the things we identified as an issue area was the 150 to 200 percent federal poverty level population. This is the hardest group to identify because they have the highest incomes and sometimes they're not even aware that they qualify for the SCHIP program. We thought that one of the best ways we could inform these people that they are indeed eligible for SCHIP would be by targeting employers. We can also target housing authorities when individuals go to buy a house. I think the top price for which they could qualify for a house was about $125,000, and we could target those authorities and let them known about SCHIP. Jason Cooke, the state director of SCHIP, mentioned that the new advertising campaign that's coming out in the near future is "People Like Me," meaning that there are people all across the state, of different ethnic backgrounds and different professions, who may not be aware that they are eligible for SCHIP.

Another area was initial enrollment. With respect to enrollment right now, there are programs like the school-based lunch programs where kids are being sent home with literature and statistics are gathered on them if they are currently eligible for breakfast or lunch programs at school. I think Jason Cooke also mentioned that 50 percent of those who are eligible for SCHIP and who are currently enrolled found out about the program through the school system, so that was a really effective way of getting the word out. Another trusted source of outreach can come from religious organizations, because they generally have strong ties to the communities they serve. Gaining people's trust is the most important element of outreach.

KENNETH APFEL: Thank you, and now we will hear from our moderator, DeAnn Friedholm, for some additional comments.

DEANN FRIEDHOLM: I really don't have anything major to add to the subjects that Andy covered perfectly. I think that our group will agree that that was a very nice summary. The other area that we spoke about during the meeting was Medicaid simplification. I'm sure the people in this room are aware of that issue, so there's not much more to say about it other than we just have to do it! The ideal would be a single-intake system, where families are treated equally and sent to the appropriate program based merely on the income qualification for that program. So that was the other half of our topic. Most of our conversation was about outreach, however, because once you know that we must simplify Medicaid, there's not much more to say about it. That's the only other additional comment I would make. Thank you, Andy.

KENNETH APFEL: Moving on to the high risk pool workshop, we will hear from Kate Suratt.

KATE SURATT: Good afternoon. In the high-risk pool breakout session, we were lucky to have Steve Browning, who is the director of the high-risk pool in Texas, to guide us. Our discussion was divided into five main parts, mainly because we had a list of four key questions and then left time for recommendations.

We started out with a brief background. Many people are unfamiliar with the pool because it serves such a small niche, but it does serve an important part of the population. It serves those people who are eligible for HIPAA, so it serves as our HIPAA mechanism for Texas. Also, it serves those who are medically uninsurable, so if you have a condition such as cancer where your premiums are going to be very high, you may be eligible for the pool. At present there are 13,000 participants in the pool, and the current average monthly premium is $400. We also talked about several people who are paying $150, so the range is pretty broad. We talked about funding: currently the risk pool is funded with assessments and premiums. So aside from the premiums the participants pay, the risk pool pays out more than it gets in, so they assess insurers. This is a pretty complicated process, but I have it summarized as, "Insurers are assessed based on the ratio of gross premiums collected by the insurer, compared to gross premiums collected by all the insurers."

In funding, we discussed a few options. We talked about some medical savings account options, and a bill that's currently in the House, HB 1709, sponsored by Rep. Averitt, that proposes a premium tax credit. That would mean that insurers would get a tax credit based on what they are assessed every year, and if it passes it will be phased in over 10 years. We also talked about equity, and with the risk pool, the equity problem is that the higher and higher the premiums get, the more lower-income people there are who can't pay the premiums. We talked about the pools in other states that use mechanisms like sliding-scale premiums or state subsidies. There are several different methods that some states employ to help those with low incomes who are ineligible for individual insurance. One of the methods we considered with respect to low-income participants was a possible federal tax credit. If it were $1,000—it depends on the legislation—that money could go toward the premiums of the risk pool, so that would benefit participants in the risk pool. The $1,000 wouldn't cover everything, though. If their premiums were $400 per month, it wouldn't cover the whole year, but it would help.

The last two issues we talked about were dumping, which occurs if small groups drop their coverage, and encourage the sick to get into the pool so that everyone doesn't have to pay really high premiums, and then everyone else gets coverage again—that's not legal. The pool is trying to come up with different methods to address this problem and inform people about who's eligible and under what circumstances, and they're also sending out letters, so they're being very proactive. There's also HB 2191, which addresses some of those issues. That brings me to our last discussion topic, pending legislation. We talked again about HB 1709 regarding a premium tax credit and HB 2191, which Director Browning refers to as his "house-cleaning" bill. There were a number of small errors in the original legislation and the pool is hoping to correct those. HB 2191 eliminates a citizenship requirement—Texas is the only state that has one—so that now a person has to be a three-year permanent resident to receive benefits. It addresses dumping, it allows people coming from other state pools to go directly into our state pool, and it addresses a penalty for nonpayment. That's my summary of what we covered. Thank you.

KENNETH APFEL: Thank you very much. Since Gregory Barbutti, our moderator, is not here, David Warner will provide supplemental comments.

DAVID WARNER: I sat in on some of the discussion, and just have a couple of clarifications. The rates are set based on age and how much an individual policy would cost, and also by area of the state. There really are three separate policies. I believe these are a $500 deductible, a $1,000 deductible, and a $2,500 deductible, and there's also a co-pay. There were several concerns. One issue was that that people were a little worried that if you had a tax credit you would not be able to apply it to a premium in a high-risk pool, if that were the insurance you had to get. And the second was some notion that the risk pool should somehow also have a fourth option that sort of mirrored the medical savings accounts.

KENNETH APFEL: Thank you. We will now hear from our fifth workshop, Expansion Options for SCHIP and Medicaid. Michelle Harper will speak first.

MICHELLE HARPER: I would like to summarize some of the key points that we covered during our workshop on public expansion options. First, we talked about those populations in Texas that would benefit from gaining coverage under an expansion. The majority of participants agreed that coverage should be extended to include parents and childless adults.

Second, we discussed expanding benefits and services. Most participants felt that mental health services should be improved and extended to all populations. Additionally, participants felt that dental care and prescription drug benefits should be provided to the adult population. There was, however, the perception that the federal government would solve the prescription drug program, and, thus, action at the state level was unnecessary. We also discussed the special needs of specific populations, like the homeless, who need multiple services.

Third, we talked about how to finance expansions to new populations and expansions of services and benefits. Specifically, our group discussed how we could utilize existing funds. For example, we discussed expanding coverage through two waivers: an SCHIP waiver to cover parents and a Medicaid waiver to cover childless adults. Currently, counties in Texas are responsible for providing health care to their indigent populations. Thus, a Medicaid waiver would enable the counties to receive help from the federal government to finance these services. Federal monies cannot be used to finance services provided to legal immigrants who arrived after August 22, 1996, however, nor to the undocumented, and it is important that these populations still have access to services.

The importance of getting counties to buy into all proposals at the state level quickly became clear during our discussion. The state needs to ensure that counties are "at the table" from the beginning, and included in discussions pertaining to the use of their money. Counties fear losing control of their money—they do not want to give up their local dollars because they feel that they will never see them again. Finally, there also was discussion about the need for education about the Medicaid program: specifically, the way Medicaid works and the benefits and services available, as well as the options in place for expanding the program. That summarizes our discussion. Thank you.

KENNETH APFEL: Thank you, Michelle. And now we will hear from the workshop's moderator, Anne Dunkelberg.

ANNE DUNKELBERG: I don't think I have a lot to add to that. I think Michelle did a great summary. Just for some color commentary, we had several people in the room from smaller counties who have active county indigent health care programs, and so it was very interesting to hear their responses and reactions to the notion of possibly trying to trade in the current county indigent health care obligation, get rid of it and replace it with some sort of funding obligation to help pay for an expanded Medicaid program that could pick up all of our adults up to some population level. I think it was very educational for all of us in the room to see the reactions to what to some of us seems like a great idea, to trade in this program that you don't like, and suddenly get rid of a big chunk of your uninsured population. There was an immediate level of concern and anxiety about that. This really drove home the message that we have an extremely

diverse group of county officials across the state, and a lot of work would have to be done, as was pointed out, just in educating them about the basics of what we've been talking about, much less moving on to selling them on the idea that this could be a winning proposition for them from a fiscal point of view.

KENNETH APFEL: Thank you, Anne. We also wanted to hear from Jocelyn Guyer for a Washington perspective. We wanted also to ask Dean Clancy to comment, but I'm afraid he just left for the airport. Did you have anything you wanted to add at this point?

JOCELYN GUYER: What I was struck by in our session was the depth of experience and knowledge in the room, and the interest in moving forward on this issue. One of the most helpful pieces for me about coming to a conference like this is to hear from a state perspective and a county perspective what the concerns are. I think that Michelle and Anne already keyed in on those for this session: from a policy perspective there's a clear policy that would make considerable sense in terms of maximizing federal funds and covering a lot of people, but the political and policymaking processes will take a lot more work and a lot of involvement from folks. So that's what I'd say from our session.

My other general comment about the day is that I'm quite struck that there seems to be in some ways a difference between where Congress is looking, in terms of focusing in on tax credits as the key option, vs. some of the interest at the state level in building on public programs or working with small businesses to figure out how to encourage them. So I think one important thing is for the kind of discussion that went on today to end up informing the folks in Congress when they think about the next options for addressing the problem of the uninsured.

DAVID WARNER: In closing, I will say one thing, and that is that perhaps we have made a mistake in talking about a country's indigent health care obligation. Rather, instead of saying that you need to take care of the poor people in your county, the health policy could be "this is an economic development program, and county taxpayers can get a four- or five-to-one match on contributions to Medicaid. These funds will pay for additional jobs in your county and lead to higher incomes and more employment." Essentially, out of the money that you're supposed to be spending now on this, and many are, the state would draw down a lot more federal money, and be able both to raise reimbursements and cover more people. That's just one scheme. But it seems to me, if we can build all these stadiums by calling it economic development, while absorbing major new tax cuts, surely we can adequately pay providers and cover more people by simply redirecting local funds and bringing an additional billion dollars into the state.

KENNETH APFEL: I'd also like to reiterate that this conference is part of a two-year project. As we look to next year's activities, it's very clear that carefully examining some of the big options could make a tremendous difference in Texas in terms of health care for the uninsured. Federal legislation may emerge that will help the state of Texas expand coverage. But it may take many years before federal legislation gets enacted. Digging deeper on examining state options could be beneficial.

I hope that what we can do next year at the LBJ School is help provide the forum for some of the big options, to start the discussion going with counties, providers, insurers, consumers, and others, to start to examine how we might look at changes in both federal and state legislation, as well as creative ways to provide significant expansions for the uninsured in Texas. That's our goal for next year, and we hope to be able to do that with all of you. Thank you.