



## **Health and Human Services Task Force - Phase III**

### **Improving Health Care for ALL Texans**

#### **Legislative Recommendations**

**Direct the Health and Human Services Commission to apply for a Section 1115 waiver to participate in a demonstration project designed to empower certain disabled Medicaid beneficiaries.**

Arkansas, New Jersey, and Florida were the first states to be granted Section 1115 waivers to participate in a demonstration project designed to empower certain disabled Medicaid beneficiaries by giving them a cash allowance with which to purchase needed services. At the national level, this experiment is called the Cash and Counseling program. Its purpose is to evaluate how Medicaid beneficiaries (consumers) would fare in a system that allows them to buy their own personal and community-based services, assisted by a consultant, with a defined contribution from their state's Medicaid program. Initial reports have concluded that the experiment is overwhelmingly popular with Medicaid beneficiaries.

Before Cash and Counseling began for these eligible populations, the state typically would contract with a home care agency to provide services to an eligible Medicaid recipient without input from the beneficiary being served. This often meant the beneficiary would have little or no say with regard to how, when, and by whom they were served.

Under Cash and Counseling in all three states, the beneficiary must first be enrolled in Medicaid, meet age and eligibility requirements, and require personal assistance services. Each participant receives a cash allowance, the amount of which is based on the level of professional

assistance needed. Under the waiver, the program must be budget neutral, so the amount is generally equivalent to the value of services purchased by the state. While beneficiaries have considerable flexibility to hire, fire, and alter service providers, their allowance under Cash and Counseling must be spent on health care needs. A counselor or consultant reviews the list of services being purchased to ensure proper usage. The state also provides a fiscal intermediary to cut the checks, pay the appropriate taxes, and handle associated paperwork. The fiscal intermediary represents a final check on spending decisions of the beneficiary to weed out fraud and abuse.

*Budget Impact.* Under the Section 1115 waivers, Cash and Counseling is initially budget neutral. However, it has the potential for considerable savings in the long term.

First, it moves Medicaid away from its traditional bias in favor of institutional care toward home care. As mentioned earlier, nursing home and institutional care account for the largest and fastest growing portion of Medicaid spending, approaching 50 percent of the Medicaid budget in some states.

Second, by creating the proper incentives for appropriate use of care and engaging Medicaid beneficiaries in their own health care decisions, it puts market forces in play in an arena where they have never before existed. A properly functioning market in any economic sector will always improve quality while simultaneously bringing down cost. As evidence, beneficiaries in Cash and Counseling have received more care of better quality, resulting in higher satisfaction rates.<sup>i</sup>

### **Maintain reforms made to Medicaid and CHIP in House Bill 2292, 78<sup>th</sup> Regular Session.**

Critics have challenged the changes to the health and human services system, and the political pressure to turn back the clock on the reforms made last session has grown. Policy makers must stay the course and reject temptations to bow to pressure.

First, the reasons behind the reform are solid. For instance, requiring people to prove their eligibility every six months instead of every year is not to be “mean.” Instead, the six month period is intended to respond to possible changes in recipients’ lives and to ensure that they still qualify for the benefits. Quite simply, the state should not allow for fraud in the system, which is precisely the case when ineligible people participate in the program. The eligibility guidelines are there to ensure that services are available to the people who qualify; those who are ineligible simply draw resources from the program fraudulently.

Second, the budget crisis of the 78<sup>th</sup> Regular Session is bound to be repeated if the state returns to a failed way of business. Having a tight budget meant reevaluating priorities, which should not change according to revenue estimates. Strictly defining the role of government and efforts to slow the growth of government programs is always the right policy.

Third, the state has not yet seen the full effects of reform. The reorganization of health and human services agencies and program changes are still in the works and reversing course before the results are in makes little sense. In fact, there will likely be need for reform in the future, and the most recent reforms will serve the state well in that regard.

**Enforce meaningful cost sharing in the CHIP program, particularly the monthly premiums.**

The 78<sup>th</sup> Legislature passed increased cost sharing requirements for CHIP enrollees. Among these cost sharing requirements were monthly premiums, tiered according to the income of the enrollee. According to those guidelines, enrollees with incomes from 101-150 percent of the federal poverty level (FPL) paid \$15/month, 151-185 percent FPL paid \$20/month, 186-200 percent FPL paid \$25/month. When the changes went into effect October 1, 2003, the media highlighted the plight of families who could not afford those payments. Many Texas newspapers reported factually inaccurate information, only lending to the confusion.

In August 2004, the Governor directed HHSC to delay the implementation of the disenrollment deadline for families who have missed three monthly payments or more. In November 2004, HHSC temporarily suspended the collection of monthly premiums.<sup>ii</sup>

Despite the outcry, a survey of CHIP disenrollees commissioned by HHSC and released December 22, 2004, found that most participants had little trouble making those monthly premium payments. According to the survey:<sup>iii</sup>

- More than 94 percent of families said they felt better paying part of the cost of their children's health-care coverage.
- More than 90 percent of families said the premium was the right amount or too low.
- 80 percent of families said they never or rarely had difficulty paying the monthly premium.

These numbers not only stand in stark contrast to reports of child suffering as a result of the CHIP premium increases. They also reinforce the earlier argument that the state should stay the course on reform because we have yet to see the effects of these recent policy changes. This survey only illustrates this point more. Clearly, given time and something more than anecdotal evidence, the results have shown that the premiums were *not* too demanding for CHIP enrollees to meet.

Cost sharing is an essential element to bringing value to health care services. What's more, ostensibly CHIP enrollees are seeking temporary assistance until they are able to find health insurance on their own. If this is truly the case, what better preparation for the world of health insurance than to follow a similar model, requiring monthly premium payments and co-payments for services and medication. CHIP should not be a more attractive alternative to private insurance, but rather a step out of government assistance and into the private market.

Finally, terminating enrollment once a family has missed three or more monthly premium payments makes sense. In the first place, this arrangement is more like private health insurance; secondly, parents may decide that they no longer want to participate in the program and can terminate their enrollment by not paying their premiums, rather than lagging on the rolls until the next renewal period. HHSC's survey cites Florida for its policies regarding cost sharing, including the use of premiums and dis-enrollment for non-payment. Additionally, since CHIP ought to be preparation for private insurance, it is worth noting that no private health insurance company would forgive three months of missed premium payments and cover services provided during that time. CHIP shouldn't do it either.

**Implement an HSA pilot program for state employees and teachers. Require ERS and TRS to provide all state employees with an annual statement showing their total compensation, including the value of benefits.**

HB 2632 (77R) could be a model for this proposal. Texas should give all state employees and teachers the option to hold an HSA rather than a traditional insurance policy. During open enrollment, the state must ensure that the state employees fully understand the HSA option.

In addition, in preparation for annual enrollment, ERS and TRS should mail all employees a statement of their **total** compensation that includes the increase cost of benefits over the previous year, and a comparison of total compensation with and without benefits.

The value of any benefits received through an employer are, in fact, wages hidden from view. With the cost of health insurance increasing every year, employees get a de facto wage increase, even if they don't ever see more money in their pockets each month. Were employees to know the total increase in compensation they receive each year, no doubt many of these employees would begin asking to forego the benefit, opting instead for the cash. In September, the Kaiser Family Foundation and the Health Research and Educational Trust reported that premiums for employer-sponsored plans rose slightly more than 11 percent for the fourth straight year.<sup>iv</sup> In terms of state employees, the Legislative Budget Board's Fiscal Size up for 2004-05 states that in the last budget cycle, the state needed to increase spending on health care benefits to maintain 2002-03 levels. One major factor the LBB noted was that the benefits costs were up 13 percent, in an attempt to keep pace with cost trends and utilization increases.<sup>v</sup> A 13 percent increase in the cost of benefits translates into a significant increase in total compensation, even if the employee never sees it in their pocket. Health Savings Accounts and a total compensation statement would go a long way toward raising some awareness among employees, as well as controlling cost and utilization.

Any legislation must make it clear that employees have the option during open enrollment period to switch back to their basic insurance if they are unhappy with the HSA.

**Implement an HSA program for children under permanent state conservatorship through the Department of Family and Protective Services.**

Recent attention to the state's foster care system has revealed that when these children age-out of the system, they often face a difficult transition to independent living. Although accommodations have been made to continue providing certain government assistance for eligible foster care children for a limited time when they age out, many find themselves without jobs, without insurance, and with nowhere to go. Allowing children in the permanent care of the state to accrue money in a health savings account would give some of these young adults a cushion as they transition out of state care.

For those children who might not accrue any savings, the health care they receive would be the same as the care they would have received on traditional Medicaid. For those who accrue savings, however, they can use those funds for qualified medical expenses as an adult, including paying premiums, co-payments, or for other medical services. This cushion could provide these former-foster care children with an important source of financial support until they are able to settle on their own.

**Repeal the Interagency Council on Pharmaceutical Bulk Purchasing.**

The Interagency Council on Pharmaceutical Bulk Purchasing, created through legislation by the 77<sup>th</sup> Legislature, was intended to establish uniform procedures and options for state agencies and institutions purchasing pharmaceuticals. However, the council has accomplished nothing since it was created four years ago, even though the estimated savings from establishing the council was approximately \$11 million according to the original fiscal note. Furthermore, legislation last session implementing the Preferred Drug List and prior authorization requirements have eliminated the need for a separate council coordinating the purchase of pharmaceuticals.

We recommend repeal of § 111.001- § 111.006, Title 2, Health and Safety Code.

**Ensure that the Pharmaceutical and Therapeutics Committee, which develops recommendations for the preferred drug lists and adoption by HHSC, meets in open public meetings.**

The 78<sup>th</sup> Legislature passed a prescription drug list as a cost saving measure in House Bill 2292. The Pharmaceutical and Therapeutics Committee, made up of doctors and pharmacists appointed by the Governor, develops recommendations for the preferred drug list, considering the efficacy, safety, and cost-effectiveness of the drugs. This committee is deciding issues affecting the health of Texas patients, as well as hundreds of millions of dollars in state drug purchases necessitating the input of stakeholders in the process. Unfortunately, these meetings have not been held in public in accordance with the Texas Open Meetings Act. Ostensibly, HHSC justifies the closed meetings by claiming that it is necessary to protect proprietary pricing information. Despite an AG's opinion rejecting this same justification by another governmental body and the support for open meetings by affected parties, HHSC continues to conduct a portion of the meetings in executive session outside of public view.

We recommend that the Legislature amend HB 2292 (78R) to mandate that the process complies with the Open Meetings Act.

**State Government should not advocate, encourage or allow the illegal importation of prescription drugs from outside the United States.**

The Department of Health and Human Services (HHS) Task Force on Drug Importation, chaired by Surgeon General Richard H. Carmona, found that the majority of imported drugs are unapproved by the Food and Drug Administration (FDA) and do not appear to conform to standards mandated in the U.S. Specifically, the report found that, *“Importation increases the opportunities for counterfeit and other substandard drugs to enter and be dispersed into the U.S. drug distribution system...American consumers currently purchasing drugs from overseas are generally doing so at significant risk.”* The threat to consumers is real. The State of Texas should formulate policy to prevent drug reimportation.

We recommend amending § 551.002, Subtitle J, Occupations Code to include a statement of policy prohibiting illegal importation.

**Strengthen existing licensure regulation governing distribution of pharmaceuticals in order to protect the state’s drug supply and ensure consumer safety.**

Prescription drugs follow several paths from manufacturer to patient. The most common path is normally manufacturer to wholesaler to pharmacy to patient. Although the vast majority of prescription drugs are distributed by three Fortune 500 wholesalers (AmerisourceBergen, Cardinal Health Inc. and McKesson Corp.), and other full-line wholesalers, some medicines are sold through smaller wholesalers known as secondary distributors.

Specialty distributors serve niche markets, such as rural areas and independent pharmacies. There are more than 6,000 secondary wholesalers in the U.S. and approximately 2600 in Texas. Each state has its own licensing and oversight regulations over these firms. However, fewer than 100 distribution companies meet the standards to qualify as members of the trade association for wholesalers, the Healthcare Distribution Management Association.

To better ensure the safety and quality of pharmaceuticals, legislation should be passed that increases oversight on wholesalers, especially those operating outside of the usual distribution channels, to ensure counterfeit drugs do not enter our state's drug supply and to continue strong consumer safety.

**Look for opportunities to strengthen Medicaid Managed Care, including continued expansion of the STAR+PLUS program.**

The STAR+PLUS program could be important tool in balancing the increasing cost and variable quality inherent to Texas' long-term care system. The STAR+PLUS program should be expanded to additional urban areas beyond Harris County, where it has been used since 1998, in an effort to further advance long term care integration *provided* that the Health and Human Services continues to verify the credibility of the Lewin Report (December, 2003), which demonstrated the cost-effectiveness of STAR+PLUS.

House Bill 2292 passed by the 78<sup>th</sup> Legislature asked the Health and Human Services Commission (HHSC) to provide Medicaid services through the most cost-effective model(s) of managed care. Upon passage of HB 2292, HHSC contracted for an independent assessment of the cost effectiveness of various managed care models. As a result of that study, HHSC issued a Request for Proposal (RFP) for Medicaid Managed Care Expansion in July of 2004. The RFP proposed to expand STAR+PLUS beyond the Harris service area so that STAR+PLUS operates in all seven service areas in which the STAR HMO Program currently operates: Bexar, Harris, Dallas, Lubbock, El Paso, Travis and Tarrant.

Expanding the STAR+PLUS program could result in enhanced cost savings to the state and improved access and quality of care for clients. Since 1998 the STAR+PLUS program has demonstrated positive outcomes with regards to access to health care services, quality of care, member satisfaction and cost effectiveness. The STAR+PLUS program has demonstrated the ability to maintain aged, blind and disabled individuals in their communities and produced significant cost savings for a high-risk population that traditionally accounts for a disproportionate share of Medicaid expenditures. In addition, the STAR+PLUS program has increased access to care with enrollees receiving 31% more attendant care services and 30% more Day Activity and Health Services (DAHS) than they received under traditional Medicaid fee-for-service.

STAR+PLUS appears to reduce costs to the state. For instance, because home health providers currently perform the client assessments – as well as provide the care – the new approach will help ensure that assessments are made by an independent party and that the treatment is done by the medical provider, preventing the potential conflict of interest when the same person billing for the service is also performing the assessment. Importantly, STAR+PLUS savings estimates involving managed care savings are not reflective of savings achieved through price discounts, but rather savings that occur from truly *managing care* by

avoiding higher cost services and products when lower-cost clinically appropriate services can be rendered.

Texas' current long-term care system does not meet the needs of its most vulnerable consumers -- it's aged and disabled. Long-term care services are fragmented and uncoordinated, leading to intermittent quality and uncontrolled spending. STAR+PLUS expansion can be a viable solution to these problems by giving more Texans access to long-term care services and personalized care coordination, while reducing the costs to the state. This approach has proven to enhance the LTC system at a reduced cost to the State.

**Continue to allow parents a conscientious objector option for childhood immunizations, and reject mandates that undermine parental choice.**

Immunizations are truly a public health issue, protecting and preventing the spread of many diseases in young children in particular (i.e. polio vaccine). While immunizations are an important tool for managing public health, parents are ultimately responsible for what medical procedures and shots their children receive. There is a growing number of vaccinations coming on the market for illnesses that are life threatening and some that are not. As the number of vaccinations grow, it is increasingly important that parents maintain the right to decide what vaccinations are important for their own children.

In addition, the state should reject mandates that would expand the number of immunizations that health plans must cover. State mandates force the cost of insurance to increase forcing more families out of the private market. We should do more to lower the cost of private insurance, not raise it through additional mandates.

Lastly, the State should reject attempts to require the Texas Board of Health to automatically adopt the recommendations on immunizations by the Advisory Committee on Immunization Practices (ACIP) at the Center for Disease Control and Prevention. The ACIP is an appointed panel that formulates recommendations on guidelines for the administration of vaccines. The ACIP is not accountable to anyone in Texas. Furthermore, the Congressional Committee on Government Reform issued a staff report that found members of the ACIP had conflicts of interest when they made recommendations on various vaccines. This committee reviewed the controversial rotavirus vaccine in 1997 and 1998. Despite concerns that the drug could possibly have serious side effects, the committee unanimously voted to support the rollout of the vaccine. Within a year, the vaccine was pulled off the market because it was causing severe bowel obstructions in infants that

required surgery to correct. One child died. The report found that four out of the eight ACIP committee members who supported the vaccine had conflicts of interest with the company that made the vaccine. Members of the Legislature may want to review and reconsider the process by which vaccines are placed on the Texas vaccination schedule for children. Currently the Dept. of Health Services has been delegated the rule making authority for mandating vaccines for Texans.

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<sup>i</sup> The Heritage Foundation, “The Future of Medicaid: Consumer Directed Care,” Backgrounder #1618, 01-10-03,

<http://www.heritage.org/Research/HealthCare/BG1618.cfm>

<sup>ii</sup> Texas Health and Human Services Commission, “CHIP Monthly Premiums Temporarily Suspended,” 10/1/04, [http://www.hhsc.state.tx.us/news/post78/CHIP\\_CostSharingSuspended.html](http://www.hhsc.state.tx.us/news/post78/CHIP_CostSharingSuspended.html)

<sup>iii</sup> Texas Health and Human Services Commission, “Institute for Child Health Policy Survey Findings,” 12/22/04, [http://www.hhsc.state.tx.us/chip/reports/120304\\_DisenrollSurvey.html](http://www.hhsc.state.tx.us/chip/reports/120304_DisenrollSurvey.html)

<sup>iv</sup> Deshundra Jefferson, “Insurance premiums soar 11%,” CNN Money, Sept. 9, 2004, <http://money.cnn.com/2004/09/08/pf/insurance/health/>

<sup>v</sup> Legislative Budget Board, Fiscal Size-Up 2004-05, p 87. < [http://www.lbb.state.tx.us/Fiscal\\_Size-up/Fiscal\\_Size-up\\_2004-2005\\_1203.pdf](http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal_Size-up_2004-2005_1203.pdf)>