



## *LIFT Perspective*

*Limited Government Series*

October 9, 2006

# **Medicaid and Health Care Reforms for Texas**

### **Background**

Combined federal and state spending on the Texas Medicaid program alone for the 2006-07 biennium is \$36.2 billion<sup>i</sup>. For this price, the state covers some 2.7 million Texans under Medicaid<sup>ii</sup>, showing the steep growth in the program since the days when it covered less than 1 million people, as it did at the program's inception in 1967. Assuming that the state could enroll all of the approximately 5.5 million<sup>iii</sup> uninsured Texans in public health insurance, the state would face almost tripling the number of Texans on state-run insurance. At a biennial expenditure of \$36.2 billion, the state Medicaid program currently comprises slightly more than 26 percent of the state's budget, and would skyrocket to around \$90 billion each biennium to cover an additional 5.5 million people, based on 2006-07 spending projection.

Despite the growth and increased costs in the State Children's Health Insurance Program (CHIP) and the Texas Medicaid program, each year the number of uninsured Texans continues to increase. Clearly more government has neither arrested nor reversed the number of uninsured Texans. Indeed, more government will never be the answer.

However, Medicaid and CHIP are not going away any time soon. They are a cornerstone of state health policy. As such, the focus must be on improving operations of both programs, especially Medicaid, despite the strict parameters imposed by the federal government. Medicaid could operate more effectively with certain reforms in place. In response to House and Senate interim charges relating to state and federal Medicaid

reform proposals, the Texas Conservative Coalition Research Institute makes the following recommendations to legislators:

### **1. Expand the STAR+Plus Program**

The Medicaid program has grown from costing \$9.2 billion in state general revenue in the 2000-01 biennium to costing \$15 billion in 2006-2007.<sup>iv</sup> Non-disabled children represent 60% of the Medicaid population and are the fastest growing Medicaid risk group. However, the more costly section of the Medicaid population are the aged, blind and disabled. Children, adults and others represent 74% of the Medicaid population and only 37% of costs. By contrast, aged, blind and disabled represent 20% of the Medicaid population but account for 62% of all costs.<sup>v</sup>

In 1998, the state implemented the STAR+Plus (State of Texas Access Reform Plus Long-Term Care) pilot program in Harris County. The program was designed to help reduce health care costs while ensuring patients receive the highest quality care possible. STAR+Plus provides disease management programs and emphasizes preventive care to help enrollees maintain their health, quality of life and independence in their community.

The External Quality Review Organization (EQRO) report completed for HHSC's waiver renewal to the Center for Medicaid Services (CMS) found that there was a 22% reduction of inpatient hospital visits under the STAR+Plus model as compared to fee-for-service (FFS) models. The same report found that STAR+Plus enrollees utilized 38.5% fewer emergency report visits than is typical under an FFS approach.

From a budgetary standpoint, the strength of the STAR+Plus managed care model is that the contract between the carrier and the state fixes the amount of money paid for each patient. This allows budget certainty for the state, while the insurer takes on the risk. STAR+Plus also yields more impressive fiscal results than other managed care models. For instance, for the highest acuity Medicaid clients in managed care, STAR+Plus enrollees cost the state \$3,226 a month while those in Primary Care Case Management (PCCM) cost the state \$13,160 a month.<sup>vi</sup>

Similarly, the Integrated Care Management (ICM) model, which was established by House Bill 1771 (79R), has not yet been implemented and is therefore yet to deliver any savings to the state. The STAR+Plus model is expected to save the state \$31.9 million compared to the Integrated Care Management Model (ICM) proposed model by FY 2006 budget projections, and another \$34.7 million in tax revenue.<sup>vii</sup>

Expansion of STAR+Plus is currently under way into Austin, San Antonio and Nueces counties, which will nearly double enrollment. This expansion is expected to result in total savings to the state of \$22.3 million after the first year, and \$37.2 million by the end of the fifth year of the expansion<sup>viii</sup>. In addition to current service area expansions set to be up and running in January 2007, future expansions are aimed at Lubbock and El Paso.

The expansion of STAR+Plus should be continued and consideration should be given to creating a moderated program for smaller urban communities. The quicker Texas expands this program, the quicker the state saves valuable resources and dollars. The fact that STAR+Plus also dramatically improves care for its clients while delivering these savings makes the case for expansion overwhelming.

Full integration of health care services into a capitated care model such as STAR+Plus is critical to the success of managed care for the chronically ill and disabled population. Inpatient hospital services must be included in STAR+Plus so that Managed Care Organizations (MCOs) have the appropriate incentives to meet the objective of providing good quality care in the least restrictive setting. The state tax system cannot sustain the growing cost of the Medicaid population who are elderly or disabled. As mentioned above, only 20% of the Texas Medicaid population is elderly or disabled, yet these two groups account for 62% of all Medicaid spending in the state.<sup>ix</sup> The state must act now to control these costs and provide an organized system of care that ensures our most vulnerable citizens continue to receive the care and support they need.

Experience has demonstrated the success of the STAR+Plus model as a mechanism to provide both acute and long-term care benefits to the aged, blind and disabled population. This model should form the core of the benefit design and contracting strategy for all metropolitan markets in Texas, which could be expanded, as appropriate, to include contiguous counties. Outside these areas, an enhanced State-administered network model should be uniformly available, and HHSC should experiment with approaches to bring the benefits of the HMO model to rural areas where feasible.

In both urban and rural areas, the managed home and community based services model presently implemented in the STAR+Plus model should be available for the aged, blind and disabled population. STAR+Plus delivers savings by shifting utilization to increase long term services and lowering utilization of costly inpatient and emergency room services.

For the aged, blind and disabled population, mandatory enrollment under existing STAR+Plus rules should be extended to all markets. Blind and disabled beneficiaries aged 0-21 should be mandated to enroll in either STAR+Plus, or in alternative comprehensive waiver programs.

## **2. Direct Health and Human Services to Apply for a Section 1115 Waiver**

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. This minimal level of government paternalism is clearly appropriate if a Cash and Counseling program is to work effectively in Texas.

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.

### **3. Reform the funding mechanism of the Texas Health Insurance Risk Pool**

The Health Insurance Risk Pool is one of the few areas of government intervention in the health care market which is a wholly appropriate role for the state to play. The Risk Pool essentially acts as a safety net for those who cannot find or afford health insurance as a result of a pre-existing medical condition.

Given the rising assessments against carriers (which have more than doubled since 2002) and in order to prevent a premium increase on consumers, the following funding changes could be made to the Risk Pool (in order of priority):

**Priority Recommendation:**

1. To reflect the necessary and appropriate role that the Risk Pool plays providing a safety-net to medically uninsurable individuals, the Texas Insurance Code (Section 1506.253) should be amended so that assessments made against carriers are abolished.

The assessments should be replaced by devoting General Revenue to the funding of the Risk Pool. It is recommended that the state direct the annual growth in Insurance Occupation Tax revenues to the Pool.

<b>Year</b>	<b>Insurance Occupation Tax Revenue (\$ million)</b>	<b>Growth from Previous Year (\$ million)</b>
2000	\$796.6	-
2001	\$820.0	\$23.5
2002	\$1,045.8	\$225.8
2003	\$1,169.1	\$123.3
2004	\$1,185.0	\$15.9
2005	\$1,208.9	\$23.9

As the chart above shows, this approach would have provided an additional \$23.9 million to the Risk Pool in 2005, and the average additional funding to the Pool each year since 2000 would have been \$82.5 million<sup>1</sup>.

**Alternative Recommendations:**

2. To ensure the long-term sustainability and equity of Risk Pool funding, amend the Texas Insurance Code (Section 225.004) to create a 50% Premium Tax credit for insurance companies. Ten states already provide this type of credit.
3. Amend the Texas Insurance Code (Section 1506.253) so that:
  - a) Health care providers, including hospitals (one of the biggest beneficiaries of the existence of the Risk Pool), are assessed to contribute to the pool since they are a chief beneficiary of the high risk pool (the effect of the pool is to reduce the amount of uncompensated care, therefore providers should participate in funding it.) If providers are included, they should receive a tax credit against the gross margins tax for participation.
  - b) Assessments made against stop-loss carriers are made on the same basis as assessments against other health benefit plan issuers (Insurance Code Section 1506.253)<sup>2</sup>.

---

<sup>1</sup> Source for chart: Texas Revenue History by Source, 1978-2005, Office of the Comptroller.

4. Amend the Texas Insurance Code (Section 1506.253) so that the methodology for calculating assessments reverts back to being based on the total premium dollars received by health plan providers, rather than on the total lives covered by health plan providers. This methodology was changed by Senate Bill 809 (79R), and results in inequitable assessments against providers. Specifically, providers who offer high-deductible plans with low premiums are disadvantaged since they pay the same assessment per covered life, but on average receive a lower premium from each individual they insure.
5. The federal Employee Retirement Income Security Act of 1974 (ERISA) prevents states from including all type of health coverage when assessing insurers' contributions to the risk pool. To improve the funding of the risk pool, ERISA plans should be included in the assessment calculation process. Although this revenue will undoubtedly benefit the Risk Pool, the precise amount of additional revenue that this would yield is unknown.

#### **4. Explore options for using cost-sharing as a model for Medicaid**

Given the success of cost-sharing in the Texas Health Insurance Risk Pool, a study into whether a similar cost-sharing model could be used in the Medicaid program should be undertaken.

Cost-sharing is an essential element for bringing value to health care services. The lack of cost-sharing in the existing Medicaid program shields Medicaid recipients from the real cost of the care they receive. At the minimum, significant emergency room co-payment should be introduced to deter use overuse of emergency care facilities. However, a broader approach would be to require everyone who enrolls on a government program such as Medicaid or CHIP, to contribute a minimum monthly premium of \$15. The 2004 Consumer Expenditure Survey, produced by the Bureau of Labor Statistics, found that the lowest income group (less than \$5,000 earned income per year) spends more on entertainment (including cable television) and tobacco products combined, than it spends on health care. According to the National Cable and Telecommunications Association, the average monthly cost of a basic cable television programming package is \$41.17<sup>x</sup>. The comparison here is stark. Cable television costs a little over \$40 per month, and attracted over 65 million subscriber households in 2006<sup>xi</sup>. There are only 110 million television households nationwide, yet almost 60% of these households find the money to subscribe to cable television. Research by the Texas Lottery Commission also reveals that 20.4% of people who play the Texas Lottery have incomes below \$20,000 per year<sup>xii</sup>, and in general, studies show that “the heaviest lottery players – the 20% of players who contribute 82% of lottery revenue – disproportionately are low income.”<sup>xiii</sup> With low income groups subscribing to cable television and showing a greater propensity toward

---

<sup>2</sup> A health plan provider's assessed contribution to the Risk Pool is calculated dividing the total assessment to be made against all providers by the total number of individuals insured statewide by all providers. This figure is then multiplied by the number of individuals insured by the provider in question.

purchasing lottery tickets, neither of which are essential expenditures, it would not be unreasonable to expect Medicaid recipients to contribute to the cost of their health care.

With certain limitations, federal regulations give states the authority to devise a system of co-payments that encourages the use of generic drugs. Currently, co-payments cannot be more than \$3, although states may request a waiver to increase the amount of the co-payment and to extend the co-payment requirements to the federally excluded categories of people (which currently include children, pregnant women, and people receiving either emergency services or family planning services.)

Texas should require Medicaid recipients who earn less than 100% of the Federal Poverty Level (FPL) to contribute a \$3 co-payment for a non-emergency visit to ER services. This co-payment should be increased to \$5 for Medicaid recipients earning between 101% and 150% FPL, while those earning more than 150% FPL should be required to contribute a \$20 co-pay. Generic medications should attract a \$0.50 co-pay for all Medicaid recipients (regardless of income) while brand-name medications should attract a co-pay of between \$2 and \$5, depending on the recipient's income level.

In addition to introducing the co-payments described above, the state should continue to pursue a waiver for the federal regulations that immediately exclude 82% of the Medicaid population from cost sharing programs<sup>xiv</sup>. In determining eligibility, the categories are divided not by who is most able to pay, but by characteristics all clients in the group share, such as gender, medical needs, or age; however, this neglects to recognize that regardless of these characteristics each of these categories can further be divided by income and ability to pay. It is not unreasonable to expect that a client, whether a pregnant woman or an elderly individual, be asked to pay for their services.

In general, requiring everyone to contribute to their own health care costs increases personal responsibility and creates an incentive for people to pursue healthy lifestyles. In addition, higher monthly enrollment premiums could also be charged to people who, through their lifestyle choices, increase their health care costs. Those who smoke regularly, for example, could be charged a higher premium to account for the greater risk they carry of having to be treated for various cancers, respiratory problems, and other smoking-related diseases.

## **Conclusion**

In Texas, health care reform should focus on transforming government programs, using the Risk Pool as a model, so that a measure of personal responsibility and cost-sharing is introduced to Medicaid and CHIP. Seeking to attain greater efficiency in health care spending, legislators should also pursue HSA pilot programs and expansion of the STAR+Plus managed care program, while acknowledging that Medicaid providers can also deliver cost savings, both of which save the state money and deliver better-quality health care to recipients.

Health care reform in Texas should be rooted in the acknowledgement that rather than relying on the state, it is, ultimately, an individual's responsibility to ensure that they have adequate health care coverage. The state's role should be to facilitate the effective operation of the Risk Pool and to provide basic health care to the genuinely poor and indigent. Beyond this, the state should simply focus on allowing the private health care market to operate as effectively as possible.

---

<sup>i</sup> Legislative Budget Board, Fiscal Size Up, 2006-07 Biennium.

<sup>ii</sup> Texas Medicaid Monthly Enrollment, HHSC.

<sup>iii</sup> "The Uninsured: A Hidden Burden On Texas Employers and Communities," Office of the Comptroller, April 2005.

<sup>iv</sup> Legislative Budget Board.

<sup>v</sup> Texas Medicaid in Perspective, HHSC, April 2004.

<sup>vi</sup> Health and Human Services Commission Presentation, Summer 2006. It should be noted that drug costs are separate under both systems.

<sup>vii</sup> February 28, 2005 budget estimate, based on budget documents during HB 1 Budget discussions.

<sup>viii</sup> Actuarial Assessment of Managed Care Expansion Options, The Lewin Group, January 21, 2004. All funds converted to GR based on FFY 2007 FMAP rate of 39.22%

<sup>ix</sup> "Texas Medicaid in Perspective," (Fifth Edition) June 2004;

<http://www.hhsc.state.tx.us/Medicaid/reports/PB5/PinkBookTOC.html>

<sup>x</sup> National Cable and Telecommunications Association;

<http://www.ncta.com/ContentView.aspx?contentId=65>

<sup>xi</sup> Ibid.

<sup>xii</sup> Demographic Study of Texas Lottery Players, Texas Lottery Commission, December 2005;

<http://www.txlottery.org/info/demographicreport2005dec.pdf>

<sup>xiii</sup> *Why Poor People Win the Lottery*, Christopher Solomon, MSN Money;

<http://articles.moneycentral.msn.com/RetirementandWills/RetireEarly/WhyPoorPeopleWinTheLottery.aspx>

<sup>xiv</sup> HHSC letter to CMS, accompanying "Proposed Texas Medicaid Copay Policy: Two Step Approach – Implementation Fall SFY 2002 and SFY 2004."