Center *for* Public Policy Priorities

COMMENTS

Center for Public Policy Priorities
Comments on HHSC Key Decisions for Texas Medicaid Waiver Concept Paper
November 6, 2007

CPPP thanks Commissioner Hawkins and the HHSC staff for soliciting these comments.

We provide below our responses to the survey document, after making over-arching comments related to the waiver concepts posted on the HHSC site, as well as reiterating questions and comments we provided orally at the 10/30/07 HHSC Council Subcommittee meeting.

The decision survey HHSC produced is very helpful and we applaud staff for their good work. We do, however, also note below several areas where were not sure we fully understood the meaning of a term or the intent of a question posed.

General Comment:

Despite our support for HHSC's current effort and our commitment to constructive participation in this process, it is important for Texans to understand that some working poor parents will be getting less under the proposed waiver than they might have under traditional Medicaid. One decision principle articulated in the HHSC draft that CPPP does not endorse or applaud is the notion that "Premium assistance is not an entitlement; enrollment is subject to availability of program funds." As we discuss below in our responses to the HHSC survey, Texas Medicaid could be serving all parents up to 100-200+% FPL under traditional Medicaid (as do 15 states: Arizona, California, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Vermont, and Wisconsin). Only a lack of political will has stopped Texas from already providing coverage to this group – coverage that, unlike the proposed waiver would be guaranteed available to all who qualify without enrollment caps, without waiting periods, and which would not go away in an economic downturn when needed most. Instead, Texas has chosen to create a coverage approach that potentially will be capped, may well offer narrower benefits, and could be eliminated in an economic downturn when more low-income workers are likely to need it most. Texas does this in the hopes that the pay-off will be coverage for a substantially larger number of Texans (e.g., childless low-income workers) who would otherwise remain uninsured, made possible by winning broader support for an expansion of health coverage than now exists for the expansion of traditional Medicaid. CPPP's priority in this process will be to advocate for the most comprehensive and accessible coverage for the largest number of uninsured Texans. We are eager to see Texas create meaningful and affordable coverage for every Texan, and believe that the waiver under development has the potential to provide important coverage to a substantial number of poor and near-poor uninsured Texans.

Affordability
Because the waiver discussion is limited to Texans with family incomes at or below 200% FPL "take-up" rates for coverage and access to needed health care once enrolled will both be very sensitive to cost. CPPP strongly recommends that HHSC focus on delivery and benefit models that will not simply substitute under-insured status for uninsured status. To achieve this at these low incomes,

cost-sharing must be low, benefits fairly comprehensive, and premium assistance under the waiver must be structured in ways that do not provide incentives to avoid preventive care or medically necessary care of illness or injury because of cost. Adequate benefits are a critical component of affordability; HHSC must also take into account the likely costs of any health care needs that are not covered by the plan's benefits. If the benefit package is too skimpy, then either uncovered needed care will not be delivered, or the family will be paying additional out of pocket beyond the premiums and cost-sharing limits, which diminishes the true affordability of the plan.

To illustrate, a model which presented poor or near-poor adults with a "voucher" to be applied toward high-cost and/or low benefit individual health insurance, without regard for the adult's ability to pay the gap between the voucher and the actual premium, would not be an acceptable or a cost-effective use of public dollars. On the other hand, a model which ensures nominal cost sharing for the poor and a cost share not exceeding 5% of income for those between 100-200% FPL, includes a full array of needed benefits, and for which HHSC would negotiate a group rate premium would be acceptable. A model combining high-deductible coverage with a Health Savings Account would not be acceptable unless the program ensures that the savings account is fully funded and in compliance with the 5% cap on out-of-pocket spending for adults 100-200%, and also ensures that the coverage provided after the deductible is satisfied does not exclude important medically needed benefits resulting in greater out of pocket costs above and beyond the deductible.

Comments on Material other than Survey Questions:

We wanted to note for HHSC staff three items in the discussion document where we were not sure that we clearly understood the staff's intent:

1) Coverage Options

Program decisions should maximize value for enrollees and the state. We are not sure if there is a more specific interpretation of this statement to which we could respond.

2) What types of insurance packages can premium assistance be used to purchase?

Options

- Convey to the commercial market that basic, comprehensive and catastrophic coverage options should be available for this population, based upon the individual's desired level of coverage, and solicit coverage options in each of those categories.

It would be critical to know how HHSC staff are defining "basic" coverage in order to asses the preliminary assessment here, as well as the HHSC suggestion that this "basic" plan cost be the benchmark for the size of the premium assistance. Is "basic" a conservative but comprehensive array of benefits? Is it a "bare bones" plan? Or is it a plan that only covers hospital care? Or one that only covers outpatient care but no hospitalization? Without knowing this it is not possible to give un ambiguous answers to the survey.

3) Subsidy Levels and Duration

Decision Principles

- The program should align with common practices in the commercial market.

Administration and Implementation

Decision Principles

- The program should reflect and support commercial market approaches to the degree possible.

If this refers to annual enrollment periods, then we could agree with this principle. But there are a great number of practices in the commercial market with which a Medicaid waiver premium assistance program should NOT align, including:

- pre-existing condition exclusions,
- denials of coverage for persons with any history of health care utilization,
- wide ranges in premiums for identical coverage
- medical underwriting…etc.

We attach below links reporting on the latest research on the high costs and substandard coverage in the individual market:

PRESIDENT'S "AFFORDABLE CHOICES" INITIATIVE PROVIDES LITTLE SUPPORT FOR STATE EFFORTS TO EXPAND HEALTH COVERAGE, April 3, 2007; http://www.cbpp.org/4-3-07health2.htm

WOULD TAX INCENTIVES BE AN EFFECTIVE WAY TO EXPAND HEALTH COVERAGE FOR LOW-INCOME CHILDREN AND FAMILIES? July 31, 2007; http://www.cbpp.org/7-31-07health3.htm

MARTINEZ BILL WOULD WEAKEN CHILDREN'S HEALTH COVERAGE: Bill Would Lead to Cuts in SCHIP While Creating Poorly Designed Tax Credit; November 5, 2007; http://www.cbpp.org/11-5-07health.htm

We also call HHSC's attention to analyses by Georgetown University of the Florida two-county experiment, which highlights a number of problems and issues that have affected that waiver. Many of the lessons learned can help Texas avoid the same pitfalls. **http://hpi.georgetown.edu/floridamedicaid/**

The rest of our comments are included in the survey document below. Thank you again for the opportunity to comment, and please contact us if you have any questions.

HHSC Request for Public Input

HHSC is seeking public input on key decision areas that will be discussed in the Texas Medicaid Waiver Concept Paper that will be submitted to CMS later this fall. The key decision areas are:
*** Eligible Populations for Premium Assistance Programs.**
*** Coverage Options.**
*** Subsidy Levels and Duration.**
*** Administration and Implementation.**

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Comments are due by noon November 6, 2007.

Eligible Populations for Premium Assistance Programs
1) At what income level should individuals be eligible for subsidies?
CPPP agrees with the HHSC preliminary assessment that 200% FPL is a good target for implementing statewide coverage options. We would, however, add the caveat that in the event that revenue streams are inadequate to reach this level of coverage, that we would of course subscribe to the principle that the poorest parents and adults should be served first.

We must further also comment that there is ample evidence that Texans and Americans with incomes above 200% of the FPL also lack adequate income to support the full cost of coverage (averaging over $12,000 for a family per TDI). It is critical for Texas to continue to seek solutions that will provide affordable coverage for all Texans. For example, a program could be created to allow the 43% of uninsured Texas adults and 33% of uninsured Texas kids who are ABOVE 200% FPL to purchase the same kind of coverage as the premium assistance coverage by paying 5-7% of family income in premiums.

2) What methods should be implemented to minimize or eliminate crowd-out?
We would support the 3-month uninsured requirement recommended in the HHSC preliminary assessment ONLY with the following three policies incorporated:

First, we note that the parents below 100% of the federal poverty line (FPL) are a population who, in many parts of the US, would already be receiving full Medicaid coverage with no waiting period whatsoever. Given this fact, and the fact that employer-sponsored insurance (ESI) is nearly absent among below-poverty Texans (see next paragraph), we recommend applying the waiting period only above the poverty line.

Background: 2006 U.S. Census CPS data for Texas show only 10.4% of Texas adults 18-64 below 100% FPL having employer-sponsored insurance, so—and as the body of research on this topic has established—crowd-out is not even a possibility for 90% of the poverty portion of the proposed waiver population. Of Texas adults 18-64 from 100-200% FPL, 34% had ESI in 2006. This is less than half the rate of Texas adults 18-64 above 200% FPL who had ESI (74%). So, while there is

technically some chance of substitution of coverage among the 100-200% group, it is still quite modest.

Second, HHSC must incorporate for the 100-200% FPL group a list of exceptions to the waiting period, using the list of exceptions in statute for Texas CHIP as a model. Exceptions to the 90-day rule that must be mirrored for adults under the premium assistance program would include exceptions in the case of job loss due to lay-off or plant closure, premiums in excess of 10% of family income, loss of coverage due to divorce or death of spouse, etc.

Finally, HHSC must structure the premium assistance coverage in a manner that does not result in a limit on coverage for pre-existing conditions for some people. HIPPA's protection from the imposition of pre-existing coverage limits requires that there not be a gap of coverage greater tan 63 days. HHSC must structure the timing of the uninsured waiting period in a manner that does not result in adults losing coverage for a pre-existing condition. HHSC will be in a position to contract with health plans directly to provide premium assistance coverage that does not exclude or delay coverage of pre-existing conditions (e.g., as we require of CHIP plans), but in cases where premiums assistance is provide through employer-sponsored insurance plans, great care will have to be taken to avoid exceeding the 63 day period.

3) Should other conditions of eligibility be established for participation in the premium assistance program?
HHSC should consider requiring that dependent children of adults must be insured (or have applied for coverage) in order for parents to enroll in Premium Assisstance; presumably most of these children would be covered through Medicaid or CHIP, but some would likely be covered through HIPP and ESI.

Coverage Options
1) Which qualified products should be eligible for purchase by enrollees?
We agree with the HHSC assessment that hospital- and hospital district-based programs and community based three share/multi-share programs should be considered as options, but the state should establish minimum benefit standards (floors) for these to be eligible to receive waiver funding support (just as would be required of regulated commercial products).

2) What types of insurance packages can premium assistance be used to purchase?
Per the HHSC preliminary assessment, we agree that a LIMITED variety of products be available, but with several caveats. First, HSA-type products coupled with high-deductible/catastrophic coverage for these very low income populations should only be allowed to the extent that the Savings Account itself is fully funded, and selected key preventive care services (for example, mammography, annual exams, colonoscopy) are exempted from the high deductibles in these cases.

As mentioned above, we are not certain what HHSC considers to be "basic" coverage. A benefits package for adults that does not encompass the expensive long term care coverage to which traditional Medicaid adults are entitled may be an acceptable compromise, as may some limits in amount duration and scope (i.e., of the sort that are NOT allowed for children under federal EPSDT law) of benefits. However, the premium assistance packages should not create a new group of under-insured Texans, and should therefore encompass a comprehensive array of services including primary, preventive, inpatient care, Rx, diagnostics, behavioral health, and specialty care.

At these income levels, it should be assumed that health services not insured will be services not received.

3) **How will qualified carriers be chosen to participate in the premium assistance program?**

Competitive selection of plans is acceptable as long as it is truly (not just rhetorically) based on quality and performance as well as price. If the selection (number) of plans is too narrow, the state may lose the opportunity to test potentially superior plans and approaches which might be cost effective and better for health outcomes.

4) **Should the number of coverage options available to consumers be limited?**

It is critical that plan choices and coverage models be limited to a manageable number of choices, and that the minimum standards be meaningful enough that the choices within a type of coverage model are truly comparable. We provide below a link below to Florida's Broward County waiver operations, with 15 very different plans in a single county, and suggest that this is NOT a model of complexity Texas should emulate. http://www.flmedicaidreform.com/BROWARD/English/Broward_CF_eng_Rev11_07.pdf

5) **What incentives could be established to assist small businesses in providing coverage?**

By "providing," do you mean providing an OPTION for employees to purchase coverage, or the employer actually financing part or all of the worker's premium?

Ideas to explore: (1) A true requirement that all state contractors (including HUBs) provide coverage to their workers; (2) a provision allowing small employers with more than x% o their workers below 200% FPL to purchase the premium assistance coverage with subsidy share for their below-200% employees, if they pay full costs for their over-200% FPL workers (this would work best with a guaranteed issue/limited rate variation coverage model); (3) Look at the Vermont model of ESI premium assistance administration to reduce hassle for employers (i.e., VT minimized or eliminated need for small employers to modify their payroll systems).

6) ~~**Should other coverage options or considerations be included?**~~

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Subsidy Levels and Duration

1) **How should premium assistance levels be established?**

The HHSC preliminary assessment meaning ("premium amounts should be based on the cost of a basic benefit plan"), as distinct from a set amount per enrollee or an amount based on income is not entirely clear. If this statement is intended to suggest that only a very bare-bones plan will be financed, with poor and near-poor adults having to pay more for a reasonably comprehensive package, then we do not agree. The "basic" package on which assistance is modeled should cover the array of health services we described above.

Federal law DRA options still prohibit premiums for persons under 150% FPL. While presumably different terms may be negotiated under 1115 authority, it is nevertheless likely that any premium contribution that is more than a nominal amount for these under-150% FPL populations would NOT be approved, nor would CPPP support it. Thus it seems clear that a different level of assistance MUST be available based on income groups, with the highest income (e.g., 150-200%) of FPL uninsured able to make a modest but meaningful contribution. The DRA aggregate cap on

premiums and cost sharing of 5% (i.e., not just premiums) should apply. Using the cost of the basic minimum benefit standard plan defined under the waiver as the template for full premium assistance would be logical within these caveats.

2) What is the term of enrollment for premium assistance?

We agree with the HHSC preliminary assessment of a 12-month coverage period. This is consistent with industry standards and ESI practices, and a shorter period will only introduce costly administrative costs and discourage individual and employer participation.

~~**3) Should any other approaches be taken in establishing subsidy levels or duration?**~~
~~?????~~

Administration and Implementation

1) Given the large number of uninsured Texans and the time-limited nature of a demonstration waiver (5 years), how should the program be implemented to begin making subsidies available?

HHSC's preliminary assessment appears to favor an approach that would leverage the fact that HHSC already has access to income eligibility information for a number of low-income Texas adults in its databases, such as the custodial parents of children on Medicaid and CHIP, and possibly also adults on Food Stamps who do not already qualify for Medicaid. Presumably this means these adults could be rapidly enrolled if they desire coverage. Such an approach would be ositive, but in the event that funding limits are such that the entire group of uninsured adults in these databases cannot be served, the state should ensure that enrollment favors coverage of lower-income adults first.

Several principles point to this choice. One is that, as mentioned above, Texas could have covered all parents up to 100% FPL years ago under Medicaid but has simply chosen not to. Fifteen states plus DC cover parents under traditional Medicaid (not under 1115 waivers) at levels from 100-275% FPL, and another 6 do so through 1115 waivers. Those currently uninsured parents could not only have an individual entitlement to comprehensive health care, but the state could also have an entitlement to Federal Match for the costs of their care. Texas' choice to only offer this coverage through an enrollment-capped waiver with a potentially more restrictive benefit package and higher cost sharing means we are already settling for less for our working poor parents than they would have in nearly half of the U.S. The least we can do is make sure that they get access to this new coverage before we offer it to higher-income adults.

2) Given the funding available and the fact that the demand for subsidies may exceed initial funding, how should enrollment in the program be managed?

As CPPP stated in oral testimony at HHSC's Council meeting on this Input Request, we would strongly recommend that the model either provide a first opportunity to lower-income adults, or failing that, at minimum devise an outreach and assistance structure that recognizes that some very poor and vulnerable uninsured Texas adults currently excluded from Medicaid may need additional assistance applying and/or enrolling (e.g., domestic violence survivors, chronically ill adults and others just above the threshold of disability certification, persons with language and communication barriers) and makes special effort to outreach and assist these populations.

~~3) Based on the design principles, is there another approach that should be taken to implement the premium assistance program?~~

Thank you again for soliciting these comments. Questions may be directed to:

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