Research Report

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Medicaid And The Uninsured

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EXECUTIVE SUMMARY

Medicaid continues to drive state budgets across the country. As state revenues have declined, Medicaid costs per enrollee have almost doubled in the last five years.[1] Texas is no exception, and without reform, Medicaid threatens to consume an ever increasing share of the state budget, potentially jeopardizing every other budgetary item. While spending on Medicaid has risen sharply, and many argue drastically, Texas has remained at the very bottom of the rankings nationally in terms of the uninsured. Policy-makers in Texas must take action both to contain Medicaid spending and decrease the number of uninsured. This is the first of a series of reports to be published about Medicaid and the uninsured; it examines alternative delivery models for Medicaid long-term care and strategies for increasing employer-based health care.

POLICY RECOMMENDATIONS

I. Exploring Alternative Delivery Models for Long-Term Care

A. Consumer Directed Services/ Cash and Counseling

- Expand provider base beyond traditional agencies.
- Increase outreach and enrollment through use of full-time workers, resulting in significant cost savings.
- Seek waiver authority to include additional services under consumer-direction.

B. *Team Delivery Model for High Needs Populations:* This model is characterized by prepaid, risk-adjusted financing, integrated Medicare and Medicaid funding streams, specialized primary care networks, team-based care with nurse practitioner coordination, home-based medical services, and high patient involvement.

- Convene different health care stake-holders to solicit input and support.
- Secure federal approval for integration of Medicare and Medicaid funding streams.
- Examine potential of using Texas STAR+PLUS as the implementation vehicle.

II. Increasing Employer-Based Care

- Develop tax credits tied to purchasing pool participation.
- Identify appropriate role of the state in a purchasing pool.
- Establish target expansion goal for Health Insurance Premium Payment Program and utilize premium assistance for implementing a benefit phase-out rate under Medicaid.
- Promote county level strategies for reducing the number of uninsured through more flexible use of Disproportionate Share Hospital funding.

ABOUT THE AUTHOR

Originally from Houston, Beau attended Baylor University and graduated in 2001 with a Bachelor in Liberal Arts.

While at Baylor, he worked for the City of Waco's Housing and Community Development Department and Congressman Bill Archer in Washington. At the City of Waco, Beau played an integral role in forming a faith-based partnership between the city and local churches.

Following graduation, Beau served as the founding Board President of Faith Covenant Support Services, Inc., a faith-based non-profit specializing in affordable housing.

He recently graduated from Harvard's John F. Kennedy School of Government, with a Masters in Public Policy. Beau's current work surrounds increasing the impact and effectiveness of faith-based and community groups in Texas.

He and his wife Allison reside in Austin, Texas.

INTRODUCTION

Medicaid continues to drive state budgets across the country. As state revenues have declined, Medicaid costs per enrollee have almost doubled in the last five years.[2] Largely as a result, the National Governors Association reported in November 2002 that "nearly every state is in a fiscal crisis."[3] Nationally, Medicaid and other health care services comprise 30 percent of state budgets, and these costs increased by 13 percent in 2002, which was the largest increase in a decade.[4] "Growth in Medicaid continues to put a severe strain on state budgets," and 28 states anticipate shortfalls in Medicaid spending for the current fiscal year.[5]

Texas is no exception to these trends, and without reform, Medicaid threatens to consume an ever increasing share of the state budget, potentially jeopardizing every other budgetary item. Some predict that left unreformed, Medicaid will bankrupt every state in as little as 20 years.[6] The most effective policy response to Medicaid demands first a proper understanding of the problem. How did Texas' Medicaid program get to where it is today? What is driving these costs and where should the state begin in addressing them?

RISING COSTS

Medicaid began in the 1960s as a part of President Johnson's continuing "War on Poverty." It was intended as a social safety net to provide health insurance for the poor, disabled and elderly. Not long after its inception, Medicaid expenditures quickly outgrew Congressional expectations, and its history is largely that of failed government attempts to rein in spiraling costs.

In Texas, Medicaid spending grew rapidly in the 1980s and early 1990s due to increased caseloads and costs, but by the mid-1990s, more modest single digit growth replaced double digit figures. This decline "briefly suspended [Medicaid's] image as the top state budget growth driver."[7] It is important to note that although Medicaid spending slowed dramatically from 1996 to 2000 (26 percent) compared to 1991-1996 (118 percent),[8] it still substantially outpaced nominal budgetary growth. Since 2000, Texas has experienced a steady upward trend in enrollment and a return to annual double digit growth rates.[9] The primary drivers of this growth mirror the national trends of increased enrollment due to the economic downturn, rising prescription drug and hospitals costs, and increased costs of both acute and long-term care for the elderly and disabled populations.[10] The elderly and disabled populations in particular accounted for almost 60 percent, or 50 billion, of the national growth in Medicaid spending from 2000-2002.[11]

The Texas Health and Human Services Commission along with other health policy experts expect this growth in Medicaid expenditures to continue for several reasons:

- Increased enrollment, primarily non-disabled adults and children,
- Increased utilization and cost of prescription drugs,
- Increased provider payments,
- Medical inflation, and
- Increased long-term care expenditures.[12]

HIGH OVERALL COSTS

While these factors account for Medicaid's spending growth, they do not necessarily explain why Medicaid is so expensive overall. A number of issues contribute to making Medicaid such

an expensive program. First, Medicaid simply covers a medically needier population, many of whom would be unable to attain health insurance on the private market. This population includes the elderly and disabled, but also Medicaid's general adult population who has a poorer health status compared to low-income adults with private insurance.[13] In addition, unlike employer-based health insurance, where coverage begins upon hiring, Medicaid coverage is often triggered by a specific health need. Second, Medicaid's eligibility requirements create perverse incentives for beneficiaries. Since eligibility is based on having low-income and few assets, Medicaid penalizes those who succeed and encourages the spending down of assets in order to retain or initially qualify for benefits. When a beneficiary earns a dollar over the income threshold, he/she loses 100 percent of coverage. Medicaid eligibility rules also allow individuals to divest themselves of assets, by transferring to heirs and/or other family members. They can subsequently qualify for Medicaid within 36 months. While empirical confirmation of this problem is difficult to attain, burgeoning law practices in this area combined with ample anecdotal evidence suggest its presence is real.

Third, delivery of Medicaid services isolates consumers from the cost of care. Since Medicaid beneficiaries largely do not pay for their care, excluding co-pays, they consume until their marginal benefit equals zero, resulting in procedures that cost more than their value to patients. This problem is not necessarily specific to Medicaid, but to insurance in general when consumers do not pay providers directly for their care. Medicaid managed care programs have attempted to reign in such spending, but savings thus far have been modest.[14] Managed care also introduces increased complexity for providers and beneficiaries, and while beneficiaries have been generally satisfied with the program, providers indicate high levels of dissatisfaction.[15] Overall, these factors contribute to high Medicaid spending in Texas and in the U.S.

LARGE NUMBER OF UNINSURED

While spending on Medicaid has risen sharply, and many argue drastically, Texas has remained at the very bottom of the rankings nationally in terms of the uninsured. The percentage of Texans without health insurance has largely held steady throughout the last ten years.

Figure 1.

Year	Medicaid Expenditures[a]	Persons Insured[b]	Persons Uninsured[c]	Percent of Total	National Ranking of Uninsured	Year
1996	$8,178	14,557	4,680	24.3	1st	**1996**
1997	$8,514	14,915	4,836	24.5	1st*	**1997**
1998	$8,943	15,065	4,880	24.5	1st	**1998**
1999	$9,574	15,380	4,665	23.3	2nd	**1999**
2000	$10,363	16,167	4,425	21.5	2nd	**2000**
2001	$11,186	16,105	4,960	23.5	1st	**2001**
2002	$13,128	NA[d]	NA	NA	NA	**2002**
2003	$14,265*	NA	NA	NA	NA	**2003**
2004	$15,543*	NA	NA	NA	NA	**2004**

Sources: Adapted from Current Population Survey, US Census Bureau and Texas Department of Human Services (DHS). Texas DHS sources include: Medicaid Budget: DHS Medicaid Expenditure History Report less Disproportionate Share Hospital expenditures for 1996-1999 (FFY), HHSC Biennial Medicaid Report for FY2000-2002; HHSC 4th Quarter Medicaid Report for FY2003; HHSC 1st Quarter Medicaid Report for FY2004. *Total State Budget:* FY2004-2005 Fiscal Size Up for FY1996-2003; General Appropriations Act, 78th Legislature for FY2004.

*Note: Figures for FY2003 and FY2004 Medicaid Budget are projected. Figures for FY2003 Total State Budget is an estimated amount and for FY2004 is the appropriated amount.

a In millions of dollars. Numbers reflect both state and federal contributions and exclude disproportionate share hospital payments.
b, c In thousands
d Not Available

These numbers indicate that increases in Texas Medicaid spending have had little or no impact on the uninsured, controlling for population growth. The most likely explanations include government crowd-out of private insurance and additional Medicaid dollars simply offsetting the rising medical costs for the existing Medicaid population. Since current Medicaid spending is unsustainable in the long and possibly even short-term, alternative strategies must be sought to decrease the number of uninsured. Perhaps the strategy with the greatest potential is building upon the existing employer-based system.

AREAS FOR POLICY-MAKER ATTENTION

The following research areas have been identified for potential Medicaid reform and decreasing the number of uninsured in Texas:

- **Exploring alternative delivery models for long-term care.** Long-term care expenditures are one of the major cost drivers for Medicaid nationally and in Texas.[16] In 2000, they comprised 28 percent of the state Medicaid budget and are expected to continue to increase.[17] Alternative delivery models should be examined as they have

the potential to lower costs while also offering greater consumer-direction, independence, and integration of services.

- **Increasing employer-based health care programs.** Currently in Texas employer-sponsored health insurance covers 58 percent of the population compared to 64 percent nationally.[18] Employer-sponsored programs hold perhaps the greatest potential for reducing Medicaid costs and decreasing the number of uninsured persons in Texas.
- **Managing the utilization of services.** As mentioned above, attempts have been made to manage the utilization of services primarily through managed care programs. These programs are only offered in urban areas as opposed to the fee-for-service model in rural areas, where there is little negotiating power on the unit price of health care. The fee-for-service model also creates incentives for providers to perform unnecessary procedures, depending on the level of fees. Alternative delivery models, educational programs and other strategies should be identified to better align patient and provider incentives with the tax-payers' interests. While there will be some overlap here with the long-term care section, this area distinguishes between the long-term and non-long-term care populations and recognizes the need for different approaches to their health care services.
- **Ensuring state maximization of entitled federal share (FMAP or Federal Medical Assistance Percentage).** State policymakers should continue to strive for the most efficient system to deliver medical assistance to low-income populations. They should also examine ways to increase flexibility, increase local control, and ensure that taxpayers of the state and its political subdivisions are receiving fair treatment in terms of federal funds for low-income programs.

The problems posed by Medicaid and the uninsured challenge even the most experienced policy-makers of our state and nation. There are no easy answers. While not comprehensive, the proposed topics of study encompass some of the most promising areas for change. Alternatively, each of the topics is large enough to fill numerous studies of much greater length than this one. Thus, the purpose of this study is not to detail a comprehensive solution to Medicaid and the uninsured, but rather to suggest the areas for immediate policy-maker attention and to make specific recommendations within those areas. These recommendations alone will not solve all of Medicaid's problems, but my goal is that they will bring us much closer to truly reforming the system. This report will cover alternative delivery models for long-term care and strategies for increasing employer-based health care. Subsequent reports will address the management of utilization of services, ensuring state maximization of entitled federal share (FMAP), and provide a closer examination of the uninsured in Texas.

METHODOLOGY

The methodological approach to this study was three-fold:

1. **A state by state examination of Medicaid programs and strategies for decreasing the number of uninsured,**
2. **An assessment of current proposals by Medicaid and other health policy experts, and**
3. **A survey of the perspectives of those directly affected by Medicaid and other health policies in Texas.**

A state-by-state examination of Medicaid programs and strategies for decreasing the number of uninsured. This examination included a comprehensive study of what other states are doing in regard to alternative delivery models for long-term care, managing the utilization of services, increasing employer-sponsored health coverage, and maximizing the state's federal share of Medicaid funding. The sources of information consisted of a literature review on current state programs and interviews with key Medicaid actors looking for "best practices" models. These actors included: State Medicaid Directors, chairs of State Health and Human Services Committees and other key legislators, advocacy groups, private insurance companies, doctors, and hospitals.

An assessment of current proposals by Medicaid and other health policy experts. In this area, there was some overlap of sources from the state by state analysis, but it predominantly consisted of a literature review. Sources included think tanks such as the National Center for Policy Analysis and the Heritage Foundation, other non-profits focusing on health care such as the Henry J. Kaiser Family Foundation and the Commonwealth Fund, university experts, policy journals, magazines, and newspaper articles. When research needed further clarification, interviews were conducted with authors.

A survey of the perspectives of those directly affected by Medicaid and other health policies in Texas. Lastly, it is important to garner the perspectives of those directly affected by Medicaid and other health care policy in Texas. These groups included Medicaid beneficiaries, employers, employees, health care providers, and insurance companies. Recognizing the limits of this study, information was primarily gathered through past surveys and studies of these groups. Specific information sought included cost-sharing mechanisms, factors influencing take-up rates, obstacles to providing health insurance, provider cost-drivers, adequacy of reimbursement rates, beneficiary experience with alternative delivery models, satisfaction levels, and recommendations for change.

EXPLORING ALTERNATIVE DELIVERY MODELS FOR LONG-TERM CARE

Within the larger frame of Medicaid reform, the impetus for examining long-term care is simple: it is one of the largest budgetary items and cost drivers for the state of Texas. In addition, the population that utilizes long-term services, the elderly and disabled, comprises approximately a quarter of beneficiaries, but in 2002 they accounted for almost two-thirds of the costs.[19] Thus, it is worth evaluating whether Medicaid's delivery of services for this population is cost-effective. The goal is to maintain at least the same level of quality while reducing costs; it is hoped that policy-makers can actually improve the quality of care that this population receives.

There are two models examined in this section: Cash and Counseling, and the Team Delivery Model for High Needs Populations.[*] This study sought to identify best practices and these models were deemed particularly noteworthy. An examination of Cash and Counseling is especially needed because Texas has recently implemented this approach for personal assistant services for the elderly and disabled. The findings from a large-scale demonstration and evaluation are now becoming available so that policy-makers can determine the full potential this model holds. The intent is that these models will provide policy-makers with some needed tools for addressing Texas Medicaid reform.

CASH AND COUNSELING DEMONSTRATION AND EVALUATION

BACKGROUND AND PROGRAM DESCRIPTION

The disabled and elderly communities have been advocating increasingly for approaches to health care that promote greater independence, consumer-control, and choice. Such approaches are considered forms of "consumer-directed care," and policy-makers have been exploring numerous avenues for their successful adoption.

State and federal program administrators are becoming more aware that traditional modes of service delivery may unintentionally presume a high level of personal incompetency on the part of aged/disabled beneficiaries and foster excessive dependency in the name of consumer protection and/or public accountability.[20]

The push for forms of consumer-directed long-term care is the result of several different factors including: (1) intense advocacy on the part of persons with disabilities for health care options to support greater autonomy; (2) the "demedicalization" of certain conditions, such as disability, old-age and pregnancy, and services, such as supportive home-case and child birth; (3) policy-maker interest in examining less-costly options of long-term care; (4) the *1999 Olmstead* decision by the Supreme Court relating to placement of persons with disabilities in community settings; and (5) recent shortages of workers in home care.[21]

Begun in October 1995, the Cash and Counseling Demonstration and Evaluation (CCDE), funded by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, examines a consumer-directed approach to personal assistance services (PAS) for the elderly and younger persons with disabilities. It compares a cash-option with traditional agency-delivered services to assess "the use of a cash benefit to enhance Medicaid consumers' ability to design PAS services that best meet their needs."[22] The study is a public/private

[*] I call this model the "Team Delivery Model" although it is referred to by several different names elsewhere.

collaboration between participating states, the U.S. Department of Health and Human Services, The Robert Wood Johnson Foundation, Mathematica Policy Research, Boston College's Graduate School of Social Work, and the University of Maryland's Center on Aging. A Section 1115 Research and Demonstration Waiver was sought from the Centers for Medicare and Medicaid Services (CMS) since Medicaid does not allow cash benefits.[23]

CCDE is a large-scale public policy experiment in Arkansas, Florida and New Jersey that randomly assigns Medicaid-eligible individuals with long-term functional disabilities to treatment and control groups. Because of substantial differences between the states, separate evaluations are being performed. With the cash-benefit, consumers can hire workers, including family members, and purchase other goods and services including transportation services, assistive technologies, home and vehicle modifications, adult day care, and respite services. Participants are required to develop a spending plan with the assistance, if needed, of a counselor, who will also aid them in managing their allowance and other employer responsibilities. The participant can also designate a representative if he/she is either unwilling or unable to manage responsibilities. This aspect is designed to make the program adaptable to a wide-range of consumers.[24]

In Arkansas and New Jersey, the allowance was determined by "cashing-out" of a consumer's care plan, while participants in Florida received an allowance based on their Medicaid claim's history. The average monthly allowance for participants in Arkansas was approximately $350, $975 for elderly adults and adults with physical disabilities in Florida, $1,400 in New Jersey, and $1,825 for children and adults with developmental disabilities in Florida.[25] To ensure budget neutrality, per CMS requirements, the programs discounted the number of hours in care plans while still valuing them at the agency per hour rate. Discounting adjusts for the fact that clients of traditional services receive fewer hours of care (or fewer goods and services) than planned for due, for example, to client hospitalization or to aide "no-shows."[26]

Comparison of care plans in Arkansas and Florida revealed that goods and services received were less than those planned on average, whereas there was little difference between cost of care planned and received in New Jersey.[27]

All three programs offered counseling and fiscal agent services that performed the following tasks: (1) review initial and revised spending plans to ensure that they included only permissible goods and services; (2) help with employer functions; and (3) monitor consumer condition and the uses of the allowance.[28]

Arkansas, Florida and New Jersey all made different arrangements with regards to counseling and fiscal services. Arkansas used two human resources organizations to provide both counseling and fiscal services, one for-profit and one non-profit. Agencies providing traditional personal care were allowed to bid conditional on establishing a separate business unit for services. One-third of the cash benefit was allocated for these services. New Jersey contracted with a number of public, nonprofit, and for-profit human resources organizations for counseling services while designating one organization for fiscal services. In New Jersey 10 percent of cash-benefit was designated for fiscal and counseling services. Lastly, Florida used the existing network of case-managers for counseling services for the elderly and independent contractors offering support coordination for persons with developmental disabilities. A single human services organization was used for fiscal services state-wide. Since Florida's waiver did not

include cash benefits for counseling services, funding was provided through existing Medicaid funds, and fiscal services were assessed on a fee-for-service basis charged to consumers. Counselors were required to make periodic visits and phone calls for monitoring purposes. In all three programs, time sheets and check requests were compared with spending plans before disbursement of funds. Receipts for expenditures were required in Arkansas (except for incidental expenditures) and Florida, while New Jersey did not require them.[29]

EVALUATION AND FINDINGS

There are several issues of importance when evaluating the Cash and Counseling Demonstration and the full potential the approach holds for personal assistance services in Texas. Because of the limitations of this study, the examination here will confine itself to a "high level" look at issues of access, quality of care, accountability of public funds, consumer protection and, Medicaid costs. The purpose is not to design the specifics of a program for Texas, but rather to assess the potential of the cash and counseling program in general and then its relevance for Texas. Much of the evaluation of the Cash and Counseling Demonstration is still in progress;[†] thus, findings are often not yet available for all three states on certain issues.

The lack of control over health care services has been a long and critical concern of the disabled and elderly communities. For so many this lack of control results in dissatisfaction, unmet needs, and subsequent diminished quality of life.[30] One of the primary motivations behind the CCDE is to assess if a consumer-directed model for personal assistance services increases consumer satisfaction and quality of care. The findings for Arkansas's Cash and Counseling program (IndependentChoices), the only available thus far, indicate that the program "dramatically improved consumers' lives."[31] Two telephone surveys were conducted to assess program effects on both satisfaction and quality of care. The baseline survey was conducted between December 1998 and April 2001. The follow-up survey took place between September 1999 and February 2002.

[†] For a complete list of official reports and related publications see www.mathematica-mpr.com/3rdLevel/cashcounselinghot.htm.

Figure 2.

Estimated Effects of Independent Choices on Unmet Needs and Satisfaction with Care Arrangement, By Age Group

	Ages 18-64			Age 65+		
Outcome	**Predicted treatment-group mean**	**Predicted control group mean**	**Estimated effect (p-value)**	**Predicted treatment-group mean**	**Predicted control-group mean**	**Estimated effect (p-value)**
Has unmet need for help with						
Daily living activities[a]	25.8%	41%	-15.2% (.001)	35.9%	36.5%`	-.7% (.823)
Household activities[b]	41.3	56.0	-14.7 (.002)	38.1	47.2	-9.1 (.003)
Transportation[c]	27.0	47.2	-20.2 (<.001)	29.0	36.5	-7.5 (.009)
Routine health care[d]	26.6	32.3	-5.7 (.189)	29.2	32.3	-3.1 (.285)
Satisfaction with overall care arrangements[e]						
Very Satisfied	71.0	41.9	29.2 (<.001)	68.3	54.0	14.3 (<.001)
Dissatisfied	6.0	31.4	-25.4 (<.001)	6.2	10.4	-4.3 (.026)

SOURCE: Mathematica Policy Research nine-month follow-up evaluation interview, September 1999–February 2002.
NOTE: Means were predicted with logit models.
A Daily living activities include eating, dressing, using the toilet, transferring from bed to chair, and bathing.
B Household activities include meal preparation, laundry, housework, and yard work.
C Transportation includes trips to and from a doctor's office, shopping, school, work, and recreational activities.
D Routine health care includes help taking medications, monitoring blood pressure, and performing exercises.
E Includes arrangements for unpaid and paid help with daily living activities, activities around the house and community, routine health care, community services, and transportation and for use of care-related equipment.

Treatment group members were less likely than control group members to report unmet needs for all categories including daily living activities, household activities, transportation, and routine health care. For the younger group, ages 18-64, all of the findings were statistically significant at the 5 percent level, except for unmet needs related to routine health care; these were not statistically significant at the 5 or 10 percent levels. The findings for the older group, age 65+, were smaller but still significant, especially for unmet needs related to household activities and transportation. Arkansas' IndependentChoices appears to have greatly increased consumers' satisfaction with their overall care arrangements. For the younger age group, there was nearly a 30 percent difference between treatment and control-groups for those reporting that they were "very satisfied" with care arrangements. The older age group also reported a significant increase in levels of satisfaction.

Figure 3.

Estimated Effects of Independent Choices on Adverse Events, Health Problems, and General Health Status, By Age Group

	Ages 18-64			Age 65+		
Outcome	**Predicted treatment-group mean**	**Predicted control group mean**	**Estimated effect (p-value)**	**Predicted treatment-group mean**	**Predicted control-group mean**	**Estimated effect (p-value)**
Adverse events in the past month						
fell[a]	28.4%	28.7%	-.4% (.931)	19.0%	18.6%	0.4% (.869)
Saw doctor because of fall	4.4	4.1	0.3 (.849)	5.4	4.6	0.7 (.587)
Saw doctor because of cut, burn or scald[b]	1.3	4.0	-2.7 (.070)	1.4	1.9	-0.5 (.479)
Was injured while receiving paid help[b]	0.9	2.3	-1.4 (.221)	1.8	1.4	0.3 (.673)
Health Problems in past month						
Shortness of breath developed or worsened	29.8	39.7	-10.0 (.016)	32.3	36.1	-3.8 (.161)
Had respiratory infection	31.4	32.1	-0.7 (.872)	23.3	25.3	-2.1 (.404)
Contractures developed or worsened	26.0	25.2	0.8 (.826)	15.9	19.7	-3.9 (.089)
Had urinary tract infection	19.4	21.6	-2.2 (.560)	18.2	21.0	-2.8 (.230)
Bedsores developed or worsened[a]	5.9	12.6	-6.7 (.012)	7.5	6.8	0.7 (.640)
General Health Status						
Current health poor relative to peers[a]	56.4	53.5	2.9 (.476)	48.0	50.0	-2.0 (.462)
Spent night in hospital Or nursing home in past two months	16.6	15.9	0.7 (.842)	25.2	23.7	1.5 (.551)

SOURCE: Mathematica Policy Research nine-month follow-up evaluation interview, September 1999–February 2002.
NOTE: Means were predicted with logit models.
A Effects were estimated by pooling the two age groups and including an age-treatment status interaction term in the model.
B Impacts could not be estimated with the logit model. Results presented are the unadjusted means and treatment-control differences.

Arkansas' IndependentChoices provided care that was at least as safe as traditional agency services. For most categories, the treatment group had better results, but these were not statistically significant. Particularly, the program appears to have substantially reduced the likelihood that consumers' bedsores developed or worsened and the likelihood that participants' shortness of breath developed or worsened. The Mathematica study also found that "[a]ccess to care can be improved by tapping [the] "labor supply" of family and friends."[32] Of some concern

though was the fact that treatment group members were somewhat less likely than the control group "to report certain kinds of health problems that might indicate they had received inferior or insufficiently frequent care."[33]

In addition to quality and satisfaction levels, designers of the Cash and Counseling Demonstration were concerned about accountability of public funds and the possible exploitation of program participants. The abuse of the cash allowance was "almost non-existent in the three Cash and Counseling programs."[34] Program designers cited review of spending plans, timesheets, and check requests as critical to preventing abuse.[35] The findings related to exploitation of consumers were as follows:

Consumer exploitation was extremely rare in Cash and Counseling. Of the very small number of cases of potential exploitation, some were identified at the time of the initial counselor home visit and resolved before an allowance was paid. Periodic telephone calls and visits are adequate to ensure that recipients of the allowance are not exploited as their situations change.[36]

Figure 4.

Estimated Effects of Independent Choices on Medicaid Spending, 1999-2002

	Predicted treatment-group mean ($)	Predicted control-group mean ($)	Estimated effect ($) (p-value)
Full sample: first-year post enrollment Spending (n = 2,008)			
PCS spending	4,605	2,350	2,256 (.000)
Non-PCS long-term care Medicaid spending[a]	3,084	3,505	-421 (.023)
Other non-PCS Medicaid spending[b]	4,791	5,139	-348 (.109)
Total Medicaid spending	12,480	10,994	1,486 (.000)
Early cohort: first-year post enrollment Spending (n = 1,312)			
PCS spending	4,855	2,402	2,452 (.000)
Non-PCS long-term care Medicaid spending[a]	2,892	3,396	-505 (.025)
Other non-PCS Medicaid spending[b]	4,576	5,142	-566 (.044)
Total Medicaid spending	12, 322	10,940	1,386 (.001)
Early cohort: second-year postenrollment Spending (n = 1,312)			
PCS spending	3,853	1,839	2,014 (.000)
Non-PCS long-term care Medicaid spending[a]	3,253	4,310	-1,057 (.003)
Other non-PCS Medicaid spending[b]	4,212	4,640	-429 (.182)
Total Medicaid spending	11,317	10,789	528 (.339)

SOURCE: Medicaid claims data.
NOTE: Those in the "early cohort" enrolled in the Cash and Counseling Demonstration before May 2000. Means were predicted using ordinary least squares (OLS) regression models. Elderly and nonelderly subgroups are combined here, because treatment-control differences were similar for the two groups. PCS is personal care services, also referred to as personal assistance services (PAS).
A Includes spending for nursing facilities, home health services, and ElderChoices and Alternative waiver programs.
B Includes spending for hospital inpatient services, prescription drugs, physician services, durable Medicaid equipment, hospice, and other Medicaid services.

Much of the drive behind the CCDE lies in the view by many persons with disabilities that, "If I had more control over my services, my quality of life would improve, and I could meet my needs for the same amount of money or less."[37] The findings thus far seem to indicate that quality of life has improved; now it is important to examine the costs. Overall in Arkansas'

IndependentChoices, the treatment group had higher Medicaid personal care expenditures than controls did, because many controls received no paid help, and recipients obtained only two-thirds of entitled services. By the second year after enrollment, these higher personal care expenditures were offset by lower spending for nursing homes and other Medicaid services.[38]

As a result of the control group not receiving entitled personal care services (PCS), spending for the treatment group was almost double that of the control group. Historically, PCS recipients in Arkansas received 86 percent of their authorized hours, and cash benefits for treatment-group members were discounted to reflect this fact. But during the demonstration, control-group members only received on average 68 percent of authorized hours. While it is unclear why this occurred, some suggest that it was a combination of worker shortages and induced demand. [39]

In the first year, these higher PCS costs for the treatment-group were partially offset by lower non-PCS long-term care Medicaid spending and other non-PCS Medicaid spending. However, by the second year higher PCS spending for the treatment-group was completely offset by lower spending in these other categories which appears to suggest that "Cash and Counseling enables consumers to substitute personal care services at home for other, more costly services, particularly nursing facilities."[40] There is a potential that savings to Medicaid would increase over time as this substitution continues. Overall, to the extent the traditional agency model delivers authorized hours, the greater potential for immediate savings to the Medicaid program and although additional study is needed, there is a real potential for increasing savings in the long-term.

APPLICABILITY TO TEXAS

Although the evaluation of all three state programs remains incomplete, it is reasonable to conclude that the basic findings are generalizable to Texas. This conclusion is based on the fact that the participating states are similar enough to Texas in ways thought to influence the findings, including size, institutional arrangements, demographics, and income levels. It is important to note that there is rarely if ever complete certainty of the external validity of a study; thus lies the need for pilot programs and Texas is no exception in this regard.

However, there are specific areas where Texas may face additional challenges predominantly because of its demographic make-up and geographical size, and there are already indications that these challenges are real for Texas' consumer-directed services program, which is similar to Cash and Counseling. These areas include outreach and enrollment and the delivery of counseling and fiscal services. In comparison to the demonstration states, outreach and enrollment efforts will likely be more costly in Texas because of the diversity of the population which includes cultural, linguistic, educational, and to some degree socio-economic differences. There was "some indication that less educated populations in Florida didn't like the program because of so much paper work, employment papers, tax forms etc;" for these individuals, the enrollment process was particularly intimidating.[41] Programs found that letters from the governor which explain the program are particularly helpful in overcoming enrollment barriers.[42] These diversity issues are obviously not new for policy-makers in Texas who work with a diverse population on a daily basis; they should simply be additional considerations because of the potential to increase program costs.

Being such a large state, there are certainly economies of scale concerns for the fiscal and counseling services, especially in rural areas. Agents performing fiscal services need a large

enough caseload to devote a minimum of 1-2 days a week to the tasks, or approximately 200 consumers. Otherwise program requirements are quickly forgotten. Economies of scale for counseling services are related more to proximity. Counselors must live in close proximity to beneficiaries in order to make home visits. Barbara Phillips, who specializes in the implementation issues of the CCDE, estimated that one-third of counselors' caseload time should be devoted to cash and counseling consumers, or like the fiscal services' agents, they will quickly forget program requirements.[43]

As already noted, Texas recently implemented a consumer-directed services program for personal assistance services that takes essentially the same approach as the CCDE, although there are some differences. Much of the findings from the CCDE suggest that Texas' program is a good one; thus the questions remain as to why enrollment has been so low and if Texas should completely adopt the Cash and Counseling model or retain its slightly altered approach.

Enrollment in the Texas consumer-directed services program has been substantially lower than expected[44] and the reasons for this seem quite clear. First, because of fiscal constraints the state has not committed enough resources to education and outreach. Consumers learn of the program through their case managers and there were definite problems with this strategy in the CCDE states. In Florida, case managers "were pressed by other responsibilities and sometimes opposed to consumer direction, and few gave priority to the time-consuming tasks of outreach and enrollment."[45] All three programs in the CCDE eventually relied on workers dedicated full-time to outreach and enrollment.[46]

Second, the Texas program has relied heavily on traditional agencies[47] for administrative and fiscal services. While the cooperation of traditional agencies is critical to the success of a consumer-directed approach, "[o]utreach and enrollment were marked by troubled interaction between the three Cash and Counseling programs and agencies providing traditional services."[48] In Arkansas, traditional agency opposition was so severe that the industry lobbied the state legislature to withdraw from the CCDE. In both Arkansas and New Jersey, traditional agency aids tried to persuade Medicaid beneficiaries not to participate in the CCDE.[49] These two factors largely contribute to the low enrollment numbers in Texas.

A key difference between the Cash and Counseling and current Texas model is that the CCDE utilizes Section 1115 Waiver authority while Texas has amended six of its existing 1915(c) Waivers and its Medicaid state plan to offer a consumer-directed services program. The Section 1115 Waiver allows for consumer direction of any state plan or waiver service, while consumer direction in Section 1915(c) Waivers is limited to home and community-based services. In addition, Section 1115 Waivers permit hiring of spouses or legally responsible parents of minor children, and direct cash management, whereas Section 1915(c) Waivers do not. Overall, Section 1115 Waivers provide greater flexibility for policy-makers in designing Medicaid consumer-directed services.[50]

Texas' current program also only allows consumer direction in the area of personal assistant services, whereas the CCDE includes services such as transportation, assistive technologies and home and vehicle modifications. These additional services are important since there is evidence that they lower costs as consumers make initial investments in areas such as home modifications and assistive technologies that reduce their need for paid personal assistance.[51]

THE TEAM DELIVERY MODEL FOR HIGH NEEDS POPULATIONS

BACKGROUND

The inability of the U.S.'s fragmented health care system to respond appropriately to the needs of the chronically ill, frail elderly and disabled has long been recognized. The conviction among many is that traditional managed care and fee-for-service models do not work for high needs populations. Financial incentives under managed care give a rationale for supplying fewer services to people who need more. Advocates also point out that these populations "have such great needs and such intimate familiarity with their own social and medical conditions they must therefore be free to make their own medical decisions, without managerial assistance. . ."[52] The result is poor health outcomes, avoidable and expensive hospital admissions, and duplication of services because of a lack of coordination.[53]

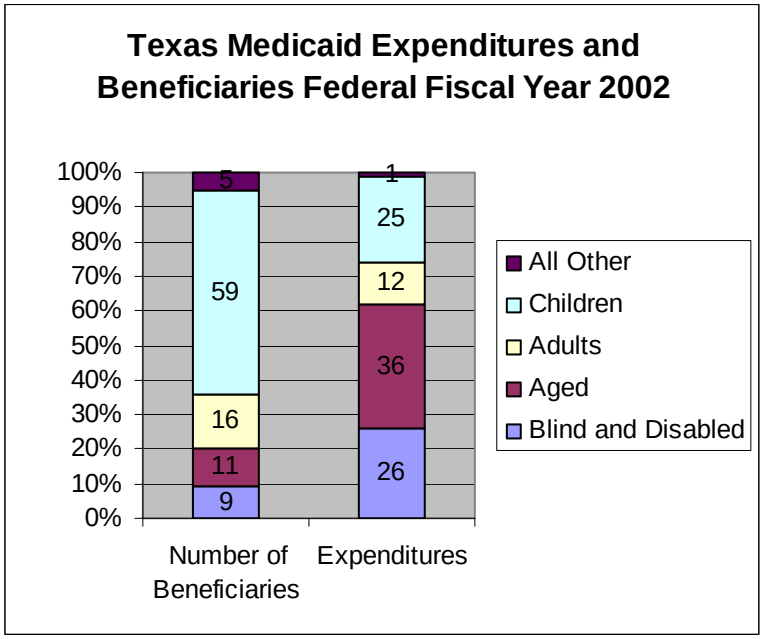
Managed care advocates respond that experience with fee-for-service models for the chronically-ill, frail elderly and disabled has not been much better. Obstacles include "limited access to medical specialists, limited time with providers, and regulatory and fiscal restrictions on the development of flexible, responsive services."[54] As already noted, the fee-for-service model also rewards physicians for the number of procedures performed, as long as they are covered, and provides no incentive for containing costs. The result is no financial incentive for coordination of care, no nexus of accountability, whether clinical or programmatic, and no mechanism to substitute home and community services for hospital and institutional care.[55]

It is also no surprise that these high needs populations are by definition the most expensive nationally in terms of health care dollars. Texas is no exception, and while under Medicaid persons with disabilities and the elderly comprise only a quarter of beneficiaries, they make up almost two-thirds of costs.

So although much policy-maker attention has been given to reducing costs for the largest Medicaid populations, women and children, it seems more appropriate to focus on the populations with the greatest costs, the elderly and disabled.

> [These high need populations] require a new paradigm of primary care, one that is empowered to harness all necessary resources and services on behalf of the persons served. Yet the provision of primary care today is characterized by high-volume, narrowly defined ambulatory encounters in the setting of the office, clinic, or hospital, often with obstacles to the use of hospital and physician specialist services, not to mention a complete inability to allocate support or long-term care services effectively.[56]

Figure 5.



Source: Texas Medicaid in Perspective, Fifth Edition, Texas Health and Human Services Commission

Numerous models around the U.S. have proven that there are alternatives to managed care and fee-for-service models for high needs populations; more specifically, the proper integration of acute and long-term care services holds the potential to improve access, increase consumer satisfaction *and* lower costs. While many may deem these findings too good to be true, it is no longer a question of their validity; it is rather of question of how to implement these models on a larger scale.

PROGRAM DESCRIPTION

Of the successful national programs, they all share most of the following characteristics: prepaid, risk-adjusted financing, integrated Medicare and Medicaid funding streams, and a flexible combination of acute and long-term benefits. The risk-adjusted premiums allow providers to estimate better the true cost of care for beneficiaries, expand support options and long-term care benefits, authorize primary-care physicians to allocate benefits, and in "some instances fundamentally redesign the primary care role and the care delivery system."[57] Although target populations differ, models include: the Health Plan of Nevada (HPN) under the social health maintenance organization (S/HMO I) demonstration, the Special Projects of Important National Significance (SPINS) demonstrations focusing on Medicaid-eligible patients with acquired immunodeficiency syndrome (AIDS), EverCare demonstrations targeting frail elderly in nursing homes, Program of All-Inclusive Care for the Elderly (PACE) for frail elderly at risk of nursing-home placement, and Community Medical Alliance (CMA) initiatives for Medicaid-eligible children and adults with severe disabilities and chronic illness. [58]

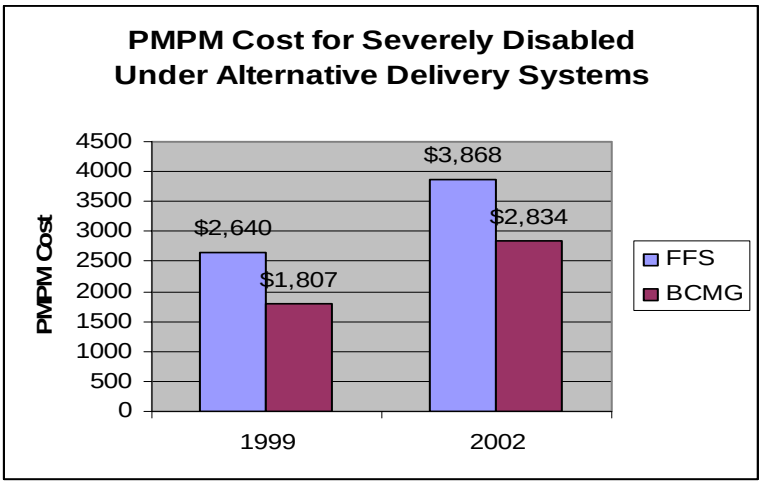
While successful program designs differ slightly, the most important components in terms of Medicaid and high needs populations include: specialized primary care networks, team-based care with nurse practitioner coordination, home-based medical services, full integration of care, and patient involvement. The importance of the specialized primary care networks lies in having physicians focused and committed to providing comprehensive health care to high needs

populations. It requires a fundamental shift in the traditional delivery of care from numerous short office visits to a holistic team model that manages every aspect of care in the home. Nurse practitioners coordinate care such that there is an ability to diagnose and respond quickly to clinical problems, 24 hours a day. Nurse practitioners also encourage greater patient compliance with physician recommendations. Home-based care empowers patients through greater autonomy and independence while also seeking their involvement in the design of care plans. The team model also facilitates greater communication among physicians regarding best-practices related to high needs populations. These teams could easily be linked on a regional and/or state level to further increase physician communication to improve quality of care, health outcomes, and cost savings.

EVALUATION, FINDINGS AND OBSTACLES TO SUCCESSFUL IMPLEMENTATION

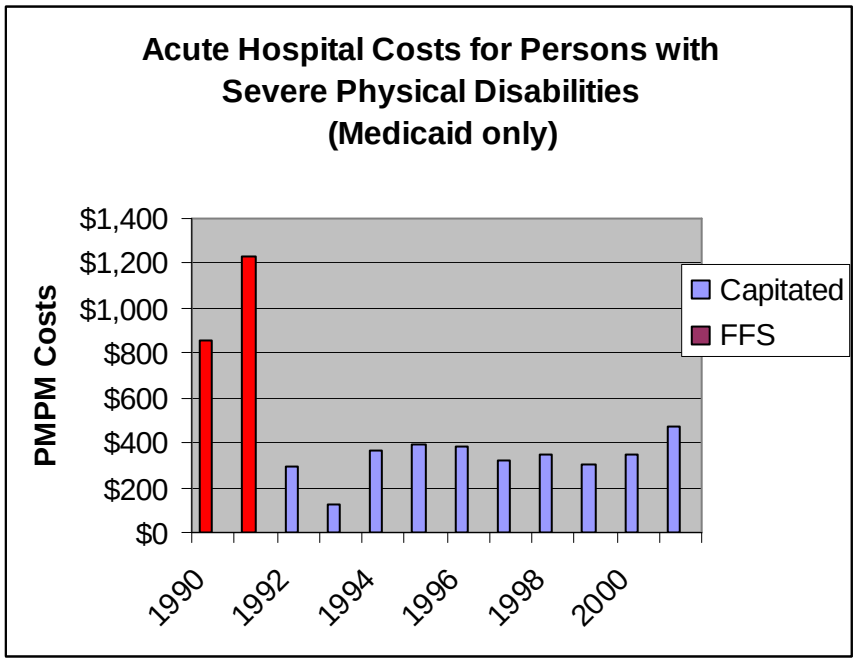
In Massachusetts, the Commonwealth Care Alliance (CCA), a state-wide not-for-profit, specializes in this alternative delivery model for the chronically ill, frail elderly, and disabled. CCA is led by Robert Master, MD, a pioneer and national expert in the delivery of health care services to high needs populations. The Boston Community Medical Group (BCMG) is an affiliated site of CCA and it demonstrates the power of this new approach to health care services:

Figure 6.



Source: Commonwealth Care Alliance and Boston Community Medical Group

Figure 7.



Source: Commonwealth Care Alliance and Boston Community Medical Group

Perhaps the most striking finding is that this model drastically reduces costs; all of CCA's sites in Massachusetts have experienced 15-20 percent savings.[59] Perhaps paradoxically, costs savings have been realized not by rationing care, but by greatly increasing access through 24 hours per day and seven days per week continuity of care. With the ability to diagnose and respond quickly to new problems, the model greatly reduces the need for hospital and nursing home care. With a focus on prevention, adverse health outcomes that lead to hospitalization are greatly reduced. Although a comprehensive consumer survey has not yet been conducted, it is safe to say that this model greatly increases consumer satisfaction. Reports from individual patients have been incredibly positive,[60] and it is no surprise since the model emphasizes what persons with disabilities and advocates for years have been promoting: increased independence, individualized care, and greater access.

The question remains then, if these programs are so successful, why are they not being implemented on a larger scale? "Not surprisingly, the factors that have defined their success are also the barriers to their expansion."[61] First of all the push for these new delivery models has been fueled by a mission-driven philosophy on the part of communities where they've been successful. Communities all have unique obstacles tied to the ecology of health care in their area. The Community Medical Alliance in Boston and the OnLok Senior Health PACE program in San Francisco were fraught with difficulties including inadequate reimbursement rates, difficulty realizing economies of scale and flexible government payment options. Although these programs were some of the first demonstrations, comparable commitment would be required of communities with high-needs populations including the support of the health care community.[62]

Second, within the confines of the Medicaid program in particular, governments must be flexible in their approaches to financing. Prepaid risk-adjusted financing is critical to the functioning of

the model, yet there are very limited opportunities for such an approach outside of a few demonstrations and waiver programs. Risk-adjustment payment options require up-front capacity investments that states are often reluctant to supply. States and the federal government must also provide easier access to combined funding streams for dual eligibles, i.e. those receiving Medicare and Medicaid assistance.[63]

Last, implementation on a much larger scale threatens physician empowerment and the flexible care delivery system. These components have helped the model to thrive, but with increased public funding comes increased public accountability. "Such accountability will require inflexible rules and regulations that are the antithesis of the very patient-centered flexibility to move resources that is the essential ingredient for success in these models."[64] Expansion would also place programs like the Boston Medical Group and the Commonwealth Medical Alliance in larger HMOs with different values, priorities, and decision-making processes. In short the traditional HMO culture and business model will likely threaten the team care model and should not be underestimated. Much time and resources should be spent to preserve the core aspects of the model when integrating it into larger health care organizations.[65]

RELEVANCE FOR TEXAS

In recent years, Texas Medicaid has made substantial progress in the provision of medical care for high-needs populations. Particularly noteworthy is the integration of acute and long-term care services in a managed care delivery system under the STAR+PLUS program. The program is similar to the team delivery model in its focus on integration of acute and long-term care services, emphasis on home delivery, care coordination, and some degree of risk-adjusted financing. However, in the author's opinion, it does not go far enough in the redesign of the care delivery system, specifically in regards to the integration of Medicare and Medicaid funding streams and the locus of control and coordination.

STAR+PLUS designers originally intended to integrate Medicaid and Medicare funding streams for dual eligibles, but found the federal government highly uncooperative. As an alternative, they identified HMOs that offered both Medicare and Medicaid products such that there would be some degree of coordination.[66] Since that time other states have succeeded in getting federal approval and Texas should again seek the appropriate waivers. The integration of the funding streams is critical for the full integration of care for dual eligibles, who are a large portion of the target population.

Perhaps most critically, Texas STAR+PLUS places the control and coordination function at the HMO instead of the provider level. For true integration of services, physicians must be empowered to redesign care delivery on an individual basis if needed and better coordinate among themselves through the use of nurse practitioners. As mentioned previously, this approach challenges the traditional fragmented delivery of health care services and it requires a strong commitment on the part of physicians. However, the returns related to quality, health outcomes, consumer satisfaction, and costs justify the rethinking of the entire delivery system for high medical needs populations.

INCREASING EMPLOYER-BASED HEALTH CARE

Although its limitations have been noted, the employer-based health insurance system supports the large majority of Americans for their health care needs. Americans have also reaffirmed their preference for the system over the most often proposed alternatives including direct individual purchasing and government-sponsored health insurance.[67] Texas' employer sponsored coverage falls short compared to the national figure, where 64 percent of the population is covered compared to 58 percent in Texas.[68]

Figure 8.

Texas Uninsurance Rates by Employment Status

(Non-retired persons 18 and older)

Employment Status	Number Insured	Number Uninsured	Percent Uninsured within Employment Status Category	Percent of Total Uninsured
Employed	7,227,920	2,365,562	24.7%	65.0%
Unemployed	302,698	291,893	49.1%	8.0%
Not in Labor Force	3,659,209	982,569	21.2%	27.0%
Total	**11,189,827**	**3,640,024**	**24.5%**	**100.0%**

Source: 2001 Demographic Profile of Texas Uninsured Population Based on March 2002 CPS, Research and Forecasting Department, Texas Health and Human Services Commission.

In disaggregating Texas' uninsured, the larger majority, 65 percent is employed. "The occupational composition of Texas workers has long been recognized as a contributing factor to Texas' uninsured problem."[69] A high number of part-time employees, contract workers, and seasonal employees, who are excluded from most employer provisions for health insurance, contributes to Texas's high uninsurance rate. In addition higher than average employment in the retail and services industries, who traditionally are less likely to offer health insurance, especially compared to manufacturing jobs, further exacerbates Texas' uninsured problem.[70]

Strategies for increasing employer-based health care aim to address many of these issues by building upon the existing and preferred source of health care provision in this country. It is recognized that this system is imperfect and falls short in many respects, especially with regards to fluid American labor markets. In response, many have argued that individual purchasing of health insurance is preferable to the employer-based system. In fact, individual purchasing would solve one of the primary criticisms of employer-based health insurance, the issue of portability where employees lose health insurance upon termination of work with their employers. However, individual purchasing would eliminate administrative economies of scale that employers now enjoy and create such adverse selection that there would likely be a higher number of uninsured. Individuals would face the same selection obstacles that small employers, especially businesses of one, now face.

Health insurance markets are defined by asymmetrical information where the insured knows more about his/her health status than the insurer. Thus, there is a large risk for companies to

cover small employers because one chronic illness could cause the insurer to lose money. Large employers mitigate these risks as the premiums of the healthy subsidize the premiums of the sick. Otherwise, many sick would be unable to afford their actuarial premiums. Individual purchasing would eliminate all of these advantages and combined with the presence of loading fees, insurance premiums could end up being unaffordable except for the healthy.

Some have suggested that individuals could form their own purchasing groups which would allow them to achieve administrative economies of scale and negotiate lower loading fees. But adverse selection would remain as the healthy would not be willing to pool with the sick. As long as groups are formed with the intent of purchasing health insurance, there will be adverse selection. Precisely because employer groups are formed surrounding employment needs, which are uncorrelated with health needs, risk is minimized.

While this study is not designed as a detailed response to the proponents of a universal government-based system, lessons from the RAND Health Insurance Experiment suggest that free medical care is not worth its costs for the entire population because of the induced medical services, but little to no cost-sharing for the very poor and chronically ill could be justified.[71] So for the foreseeable future, unless a more effective and politically feasible alternative arises, employer-based health care is the system we have; thus, in striving to decrease the number of uninsured in Texas and decrease Medicaid costs, employer-based health insurance is an appropriate place to focus our efforts.

STRATEGIES FOR INCREASING EMPLOYER-BASED HEALTH CARE

(1) TAX CREDITS

Tax credits are one of the most commonly proposed policy solutions for the uninsured. In the context of increasing employer-based health care, they allow the leveraging of the employer premium contribution with other sources. In a small employer survey conducted by the Texas Department of Insurance under a State Planning Grant (SPG), 85 percent of employers either "strongly" or "generally" supported tax incentives for small employers to provide insurance.[72] Under the same planning grant, a household survey reported that 92 percent of individuals were either "strongly" or "generally" supportive of tax incentives for small employers.[73] Tax credits also address two primary causes for lack of insurance that nearly all policy analysts accept: "Many people's incomes are too low to allow them to afford insurance, and the premium they would have to pay is too high to make insurance purchasing attractive."[74] Tax credits address these issues by simply subsidizing health insurance premiums.

One of the primary strengths of tax credits is their relative simplicity compared to other options. They do not demand any new government bureaucracies because they are administered through the existing tax system. Neither do they "require changing the health care regulatory structure, negotiating with providers, reorganizing the delivery system, or altering the philosophy of medical treatment."[75] Such simplicity is also viewed as tax credits greatest weakness: they provide access to the current system and where the current system falls short, tax credits have no remedy.[76] However, even considering these limitations, tax credits offer a viable policy tool for decreasing the number of uninsured, if they are structured appropriately.

Since approximately 65 percent of uninsured adults in Texas are employed, and the overwhelming number of the uninsured are low-income individuals,[77] a tax credit that targets the

low-income employed could be highly effective at reducing the rate of uninsured in Texas. The tax credit could be used against existing taxes including franchise, sales, and other fees/taxes related to the state's general revenue fund. The credits could also be transferable such that eligible employers could sell them to other business with greater tax liabilities. Policy-makers must consider specifically how to target the low-income employed, the particular form and size of the credit, and the likely impact on the rate of uninsured.

A few strategies have been suggested in order to target low-wage firms. First, if a firm has an average wage level below a certain amount, for example $10/ hour or the equivalent salary for a full-time worker, it would be eligible for the credit. But the credit would operate on a sliding scale such that firms with lower average wage levels would receive a larger tax credit. Another strategy would be where firms with a certain proportion of workers receiving less than $10/ hour would be eligible. This strategy allows firms with a few high-paying management positions, and an otherwise low-income work-force, to qualify. A combination could also be used so that a firm could qualify based on either an average wage level or proportion of workers earning below a set wage. The potential danger in this targeting approach is that it would encourage the breakup of firms and/or outsourcing in order to concentrate low-wage workers. However, some might consider this potential as a benefit since it allows policy-makers to better target the uninsured provided it does not result in crowd-out of existing private insurance. To prevent crowd-out, a "look back" period could be implemented such that employers could not qualify for the tax credit if they have offered health insurance within the last two years or a similar period.[78]

Firms receiving the tax credit would be required to offer the equivalent benefit to their employees. Although we confine our discussion to *employer* tax credits, it is worth noting that the approach is compatible with extending tax credits to low-wage *employees* as well. Since employer-sponsored coverage has significant advantages over individually purchased coverage, it is important to give employers inducements to offer coverage to their employees rather than simply to extend subsidies to employees so they can buy coverage in the individual market.[79]

Subsidizing low-income employers encourages the expansion of group insurance which better pools risk and capitalizes on economies of scale in relation to administrative and marketing costs.

Much of the debate surrounding tax credits concerns their size. They must be large enough to induce employers to offer insurance who did not previously do so. Studies have found that small credits do little to reach the uninsured, but credits covering approximately fifty percent of the premium for a benchmark plan could have significant success.[80, ‡] A credit covering fifty percent of a standard plan premium is substantial and its effect on state and/or federal tax revenue would be large; an additional study would be needed to determine cost effectiveness of tax credits compared to other policy options.

Lastly, it is important to assess the impact of such tax credits on the rate of uninsured. Virtually any program to reduce the number of uninsured persons or relieve the financial burden of paying

‡ A pilot study in New York found that a 50 percent reduction in the price of health insurance premiums did not have a substantial increase in the number of small firms offering health insurance. However the study had several limitations, of which perhaps most important was that employees could not finance any portion of the insurance premium. See Kenneth E. Thorpe et al, "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results from a Pilot Study," *Journal of the American Medical Association* (19 Feb 1992) 945-8.

for medical insurance will have uncertain impacts as long as people participate in them voluntarily and resources are not so lavish that any alternative to participating in the plan is economically irrational.[81]

This degree of uncertainty must be realized as it depends on employers taking advantage of the credits and employees shouldering the remaining premium costs. Obviously if employers only offer the amount of the tax credit toward the premiums, it would be difficult for many low-income employees to pay the remaining fifty percent. It is hoped that with such a generous tax credit, employers would contribute additional dollars to premium costs in the interest of retaining a more competitive workforce. Other strategies could be designed to assist low-income employees such as premium assistance programs currently offered under Medicaid and State Children's Health Insurance Program (SCHIP) and purchasing pools for small-businesses as explained below.

Although further study is needed, tax credits could have a significant impact on the rate of uninsured in Texas. They are administratively simple, allow the targeting of a large proportion of the uninsured, and could leverage private dollars with public funding.

(2) BUSINESS COOPERATIVES/ PURCHASING POOLS

Business purchasing pools have been often mentioned as policy options for increasing access to health insurance for small employers. It is widely recognized that small employers have greater difficulty attaining affordable health insurance. The higher premiums compared to large employers mainly result from greater administrative burdens and less ability to spread risk. As a result of this greater risk, there tends to be less competition in the small-group market, with health plans reluctant to participate. This fact also results in higher premiums.

Figure 9.

	Texas			United States		
	All Businesses	Small Businesses	Large Businesses	All Businesses	Small Businesses	Large Businesses
Total Number of Firms	412,368 100.0%	299,192 72.6%	113,177 27.4%	6,256,044 100.0%	4,736,180 75.7%	1,519,864 24.3%
Firms Offering Insurance	217,730 52.8%	110,701 37.0%	107,065 94.6%	3,709,834 59.3%	2,235,477 47.2%	1,471,228 96.8%

Source: Texas Department of Insurance Analysis of 2000 Medical Expenditure Panel Survey

Purchasing pools address these issues by enabling smaller firms to become a part of a larger group, typically a cooperative. Overall cooperatives attempt to accomplish two primary goals: lower premiums and greater choice of health plans for employees. Actual success in these two areas has been mixed. First of all, business cooperatives have rarely been able to negotiate lower prices with health plans.[82] The Alliance purchasing cooperative in Madison, Wisconsin represents an exception as it leveraged the negotiating influence of its small employers to attain better rates directly from providers.[83] Outside of contracting directly with providers, limited success in negotiating lower rates may be due to a common misperception that size produces savings from insurance companies. Many assume that a larger presence in the market forces health plans to take note, but this is not the complete picture. The fact is that many believe

insurance companies are in the risk-management business and thus the more business an employer can bring them, the lower the rates they will receive. However this is not entirely the case. "Health insurance companies are not in the risk-management business, they are in the money-making business," [84] and this distinction, while subtle, is an important one. Size matters only in its ability to reduce risk and thus allow health plans to turn a greater profit. Purchasing cooperatives reduce risk for insurance companies through a larger risk pool and economies of scale necessary to pursue other risk management strategies. These advantages often lead to the greatest premium reductions compared to the small-group market.[85]

Cooperatives have pursued such risk-management/reduction strategies as benefit standardization and risk-adjusted payments to plans to both prevent and compensate for adverse selection, but it has occurred nonetheless. The Alliance in Madison, Wisconsin had particular problems with groups of one,[86] which theory would predict. Most cooperatives mandate that employers must enroll at least 75 percent of employees to participate. Private companies, such as Administaff which pioneered the human resource outsourcing model, implemented employee health screenings and provided incentives for healthy behavior.[87]

Cooperatives also aim to lower premiums through administrative and marketing economies of scale, but New York's Health Pass, California's PacAdvantage, and Denver, Colorado's Cooperative for Health Insurance Purchasing have all experienced problems in attracting enough employers to benefit.[88]

As for the second goal, almost all cooperatives have succeeded in providing greater health plan choice for employees. In particular in New York, market research revealed that cost was not the only issue driving the coverage decisions of small businesses. The inability to offer a *choice* of health plans was forcing some employers to choose unnecessarily expensive plans (e.g., those with out-of-network options or relatively richer benefits) for everyone in order to meet the needs of a few. Thus, the city identified a demand for a flexible insurance product that would enable small businesses to offer coverage to employees with different needs.[89]

With an array of plans, cooperatives can also help employers contain/predict costs by switching to a defined contribution plan where employers agree to a specific contribution level and employees can then provide additional funding for a richer benefit plan if they so choose. However, with this additional choice, the potential of adverse selection among plans increases. Under a defined benefit plan, the employer contribution level would need to be tied to a standard benefit package to ensure adequate coverage for employees. New York's Health Pass implemented a defined-contribution program where employees could choose from over 20 different plans.[90]

Cooperatives are also amenable to forms of consumer-directed health care which aim to lower costs by giving consumers a greater role in their health care decisions while also assuming greater financial risk. With the risk, of course, comes the potential for reward. For example, cooperatives could offer a catastrophic health care plan with a high deductible which consumers could use with recently proposed Health Savings Accounts to manage their own care. However these plans may offer less reward for low-income employees since the tax deduction is less valuable at a lower marginal tax rate. But to the extent that full financial responsibility before the deductible is met decreases unnecessary health spending, overall costs could be lowered.

The danger for adverse risk selection is still present since these plans would be more attractive to the healthy.

The most common problems faced by cooperatives stem in one way or another from a lack of ability to attract employer participation and thus gain adequate size. With cooperatives' benefit lying in greater size, they face a "catch 22" when small employers refuse to join them until they become large. Low-risk groups in particular fear being pooled only with high-risk ones. A possible policy solution to this problem is to make receipt of tax credits, as described above, contingent upon participation in a purchasing cooperative. This strategy would enable cooperatives to become large enough to realize administrative, marketing, and risk-management economies of scale and sufficient fees for self-sustainability. As it achieves necessary size, the cooperative would then attract other small businesses at higher income levels that do not qualify for the tax credits; thus, by allowing these businesses to participate in the pool, tax credits for low-income employees are leveraged to reduce the number of uninsured at higher income levels without any additional cost to the state.

On the most important issue for this study, decreasing the number of uninsured, cooperatives have been mildly successful. New York's Health Pass in particular reported that 28 percent of its members did not have coverage previously.[91] Wisconsin's Alliance estimates that approximately 25 percent of its employers were offering coverage for the first time.[92] It is important to note that cooperatives have yet to be combined with tax credits and specifically targeted to low-income employers.

(3) EMPLOYEE PREMIUM ASSISTANCE

Premium assistance involves the subsidization of employer-sponsored insurance for beneficiaries of Medicaid and SCHIP. Considering the scope of this study, this section will focus mainly on premium assistance under Medicaid. Although the authority under Medicaid has existed for many years, the Bush Administration has renewed attention on premium assistance through its Health Insurance Flexibility and Accountability (HIFA) Waiver under section 1115 authority.[93] In the past, states were permitted to use federal matching funds under Medicaid for premium assistance if it was cost-effective, did not increase cost-sharing, and beneficiaries retained all benefits they possessed under Medicaid. These premium assistance programs were known as Health Insurance Premium Payment or HIPP programs. Enrollment in HIPP programs has been low for several reasons including: (a) most Medicaid-eligible persons do not have access to employment-based coverage; (b) it is difficult for the state to identify Medicaid applicants or enrollees with access to job-based insurance; and (c) it is difficult to obtain needed information from the employer and applicant.[94]

States have complained in particular that HIPP requirements are "excessively burdensome, both administratively and financially."[95] States must monitor plans, with often reluctant employers, to ensure adequacy of benefits and no increases in cost-sharing mechanisms. Some have also expressed concerns that HIPP and other premium assistance programs may "stigmatize" participants as employers, who would not have otherwise known about their employees' Medicaid status, become aware of it. However, outside of employers, the perceived "stigma" of participating in a public program could be reduced under premium assistance programs as participants now fall under employer-based plans.

The Bush Administration's new HIFA Waivers attempt to address many of these problems by giving states more flexibility to explore, among other things, "the kind of health insurance options available in the private sector."[96] New HIFA guidelines relax the benefit and cost-sharing requirements for optional and expansion Medicaid populations. Some are concerned that these new guidelines will adversely affect Medicaid beneficiaries, while others believe that they will give states the needed flexibility to expand coverage to uninsured populations through premium assistance programs.

There are several arguments in favor of premium assistance including: (a) it builds upon the existing employer-based system; (b) it offers the potential to reduce public costs by capitalizing on the employer's contribution; (c) it may increase low-income workers' attachment to the workforce; (d) it could reduce crowd out. Along with tax credits, premium assistance programs also address one of the main problems of the uninsured, affordability of premiums. In a Texas Department of Insurance household survey, 57 percent of respondents who do not participate in employer-based insurance health insurance for which they are eligible, report that cost was the main reason.[97] In addition, premium assistance may also allow all family members to be covered under one plan.[98] Others have mentioned the possibility that participants may experience less "churning" with a premium assistance program, or breaks in coverage as income fluctuates and thus eligibility.[99]

Perhaps the main lure of premium assistance programs for this study is the potential to lower public costs by capturing the employer's contribution. These savings would depend on the cost differential between public and private coverage. For example, if a parent of a Medicaid eligible child has access to employer-based health insurance, the cost of adding the child to private coverage must be less than the Medicaid cost. Due to distortions in the current system, the employer's premium contribution is essential to the affordability of premium assistance for states because commercial health insurance is typically more expensive than coverage through public programs, and the costs for private coverage are also rising more quickly.[100]

Iowa's HIPP program, considered by many to be the most successful, has accomplished this goal of cost-savings. It was estimated to have saved the state $18 million in 1999 and $19 million in 2000. These estimates are based on an older study that found that for every dollar spent on HIPP, Medicaid saved $3.30. The state hopes to conduct a more recent study to better quantify program savings, but the overall consensus is that the state's budget has widely benefited.[101] Nevertheless, enrollment in Iowa's HIPP program, like all others, has been low. It currently has only 5,436 Medicaid eligible enrollees. With the recent implementation of the HIFA Waivers, data are not yet available to assess cost-effectiveness and other program goals for these premium assistance programs.

Policy-makers in Texas need to examine several issues when considering either an expansion of the current HIPP program or implementation of other forms of premium assistance. These issues include access to employer-based insurance, outreach and enrollment, and cost-effectiveness. As has been previously noted, Texas' high rate of uninsured compared to other states is largely the result of limited access to employer-sponsored health insurance, especially among low-income populations. Thus, any premium assistance program would need to be combined with other strategies outlined in this report to increase employer-based care.

In addition a premium assistance program would have limited impact under current Medicaid income standards since it's difficult to work and remain eligible for benefits. While these standards rightly discourage dependence on public programs, they can also serve as work disincentives; participants lose 100 percent of benefits when they earn $1 above the income threshold. To address this issue, many have suggested a sliding scale for Medicaid benefits,[102] where cost sharing increases with income. A premium assistance program could be used in this manner; when participants are no longer eligible for full Medicaid benefits, they could continue to receive premium assistance which would phase out with income. In the short term, there is the potential for increased costs as a greater number of people would be eligible for premium assistance. However, over time this strategy would better encourage Medicaid beneficiaries to transition off of public assistance into an employer-based plan, thus resulting in cost-savings for the state. Additional study is needed to quantify the effects of phase-out rates under premium assistance programs.

When evaluating outreach and enrollment efforts in Texas' HIPP program, policy-makers quickly run into a problem: no one knows how high enrollment should be. Texas has never performed an assessment as to how many Medicaid beneficiaries meet HIPP program requirements; thus it is very difficult to determine ultimate enrollment success without some sort of target. However, this fact does not mean the program has been unsuccessful. On the contrary, each new participant in the HIPP program represents cost-savings to the state; the state simply does not know the upper bound of enrollment.

Texas' HIPP program has increased participation through a variety of pro-active efforts including meetings with community leaders, faith-based organizations, large employers, and case workers. The state often identifies potential HIPP participants through comparing Medicaid and Texas Workforce Commission data. These individuals are then directly contacted to determine further eligibility. Other outreach and enrollment mechanisms include a 1-800 line, website information, and at one time a mass mailing was conducted. The program could increase enrollment numbers through a larger marketing campaign, but budgetary concerns preclude this strategy. There is also a question as to the cost-effectiveness of a larger media/marketing campaign compared to steady program growth through existing efforts.[103]

Cost-effectiveness remains a primary consideration under premium assistance programs. HIFA Waivers' cost-effectiveness measures state:

> Each state demonstration will operate under a budget neutrality agreement that will limit federal financial payments over the life of the demonstration and that is negotiated prior to approval of the waiver.[104]

Texas utilizes a cost-effectiveness formula that compares past medical expenditures, or in the absence of this information, estimates of future expenditures based on risk categories, to the costs of HIPP program participation including premium payments, administrative costs, and other cost-sharing. In addition, program administrators perform yearly cost-effectiveness evaluations which have consistently demonstrated substantial savings to the state.[105] Also in reference to cost-effectiveness is the issue of crowd-out. There is a small portion of the Medicaid eligible population, estimates are less than 10 percent,[106] that are covered by employer-based health insurance without any type of state assistance. While this population is small proportionately, it is quite large compared to overall HIPP participation that fluctuates around

7,000 beneficiaries. If this population transitioned to premium assistance under HIPP, state costs would increase dramatically with no effect on the uninsured. In response to crowd out, other states have restricted enrollment in public programs through "look-back" periods whereby employers and employees cannot participate if they've offered or received private insurance within a certain time frame. "Look-back" periods obviously raise equity concerns in that they penalize employers and employees for shouldering burdens of insurance costs in the past. Thus, it seems that there is a real trade-off between equity and crowd-out specifically for the HIPP program, and policy-makers must decide the appropriate stance.

While other state HIPP programs have complained of the administrative burden related to benefits comparability, cost sharing, cost-effectiveness, and the need for supplementary benefits or "wrap around" programs, Texas' HIPP program has not experienced many problems.[107] As a result, pursuing the Bush Administration's new HIFA Waiver seems unnecessary. In conclusion, largely because of limited access to employer-based insurance among Medicaid beneficiaries, Texas' HIPP program is likely to have limited impact on Medicaid costs and decreasing the number of uninsured. However, as access to employer-based insurance increases through other strategies detailed in this study, premiums assistance will prove a more valuable tool in these two areas.

(4) COMPREHENSIVE COMMUNITY HEALTH MODELS/ MUSKEGON COUNTY, MICHIGAN'S ACCESS HEALTH

One of the most widely studied comprehensive community health models is Muskegon County, Michigan's Access Health Program. In 1995, through the initiative of the W.K. Kellogg Foundation, three Michigan counties, Muskegon, St. Clair, and Calhoun, developed comprehensive community health models to improve their communities' health status. Each county developed several different strategies and Access Health is one component of Muskegon County's plan; it is a health insurance plan that targets the working uninsured through their employers. Along with addressing access issues, Michigan policy-makers designed Access Health to decrease state health care costs through prevention and early intervention.[108]

In consultation with employers, employees, and providers, Muskegon County designed what it deemed an appropriate benefit package. The county then solicited HMO involvement, but the HMOs felt they could not offer the proposed benefit plan at the price employers were willing to pay, based on an employer survey. Essentially, HMOs didn't want to participate because Access Health targeted smaller employers who had not previously offered insurance. The small employer market is not really profitable and it is fraught with risk; HMOs were also very nervous about pent-up demand,[109] which ended up being somewhat of an issue.[110] In response, Muskegon County formed a separate 501(c)(3) to contract directly with providers instead of utilizing health plans.

The county then addressed the critical issue of financing. There was no public support for a tax increase and although Medicaid and CHIP expansions were considered, ultimately, the state agreed to the use of Disproportionate Share Hospital Funding (DSH), with the condition that the county also covers the indigent uninsured. Michigan possessed previous authorization to use DSH money for coverage expansion as a result of programs in other counties. In addition the new HIFA Waivers specifically mention that "States may reallocate State and Federal share of DSH funding to increase health insurance options."[111] Muskegon County developed two separate programs, both utilizing DSH funding, Access Health for the working uninsured, and

Muskegon Care for the indigent uninsured. In Access Health's three-share model, employers and employees each contribute 30 percent of premium costs while the community matches the remaining 40 percent. The community match is a combination of DSH, local government, community and foundation funds. Providers also donate 10% of fees back to the program.[112]

Employer participation in Access Health is conditional upon not having offered health insurance in the past year and the median wage of eligible employees being $10 or less. The first requirement is designed to prevent crowd-out although there are obvious equity concerns. However, Access Health planners have not received complaints from excluded businesses. Eligible employees include those that work a minimum of 15 hours per week over a 13 week period. With small co-pays, Access Health fully covers physician services, inpatient hospital services, outpatient services, emergency services, ambulance services, prescription drugs, diagnostic lab and x-ray, home health, and hospice care.[113] Enrollees choose a Primary Care Physician (PCP) and all services are on a fee-for-service basis. While some have expressed concerns regarding over-utilization of services on a fee-for-service plan, Access Health has yet to experience noticeable problems.[114]

Access Health did not initially use insurance brokers, but after a year and a half into the program, brokers asked if they could participate. As a non-profit organization, Access Health refused to offer commissions, but the brokers nonetheless agreed to sell the product with the hope that they could upgrade it to a commercial product within a few years. Since one of Access Health's primary goals is to increase access, no matter what the form, it had no problem with this type of broker participation.[115]

Access Health officially began in the fall of 1999, yet it was not fully operational until approximately a year later. Although it has been around only for a few years and thus is too early to evaluate in detail, Access Health still offers valuable lessons about community approaches to decreasing the number of uninsured. In the beginning, program officials report that the greatest obstacles surrounded "believability;" the health care community had heard so much "talk" about change that no matter how convincing the model, there was skepticism it would actually come about. Providers were weary of the constantly changing health care environment and thus hesitant to commit. Employers simply wanted solid commitment from the county; they supported the initiative but would rather have the county do nothing than begin a program and raise employees expectations only to pull out a year later.[116]

The state's role in forming Access Health was incredibly positive and its cooperation was critical to the success of the program. Specifically the state allowed Muskegon County to use disproportionate hospital funding (DSH) as a major piece of the three-share model. Hospitals did not object because they were not getting their "fair" share of DSH money anyway, and they reasoned that reducing the number of uninsured in their area might actually reduce costs through some sort of reimbursement for services.[117]

Preliminary program evaluations include the following. First, employers and employees seem to be extremely satisfied with the program. Anecdotal evidence from employers suggests that many are experiencing less turn-over in their labor and increased ability to attract new workers. Every business involved also represents one formerly not offering health insurance. Second, Access Health staff has been very pleased with participating "PCPs." Third, enrollment has been slower than expected, but Access Health needed the time to further develop program

infrastructure. Additional marketing strategies are being identified and implemented. It is also too early to assess possible decreases in hospital costs since the program began at the onset of the economic downturn.[118]

Perhaps the most important lesson offered by Access Health is Michigan's "one size does not fit all"[119] approach. Access Health demonstrates the value of releasing a community's "entrepreneurial spirit"[120] to address health care needs. So much of health care is local and when states give communities flexibility with resources already committed to them to pilot and discover new approaches, innovative models can result. Since the community develops the model, there is no need for the state to solicit buy-in and encourage cooperation because the community has driven the deliberative process. Thus the lessons for Texas include the innovative three-share model, but more importantly, the need for the state to give space to communities to individually address the challenges of the uninsured.

POLICY RECOMMENDATIONS

This study addresses two distinct yet related issues: spiraling Medicaid costs and the high percentage of uninsured persons in Texas. Because of the urgency of Medicaid and the uninsured, policy-makers should move forward on both fronts, seeking to contain escalating Medicaid costs and decrease the number of uninsured persons in Texas. Within this framework, part one examines alternative delivery models for long-term care and strategies for increasing employer-based care. This paper offers the following policy recommendations:

EXPLORING ALTERNATIVE DELIVERY MODELS FOR LONG-TERM CARE

Consumer Directed Services/Cash and Counseling

- **Expand provider base beyond traditional agencies.**
- **Increase outreach and enrollment through use of full-time workers dedicated solely to these efforts, resulting in significant cost savings.**
- **Seek waiver authority to include additional services under consumer direction including home and vehicle modifications and assistive technologies.**

Team Delivery Model for High Needs Populations

- **Convene numerous health care stake-holders to solicit input and buy-in for this alternative delivery approach.**
- **Pursue federal approval for integration of Medicare and Medicaid funding streams for dual eligibles.**
- **Examine potential of using Texas STAR+PLUS as the implementation vehicle for this model.** This includes assembling specialized networks of physicians committed to the mission, assessing the capacity of current individualized risk-adjustment mechanisms, and placing coordination and control on the physician and nurse practitioner rather than HMO level for high needs populations.

INCREASING EMPLOYER-BASED CARE

- **Examine different forms of tax credits tied to purchasing pool participation, likely take-up rates, tax revenue implications, and effects on the uninsured.**
- **Identify appropriate role of the state in a purchasing pool.** This role could range from ensuring private-sector availability of purchasing pools to directly sponsoring and administering the pool.
- **Continue expansion of HIPP program and utilize premium assistance for implementing a benefit phase-out rate under Medicaid.** This strategy will remove much of the work disincentive from the current 100 percent benefit phase-out rate where beneficiaries lose 100 percent of Medicaid benefits when they earn $1 over the income threshold.
- **Determine target enrollment goal for HIPP program.** Texas has yet to establish how large the HIPP program should be through a detailed assessment of Medicaid eligibles who would meet HIPP program requirements. There is a need for this determination so that policy-makers can quantitatively evaluate HIPP outreach and

enrollment efforts and thus determine if the state is taking full advantage of the benefits of Medicaid premium assistance.

- **Promote county level strategies for reducing the number of uninsured through more flexible use of DSH funding.**

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