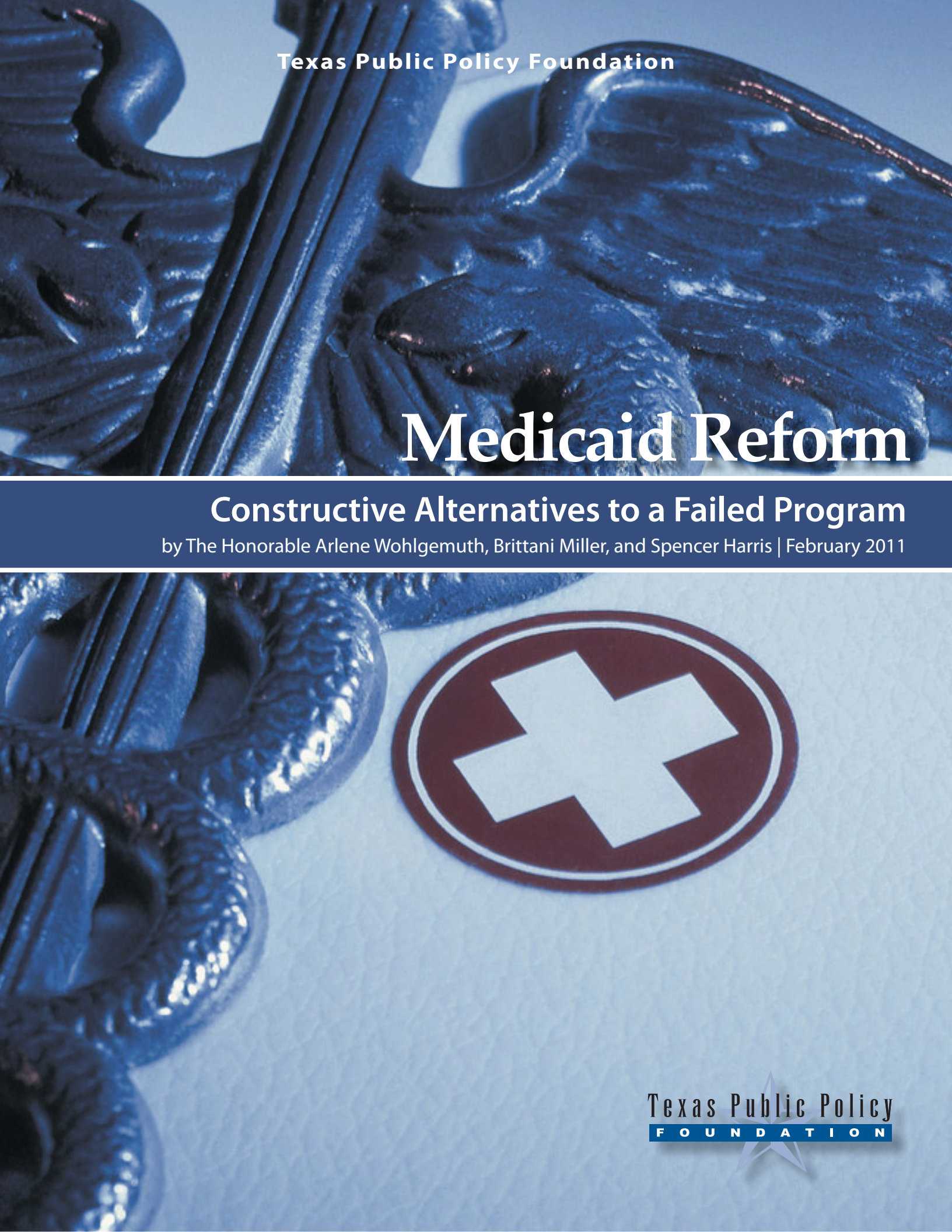

Texas Public Policy Foundation

Medicaid Reform

Constructive Alternatives to a Failed Program

by The Honorable Arlene Wohlgemuth, Brittani Miller, and Spencer Harris | February 2011

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Executive Summary

Medicaid's future is bleak at best: its annual growth of 9 percent and a poor track record of providing accessible health services leave little hope that it is the means by which Texans will have access to affordable health care.

Incremental policy changes are not sufficient to address the projected doubling of costs every decade. Texas now has the opportunity to reform the state's Medicaid program for the better. Reform must be carefully designed to ensure against recreating the same problems that have plagued Medicaid since its inception: rising caseloads and mandated benefits.

This paper proposes dramatic reforms to the way medical care and services are provided to low-income individuals, under a new assistance program: TexHealth. TexHealth offers a starting point for the discussion of reforming Medicaid into a free market based program. TexHealth would change the dynamic of Medicaid from a defined benefit program to a defined contribution program, allowing individuals to make their own decisions in regards to their health insurance needs.

A defined contribution program will not only allow better access to health care, but allow Texas to subsidize individuals earning up to 175 percent of the federal poverty level (FPL). TexHealth would subsidize the costs of purchasing health insurance in the private market, basing the amount of the subsidy on a sliding scale tied to the individual's income and assets. The sliding scale structure removed the disincentive to earn above the qualifying FPL as the subsidy decreases sharply in the upper income categories to end within 10 percent of the cost of purchasing health insurance in the marketplace. Providing direct subsidies for health insurance motivates low-income populations to obtain the health insurance that fits their particular circumstances, and not what the state decides they need. In conjunction with providing subsidies for health insurance, TexHealth continues to provide long-term services and support: including home health, nursing home care, and community based services as currently provided. By "grandfathering" in the long-term services and support population, the same services would be delivered in the same way to current enrollees. Future services will then be modeled after successful consumer directed care plans and will include enrollee financial participation where feasible.

Under a defined contribution plan, TexHealth will provide better access to health care services and be available to potentially 4 million more individuals than currently served, for less money. Initially, the state would spend $22.26 billion per biennium in subsidies to low-income Texans, $12.4 billion on long-term services and support, and $9.22 billion for implementation and administration, totaling 5 percent less than the state spent on Medicaid in the 2008-2009 biennium. TexHealth strives to offer the maximum amount of choice and freedom in health insurance decisions.

Reforming Medicaid is necessary, but it is possible only by recapturing the taxes paid by Texans to the federal government that comes back to the state for funding Medicaid. This paper explores three possible methods to restore the state's control of its budget: 1) through an interstate compact; 2) through using the requirement for a health insurance exchange to put Medicaid clients into a subsidized, private insurance market; or 3) through an 1115 waiver.

Introduction

Medicaid's financially unsustainable future is no secret among Texans, with costs growing at 9 percent annually and the Patient Protection and Affordable Care Act of 2010 (PPACA) expected to accelerate this growth. Thus far, Congress has not demonstrated the will to provide a solution to rein in the costs of Medicaid, while providing the necessary safety net for low-income individuals.

Incremental changes to Medicaid at the state level will have little impact as long as federal Medicaid dollars continue to come with an increasing number of strings. Texas should take the lead in reforming Medicaid in a creative and bold way.

This paper presents one viable state level reform to replace Medicaid. Under the proposed restructuring, Texas will apply free market principles in such a way that enrollees will be responsible for managing their own health care. The proposed solution emphasizes personal responsibility for enrollees in Medicaid in several ways. Personal responsibility—lacking in the current Medicaid structure—incentivizes enrollees to manage their own health care in a fiscally responsible manner, reducing overall expenditures. The proposed solution is discussed fully below.

Present Medicaid Structure

In 1965, the federal government enacted the Social Security Act which created the federally subsidized Medicaid program to provide health services to low-income Americans. Texas established its Medicaid program in 1967, initially providing health benefits to individuals receiving cash assistance under what is now Temporary Assistance to Needy Families and other recipients of cash assistance.[1] Nursing home care was also included in the initial coverage. In the past 40 years, Medicaid coverage has expanded in both size and scope to include individuals earning more income, the disabled, pregnant women, and medically needy populations.

Because Medicaid is a federal entitlement program, Texas cannot limit the number of persons enrolled nor deny coverage to any who meet the specified criteria. In 2001, 2.6 million persons in unduplicated annual counts were covered under Texas Medicaid.[2] In 2009, that number had grown to more than 3.3 million.[3] Nationwide, Medicaid has grown from 45.76 million[4] enrollees in 2001 to 64 million[5] in 2009. Its costs have grown significantly as well, attributable not only to the larger caseload but also a general increase of the cost of health care.

Medicaid pays in full for all of an individual's health-related expenses—meaning the enrollee does not have a financial responsibility for the medical expenses incurred. While Medicaid does allow for copayments for specific populations in limited instances, the costs of collecting the copayments for such a small number of recipients outweigh the benefit. Without reform, the growing costs and caseloads will bankrupt the state government.

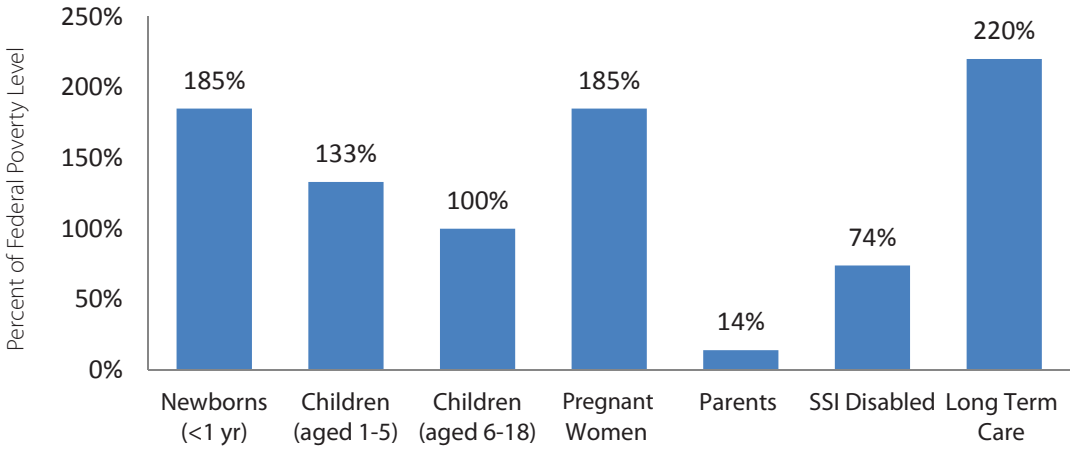
Who Is Covered Under Texas Medicaid?

In Texas, two distinct populations are eligible for Medicaid: the low-income population that comprises primarily women and children (referred to as the non-disabled population), and the aged, blind, and disabled population who require long-term care (referred to as the ABD population). There is a degree of overlap between these populations to the extent that some low-income women or children are also blind or have a disability. As shown in **Figure 1**, individuals qualify for Medicaid benefits based upon age and family income in relation to the federal poverty level (FPL). The ABD population includes elderly and/or disabled individuals who may or may not qualify for Supplemental Security Income, a federal cash assistance program for low-income individuals with disabilities. Institutional and residential services include care in a skilled nursing facility, a state-supported living center, a state hospital, or an intermediate care facility for persons with mental retardation (ICF/MR). Community-based services provided under a federal waiver include home health care, attendant care, and others.

Medicaid Funding

The federal and state governments jointly fund Medicaid. The federal government pays states Medicaid matching funds according to their Federal Medical Assistance Percentage (FMAP)—calculated annually based on the state's per capita personal income. However, a state's per capita personal income does not necessarily reflect the number of persons living in poverty for a particular state, i.e., persons who qualify for Medicaid benefits. For instance in 2009, Texas had the nation's 25th highest per capita personal income but was also home to approximately 10 percent of the nation's population living in poverty—a larger share than any state except California.[6]

Figure 1: Texas Medicaid Eligibility by Percent of Federal Poverty Level



Source: Texas HHSC & TDI, "Impact on Texas if Medicaid is Eliminated" (2010) 3, Fig. 2.

The federal government does not assign FMAPs below 50 percent or above 83 percent. Historically, Texas receives a FMAP of approximately 60 percent. Small fluctuations in the FMAP have a significant impact on the state's budget by millions of dollars. Each one-tenth percent decline in the FMAP shifts approximately $25 million of the costs of Medicaid to the Texas general revenue.[7] Important to note is that Texas' FMAP rating will decrease by 2.3 percentage points to 58.22 percent in 2012 (resulting in a loss of $1.25 billion for the 2012-2013 biennium).[8]

Further reductions in the Texas FMAP are anticipated, even though Texas' Medicaid population is growing.[9] **Figure 2** (next page) illustrates Texas' FMAP rates from 2002 through 2012. The American Recovery and Reinvestment Act of 2009 provided temporary increased FMAP rates for all states during the recession (2009-2011), to ensure that health care services operated at the same level as before the economic downturn.

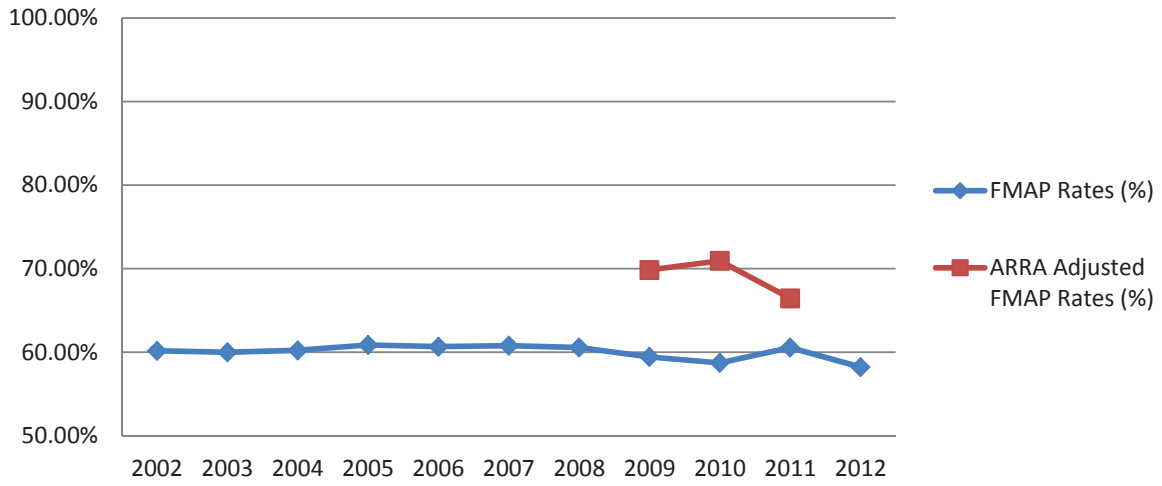
The federal government does not limit the total amount of federal matching Medicaid dollars that a state may receive. Total Medicaid spending increased an estimated 8.2 percent between fiscal years 2009 and 2010, and will continue increasing in the years ahead.[10] Further, the more individuals and services that a state chooses to include in Medicaid programs, the more total money a state receives in federal matching dollars. New York, in particular, has taken maximum advantage of the funding structure by expanding eligibility requirements.[11] Even though New York is home to only 6.9 percent of Americans living at or below the poverty line, the state receives approximately 12.4 percent of total federal Medicaid dollars ($23.8 billion annually)—more than any other state and nearly twice as much money as Texas—with the FMAP rate set at the minimum rate of 50 percent.[12] Even though Texas is home to almost 10 percent of Americans living below the poverty line, and contributes 8.4 percent of the total federal tax revenue collected, the state receives only 6.8 percent of total federal Medicaid funding.[13] This results in a net outflow of $3.2 billion annually.[14]

In Texas, Medicaid is the second largest budget item. In the 2008-2009 biennium, Medicaid required 28.2 percent of the all funds budget but will consume 46.6 percent for 2014-2015.[15] Without limitations or reform, Medicaid will continue to grow at the expense of other state activities, like public safety and education.[16]

Costs of the people who are covered

In Texas, the non-disabled population makes up approximately 70 percent of the total caseload; the aged, blind, and disabled make up the rest. Because each population requires different health services, the non-disabled popula-

Figure 2: Texas FMAP 2002-2012



Source: Dr. Jagadeesh Gokhale, Senior Fellow, Cato Institute, "Final Notice: Medicaid Crisis" 8 (2010); Texas HHSC & TDI, "Impact on Texas if Medicaid is Eliminated" 14-15 (2010).

tion accounts for 42 percent of total expenditures, the ABD population for 58 percent. The ABD population requires more expensive treatments, such as residential or long-term services and supports; the non-disabled population, whose members are generally healthy, need less expensive primary and acute care. The ABD population is a growing portion of Medicaid, exacerbated by baby boomers now entering retirement.

Effects of Patient protection and Affordable Care Act

In addition to mandating individual health insurance coverage, the new federal health care law expands the scope of Medicaid. If states continue to run Medicaid programs, they must expand the income threshold to 138 percent of the federal poverty level (FPL)* to childless adults. Dr. Jagadeesh Gokhale of the Cato Institute, in Washington, D.C., projects Texas general revenue Medicaid spending, after adjustments for inflation and population change, will increase 866 percent between 2009 and 2040.[17] Even without the new law's mandates, Texas general revenue Medicaid spending is projected to increase by 770 percent during the same time period.[18] The additional increase added by PPACA is largely attributable to the increased scope of Medicaid and the individual mandate. **Figure 3** illustrates how each category of eligibility will expand under PPACA.

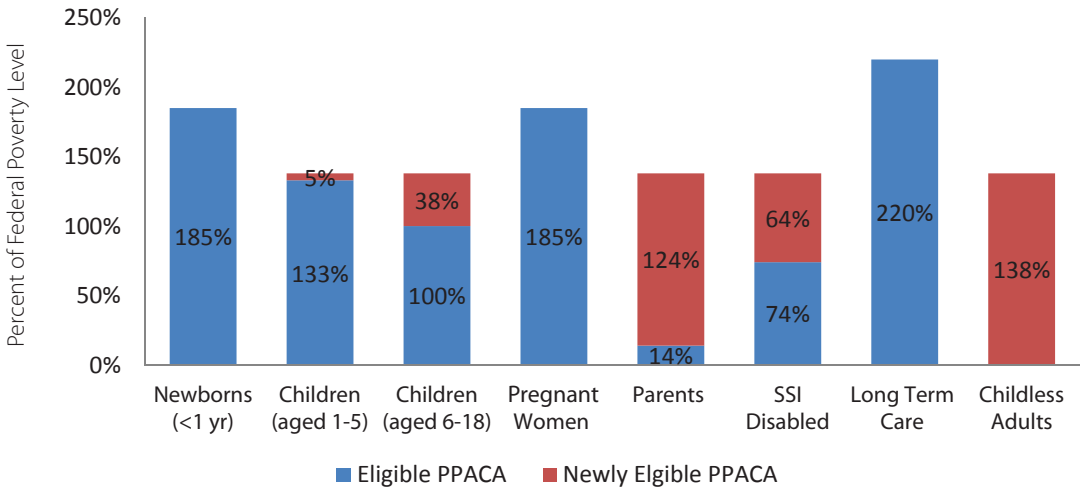
The federal government initially pays the entire costs of newly eligible persons enrolling in Medicaid, i.e., an effective Federal Medical Assistance Percentage of 100.[19] Over time, the FMAP for the newly eligible enrollees will be reduced. By 2020 the FMAP will be no more than 90;[20] however, the federal government will more likely reduce the FMAP to a state's standard FMAP rate.[21] Providing Medicaid benefits to the newly eligible persons and new previously eligible persons will cost Texas at a minimum an additional $4.3 billion in the 2014-2015 biennium.[22]

Other Models of Health Care for Low-Income Populations

Texas is one of many states searching for ways to reduce the burden on the budget. It should look to the successes and lessons learned from other states' experiments in structuring and implementing an alternative to the Medicaid structure, referred to as TexHealth within this paper. TexHealth strives to reestablish a financial relationship between enroll-

* The federal health care law applies a 133 percent FPL income threshold to qualify Medicaid. When determining eligibility 5 percent of the individual's income and assets is disregarded, effectively applying an income threshold of 138 percent FPL.

Figure 3: Texas Medicaid Eligibility by Percent of Federal Poverty Level after PPACA



Source: The Patient Protection and Affordable Care Act (Public Law 111-148), Title II, Subtitle A, sec. 2001 (a) (2010); Texas HHSC & TDI, "Impact on Texas if Medicaid is Eliminated" (2010) 3, Fig. 2.

ees and their health care at each decision point for enrollees. Requiring participation in the private health insurance market will introduce low-income individuals to proven approaches in keeping medical costs down without sacrificing the health of the individual. Among these approaches are state flexibility in spending, sliding scale participation, and consumer choice. Rhode Island's Global Medicaid Waiver, Indiana's Healthy Indiana Plan, Florida's Cash & Counseling program, and University Health System's CareLink program in San Antonio have all shown success in that area.

Under a waiver application approved in 2008, Rhode Island received $12 billion federal Medicaid dollars spread out over five years to pay the federal portion of the state's Medicaid costs. Rhode Island still spends up front the equivalent amount of state dollars that it would under the Federal Medical Assistance Percentage rates but with more flexibility to spend the money on custom programs. These are not customarily permitted under Medicaid rules.

Thus far, Rhode Island has not cut services, run out of money, or dropped people from enrollment—contrary to what critics predicted. The Rhode Island plan pays for community care and home health care in preference to nursing home care. Already the state has spent less money than anticipated under the plan. Of the $2.6 billion planned in the first year of the waiver, only $1.7 billion was actually allocated and spent.[23] Flexibility and lack of federal strings attached to the money are the factors generally credited for the savings.

Beginning in 2008, the Healthy Indiana Plan (HIP), a waiver program, extended subsidized health insurance coverage to low-income adults, ages 19 to 64, who earned less than 200 percent of the FPL and failed to qualify for state Medicaid benefits.[24] Indiana, acting as a market organizer for HIP, permitted private insurers to create customized plans for HIP enrollees within specified parameters. HIP is modeled after a high-deductible health plan paired with a health savings account. Enrollees make monthly contributions to a health savings account-like account, called a POWER account. The amount of the contribution is determined by a sliding scale based on income, not to exceed 5 percent of that income.

Indiana prefunds the POWER account with a subsidy. Through the account the HIP enrollee pays for health services. Preventative care is not charged against the enrollee. Enrollees are charged a copayment of no more than $25 for emergency room services where emergency care is found to have been unnecessary. Already, HIP enrollees use emergency room services at a lower rate than the traditional Medicaid population in Indiana.[25]

In the first two years of the program, the Healthy Indiana Plan enrolled 61,000 individuals—the majority of whom were below the federal poverty level.[26] Further, HIP experienced only a 26 percent rate of attrition among enrollees, and Indiana disenrolled only 3 percent of individuals for failure to make monthly contributions.[27] The state spent approximately $100 million less in 2009 than in 2007 on supplemental payments to hospitals which provide care to indigent individuals.[28]

These savings must be balanced with the claims paid under HIP, amounting to $97.7 million, including money contributed by HIP enrollees to their POWER accounts. Thus total savings on indigent care amount to at least $2.3 million.[29] Actual savings may have been even higher, because the $97.7 million paid out through HIP included non-state funds contributed by the enrollees. HIP members have demonstrated that low-income individuals can and do contribute to the costs of their health care and make responsible choices when given access to low-cost health insurance.

Florida's Cash and Counseling program applies free market principles by providing choice to low-income individuals with disabilities. The state gives participants a monthly budget, equivalent to the value of services previously received under Medicaid and used to "cash out" for long-term services and supports (LTSS). The monthly budgets are managed by a state agency, but the agency does not control which services are provided. Enrollees are encouraged to select services from a range of options that best meet their individual needs.

Enrollees preferred the Cash and Counseling program, because of the range of options and services available to them. Further, fraud and abuse among providers have virtually disappeared.[30] When given the freedom to choose, individuals are empowered to meet their needs at reduced overall costs. In June 2010, Florida's Cash and Counseling waiver program filed for an extension of the waiver program. However, the U.S. Department of Health and Human Services has yet to approve an extension of this successful program.

Even innovations within the state of Texas can be expanded into statewide programs. Established in 1997, the CareLink program within the University Health System in Bexar County provides low-cost care to uninsured indigents with income up to 300 percent FPL.[31] The individual is automatically enrolled in the CareLink program when treated in the hospital.[32] In exchange for offering negotiated rates and discounts on prescriptions, CareLink requires a monthly debt repayment based on a sliding scale. Collection is enforced.[33] Persons earning between 200 and 300 percent FPL pay at a flat rate instead of the subsidized sliding scale rate.[34] In contrast with the out-of-control spending of Texas Medicaid, CareLink provides health care services to indigents at affordable prices and keeps the hospital's budget in the black.

Texas should take elements of each of these programs and introduce new features to create a sustainable alternative to Medicaid.

TexHealth: Financing a Texas Alternative for Medicaid

A joint report by The Texas Health and Human Services Commission and Texas Department of Insurance states that without Medicaid reform at the federal level "states are left facing a no-win dilemma."[35] Failure to make bold reforms to Texas Medicaid now will result in, at best, a 3 cent sales tax increase or major budget cuts in other areas, such as education and public safety.[36] At worst, Medicaid will bankrupt the state government. Further, the state cannot afford to provide the necessary services without the return of tax dollars paid to the federal government, now coming back to the state through the Medicaid program.[37] The first of the three possible ways to recoup the federal money examined in this paper, and likely the best long-term solution, is the interstate compact. Texas must reform Medicaid by changing the method through which services are provided and, where possible, require financial participation by enrollees while making it easier to earn their way off state assistance. Texas can utilize an interstate compact to receive federal income tax dollars to fund a Medicaid replacement program, referred to as TexHealth. Looking to other states' approaches to Medicaid reform and the private market, Texas can structure a sustainable alternative to Medicaid.

Interstate Compact for Medicaid

The ideal method of financing available to Texas involves entering into an interstate compact stipulating receipt of the aggregated amount of funding that Texas received in 2010 from the federal government. Because the outlined plan would spend money more efficiently and provide bet-

ter service to low-income people, Texas could go a step further and take only 95 percent of the aggregated amount of funding. The proposed plan will be budget-neutral but more likely budget-positive for both Texas and the federal government.

An interstate compact is a contract between two or more states that allows joint cooperation in addressing broad public policy issues. With over 200 already in effect, compacts have been used to address a multitude of challenges: border disputes, transit authorities, energy management, worker's compensation, and law enforcement. Health care reform, particularly Medicaid, is a prime example where an interstate compact could be utilized to overcome federal entitlement mandates that do not effectively serve Texans' needs.

Article I, Section 10, Clause III of the U.S. Constitution states in part that "no state shall, without consent of Congress, enter into any agreement or compact with another state." Not all compacts require consent from Congress, but congressional consent is necessary where a compact affects a power delegated to the federal government or alters the political balance within the federal system. An interstate compact to accomplish health care reform by the states would require congressional approval, because the compact would seek to supersede the federal mandates related to health care. An interstate compact, once passed as legislation in two or more states, would be submitted to Congress directly, unlike Medicaid waiver applications, which are submitted to the Secretary of Health and Human Services for approval.

An interstate compact would provide Texas the most flexibility to replace Medicaid. The compact would include provisions to allow each state that is a party to the compact to appropriate pass-through funds on health care benefit programs provided through a variety of delivery models without federal mandates. Pass-through funding refers to the aggregated federal funds Texas received in 2010 for a particular health benefit program, adjusting for inflation and population changes on an annual basis.

The Internal Revenue Service collects federal income tax payments into designated accounts at regional Federal Reserve banks, from which the federal government withdraws funds for appropriation. Under an interstate compact, these regional banks could instead, according to a set formula, distribute health care tax dollars directly to those states participating in the compact. Federal tax dollars collected from Texans would directly fund Texas health care programs; Oklahoma funds would pay for Oklahoma programs, if that state were a party to the compact.

Programs operating under an interstate compact could include health care services to low-income populations; however, neither the compact nor Washington, D.C., should proscribe the regulations or the methodology of care delivery. Thus a state belonging to the compact could design a subsidized free market model for health insurance or a single-payer system. Flexibility of this sort makes an interstate compact the preferred method of financing for TexHealth.

Structuring TexHealth as a Sustainable Program

In addition to the overall goal of providing health care services to low-income populations, including the aged, blind, and disabled population, the state should simplify the process and administration, lower the state's fiscal burden, provide consumer choice, require personal responsibility, allow for enrollees to smoothly transition to self-sufficiency, and create a flexible program to serve a culturally and economically diverse state. The result would be better care for low-income individuals at lower cost to the state.

As proven time and time again, the free market responds better to market forces, offers more consumer choice, and better manages complex programs than does a government organization. To best utilize free market principles, TexHealth should act as a market organizer in establishing a new safety net for the low-income population. Texas should release guidelines pursuant to the plan as proposed below, allowing insurance companies that meet the current standards for selling insurance in the state to compete for TexHealth enrollees in the marketplace. TexHealth should be exempted from federal requirements including the minimum coverage requirements under the new federal law. The private insurers should be given the opportunity to offer customized plans that offer additional benefits in addition to the minimum requirements. These insurers should likewise have the freedom to set the deductible amount, copayments, and coinsurance to the extent they do so for the non-Medicaid population.

TexHealth: Know Your Benefits

Provide Low-Income Individuals Subsidies to Purchase Health Insurance

Eligibility: Up to 175 percent of the Federal Poverty Level

Benefits: Sliding Scale of subsidy amount based on income and assets

0-49% FPL: 100%	100-124% FPL: 50%
50-74% FPL: 90%	125-149% FPL: 30%
75-99% FPL: 75%	150-174% FPL: 10%

- Subsidy enhancement for selecting health insurance plan paired with a health savings account
- Subsidy amount set by the average health insurance premiums in the market
- Counselors to advise on health insurance plan selection

Wrap-Around Benefits for Long-Term Services and Support

Eligibility:
- Grandfather current enrollees
- Below 139 percent FPL for future enrollment

Benefits:
- Current Medicaid enrollees: same benefits as current
- Individualized accounts funded annually
- Counselors to assist in health care planning

Indigent Care

Eligibility:
- Uninsured individuals who cannot afford hospital bill

Benefits:
- Guaranteed enrollment into a combined debt repayment program and primary health care plan
- $500-$1,000 penalty for same-day enrollment

For successful implementation and automatic updates to subsidy amounts, TexHealth must have a centralized web portal, where applications for subsidy eligibility may be downloaded and submitted to TexHealth. The web portal should act as a single point of entry for all enrollees of TexHealth. Texas may be able to utilize the "Your Texas Benefits" webpage, to screen individuals for eligibility.

As a market organizer, TexHealth would determine eligibility through a simplified application and an income and assets test, and then allow individuals to select an insurance provider. Eligibility under this program should be reviewed on an automated quarterly basis to ensure the temporary nature of the safety net for low-income individuals is reinforced.

Structuring TexHealth as a market organizer minimizes the state role in administering health care services to enrollees. The private market has inherent incentives to maintain efficient practices in managing health care costs and service availability. Further, it would be more difficult to distinguish TexHealth beneficiaries from other insured individuals because the insurance would provide access to the same health care services. TexHealth should still determine eligibility, subsidy amounts, and offer counseling, but private insurance providers should have the flexibility within these parameters to offer a full range of plans providing varying degrees of services and benefits from which to choose.

Simplified Eligibility and Sliding Scale of Subsidy Based on Income

Under the current Texas Medicaid structure, individuals qualify for benefits in accordance with age, sex, disability, pregnancy, and an income and assets test. Each of these classifications increases the costs of administering the program. Simplifying the income eligibility requirements will lower costs of administering the subsidies. TexHealth would provide subsidies to individuals or families living below 175 percent FPL, based on an income and assets test.

TexHealth would promote personal responsibility by financially connecting the enrollees to the health care services obtained. However, Texas must strike a balance, being careful not to overcharge its most vulnerable populations while providing an easy transition off the program. The state should offer a subsidy, in an amount dependent upon income and family size. The sliding scale nature of TexHealth would correct an inherent flaw in Medicaid: individuals below the income cap receive 100 percent health benefits, but those who earn $1 more than the cap lose all benefits. The sliding scale would instead ease higher-earning enrollees into assuming full responsibility for purchasing health insurance.

The subsidy amount would then be transmitted directly to the insurance company. It should be provided in such a way as to incentivize the enrollee to purchase a health insurance plan paired with a health savings account without requiring purchase of any particular plan. Health insurance plans paired with HSAs have been shown to reduce overall costs of health care and reestablish a financial relationship between the patient and the medical services received.[38] The individual, working with a counselor, would select the health insurance plan that best served his needs. Any difference between the premium costs of the plan selected and the subsidy amount would be paid by the individual. One possible scenario could be as follows.

For a family of four at 110 percent FPL, TexHealth would subsidize 50 percent of the costs ($198) of the average health insurance premium (approximately $397 per month). TexHealth could allow an additional 5 percent subsidy if the individual selected a health insurance plan paired with a health savings account. In other words, the family of four at 110 percent FPL would now have a $218 per month subsidy. **Table 1** provides an estimate of the minimum and maximum monthly subsidies for a family of four. **Appendix A** provides similar tables for different family sizes.

In the private individual insurance market, a family of four can purchase insurance for monthly premium payments ranging from $260 to $900, with an average of $397.[39] Deductible amounts vary among the offered plans between $2,500 and up to $10,000.[40] Enrollees would be responsible for making premium payments in any amount not covered by the subsidy. Further, enrollees would pay for any copayments, to the extent required by their selected health insurance plans. Therefore, using the subsidy, a family of four at 110 percent FPL could purchase health insurance plan using the $198 subsidy and $198 of personal money.

Special Considerations under TexHealth

There are three areas where the particularities of the Texas insurance market impact the overall design of the TexHealth program. TexHealth must be structured mindful of the following's unique impact on the low-income population: (1) payment of deductibles and other out-of-pocket expenses related to health insurance policies, (2) maternity care, and (3) children in the Texas foster care system.

Table 1: Subsidies Available to a Family of Four below 175% of Federal Poverty Level

Percent FPL	Income	Premium Subsidy Percentage	Monthly Subsidy Amount	HSA Monthly Subsidy Amount	Annual Deductible Subsidy
0-49	$0 – $11,174	100%	$397	$416	$3,000
50-74	$11,175 – $16,762	90%	$357	$377	$2,700
75-99	$16,763 – $22,349	75%	$297	$317	$2,400
100-124	$22,350 – $27,937	50%	$198	$218	$1,950
125-149	$27,938 – $33,524	30%	$119	$138	$1,500
150-174	$33,525 – $39,112	10%	$40	$60	$1,000

Source: eHealthInsurance, Inc., "2010 Fall Cost for Individual and Family Policyholders" (2010) 5; author's calculations based on the 2011 federal poverty index.

Nearly all health insurance policies available in the market require a deductible be paid first by the policy holder before the insurance provider begins paying out claims. These deductibles range from as low as $0 up to $10,000, where the monthly premium pricing varies in proportion to the amount of the deductible, copayments, coinsurance, and benefits offered under the policy. For the low-income population, i.e., for TexHealth individuals, paying deductibles out-of-pocket presents a significant hurdle to seeking health services after a health insurance policy is procured. One approach is requiring TexHealth to further subsidize the deductible payment based on the sliding scale. Based on a median deductible amount of plans offered, TexHealth would make available a percentage of the deductible amount in an individualized prefunded health care account.*

The second issue that requires special consideration is maternity benefits for women in Texas. In 2007, Texas Medicaid paid for more than half of all live births in Texas, and the cost of providing prenatal services, delivery, and health care for the first year of the newborn's life was 10 percent of the total Medicaid budget.[41] Secondly, most insurance providers in Texas do not include maternity benefits in standard policies offered.[42] Given the high utilization of Medicaid for maternity services by Texans, it is prudent to include a subsidized maternity rider within the TexHealth program. Because the individual market in Texas does not offer maternity riders in the individual market, there is insufficient data available to assess what a maternity rider would cost under TexHealth. However, knowing that Texas Medicaid spent $3.2 billion on pregnant women and newborns in state fiscal year 2009, if actuarial data shows that a maternity rider would total more than $3.2 billion then other options should be assessed.

Lastly, TexHealth would purchase for Texas foster care children health insurance plans that provide both for basic primary and acute care. The majority of children in foster care are categorically eligible for Medicaid services until age 18. Children in foster care should not be forced to financially contribute to the monthly premiums for health insurance. Currently, Texas spends approximately $415 million annually for direct health care costs for children in foster care.[43] It may be less expensive to purchase health insurance for these individuals, who are relatively healthy and generally do not require expensive health care services. It is difficult, all the same, to know just how much the state would spend on these plans, because children are typically included on parental health insurance plans.

Through this structure, TexHealth would connect the enrollee to the costs of care. This should in turn lead to an overall reduction in expenditures for health care. TexHealth enrollees should spend approximately the same amount of money as the Texas general population, excluding the costs of long term supports and services. Most likely, the ABD population would not be able to purchase health insurance for the costs of their long-term services and support, but they should be able to buy it for primary and acute care needs.

Reinsurance by the State

One way TexHealth could induce insurance companies to sell health insurance plans to previous Medicaid clients is through reinsurance. Reinsurance allows an insurance provider to transfer some of the risk inherent in providing an insurance policy. Once the costs of paying out on a specific policy exceed a specified amount of money, the insurer transfers a portion of the payment obligations to the reinsurer to pay out. How much of the risk is transferred to the reinsurer depends on the type of reinsurance purchased.

Limiting the overall risk an insurance provider must accept for policies issued lowers the overall costs of selling any particular policy. Further, lowering the costs of providing a health insurance policy induces more healthy individuals to purchase insurance. Insurance providers pay reinsurance premiums to the reinsurer for the risk absorption service.

* For instance, if the median deductible amount for a health insurance policy for an individual in his 30s is $2,000, who qualifies for TexHealth subsidy of $157 per month (earning $8,167 annually, 74% FPL), then he would also receive an individual account prefunded with $1,800 (90% of $2,000). The individual account would have limited use, i.e., it could only be accessed to pay for health care related services and be counted toward the deductible. If an individual selects a policy with a high deductible, then any subsidy dollars not spent on the premiums should be available to pay the higher deductible. In our example, the individual would purchase a plan for $175 per month premium with a $3,000 deductible. TexHealth would provide for 90 percent of these costs, $157 per month for the subsidy and $1,800 in the deductible account, and the individual would be potentially be responsible for an annual total of $416 ($18 per month in premiums plus $200 in the deductible).

However, TexHealth should forgo charging premiums for reinsurance because the goal is to lower monthly premiums for purchasers. Any premiums charged for reinsurance would ultimately be reflected in the monthly premium cost to the individual.* If set up properly, TexHealth's role as reinsurer would keep insurance costs affordable.

Long-Term Services and Support under TexHealth

The aged, blind, and disabled population includes approximately 290,000 individuals, on whose behalf Texas paid approximately $23.2 billion from the all funds budget in the 2008-2009 biennium, primarily for long-term services and support.[44] In state fiscal year 2007, nursing homes alone received 13 percent of all Texas Medicaid spending.[45] Long-term Services and Support (LTSS) includes a range of skilled and unskilled services: home health care, nursing homes, and non-medical care for the disabled comprising activities such as help in getting dressed, managing medications, preparing meals, and cleaning the home. TexHealth should be customized to meet the unique needs of this population for primary and acute care, along with support services. As discussed above, the primary care needs in question should be managed through subsidies to purchase insurance. However, long term needs require further consideration and changes to statutory law.

TexHealth should "grandfather" current Medicaid enrollees who utilize LTSS. Individuals currently receiving long-term care, either in a nursing home or in the community, would neither be forced to leave that care nor required to pay for it out-of-pocket. Maintaining long-term care at the current level costs approximately $12.4 billion per biennium.[46] However, for persons seeking new long-term care benefits—without previously receiving Medicaid benefits—TexHealth would apply a 138 percent income and assets test for eligibility. This contrasts with the current 220 percent FPL test. An aged, blind, or disabled person needing services not covered by the private market could receive wrap-around services under the long-term support program. Unlike Medicaid as currently structured, TexHealth should allow the enrollee or relatives to financially contribute to the costs of LTSS.

TexHealth would conduct a case-by-case assessment of the enrollee's needs to determine the amount of subsidy required for long-term services and support. A separate health savings account-type account could be used to pay for all such services, including attendant care, nursing home care, and durable medical supplies. TexHealth should provide counselors to assist enrollees in making sure their funds last the entire year. Counselors should also assist in planning for large purchases of durable medical supplies, such as wheelchairs. If a wheelchair's useful life is five years, then the enrollee should plan to buy a new one every five years, saving up for it meanwhile in an LTSS account. If an enrollee designated a set amount of money to be put aside for such larger but more infrequent purchasers, TexHealth could match the enrollee's savings for the purchase.

For lasting success, TexHealth would have to close legal loopholes that allow the middle class to utilize the safety net meant for low-income individuals. Statutory changes would affect the availability of TexHealth subsidies. One necessary change would be requiring reverse mortgages to pay for the costs of long-term care prior to or in conjunction with receiving TexHealth benefits. TexHealth should find ways to incentivize saving for long-term care costs or the purchase of long-term care insurance. Under current Medicaid law, a legal loophole known as a "Miller trust," allows income-shifting into a trust account typically belonging to the individual's children. Such income is not counted in determining eligibility under federal Medicaid law. Because TexHealth would operate outside Medicaid, Miller trusts could be included in the income and assets evaluation.

* TexHealth would offer reinsurance that would retain coinsurance on a sliding scale after an attachment point was met. That is to say, the insurance provider would accept the risk of a set dollar amount—the attachment point, $50,000 for example. But he would sell a policy with a $200,000 payout limit with a reinsurance policy. If a loss occurred on the policy at $150,000, the insurance provider would experience a loss of $50,000, and would recover $100,000 from the reinsurer. However, without some level of coinsurance after the attachment point the initial insurer would not have an incentive to keep costs low. Thus the reinsurer—TexHealth—would have to require coinsurance after the attachment point. So the reinsurance purchaser could be responsible for 15 percent of the costs above the attachment point, $50,000 to $100,000; 10 percent for $100,000 to $200,000; 12 percent for $200,000 to $300,000; no reinsurance for costs above $300,000. Therefore under our outlined example, an insurer would pay $63,500 ($50,000 + $7,500 (15 percent) + $5,000 (10 percent)), and recover $86,500 from TexHealth as the reinsurer. The coinsurance percentage rates could be adjusted to find the right balance between the insurance provider and the state.

Economic Analysis

Because a TexHealth plan must be fiscally sound, the authors created a mathematical model to show how TexHealth would allocate funds among low-income residents. The percentages of Texans residing below 175 percent FPL were utilized from the 2000 Census. Secondly, the model took into account the percentage distribution of the number of persons per family per household for the state. The 2010 Census information for these particular data sets was not available at the time of this publication. Figures 4 and 5 illustrate the percentage of Texans living below 175 percent FPL and the distribution of family sizes in 2000, respectively. From 2000 to 2009, Texas population grew from 20,283,230 to 24,782,302.[47] The percentages based on 2000 data were applied to the increased Texas population when calculating the costs of TexHealth.

Subsidy amounts were calculated based on the average of the available health insurance policy premiums for an individual and families plus the median deductible amounts ($2,000 for individuals and $3,000 for families). Most current Medicaid families consist of three persons.[48] Today, an individual may purchase a health insurance plan for approximately $175 per month in the individual market.[49] Determining the average monthly costs of a health insurance plan is difficult on multiple levels because rates vary dependent on age, sex, location, and medical history of any one person applying for health insurance. The subsidy amounts can be adjusted up or down to account for the average health insurance premiums in the individual market. These subsidy amounts were then applied to the mathematical model to show the fiscal impact of TexHealth.

The model determined the total subsidy needed for each of seven different cohorts which together make up the entire population covered under TexHealth. The cohorts break down as follows: 0-49 percent of federal poverty level (FPL), 50-74 percent of FPL, 75-99 percent of FPL, 100-124 percent of FPL, 125-149 percent of FPL, and 150-174 percent of FPL. The model takes the percentage of Texas' population which each cohort represents and thus, determines the population of each cohort. Now the model must break the individual cohort into the varying family sizes, each of which dictates a different premium and thus a different subsidy amount. For instance, taking the population of the 0-49 percent FPL cohort and multiplying it by the percentage of people who belong to a one-person household gives a relatively accurate picture of the number of people in this cohort who belong to a single person family. To find the number of actual families this number is then divided by the number of people in the family size group being considered. This figure is then multiplied by the annual premium required for a family of one and then by the percentage of the premium which TexHealth will be covering. The same equation is then applied

Figure 4: Texas Population Living Below 175% FPL

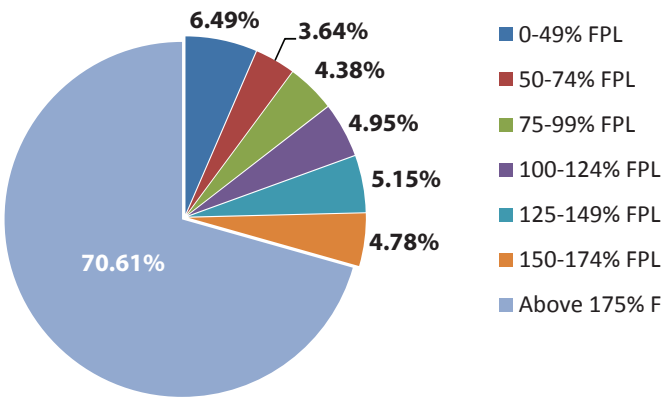
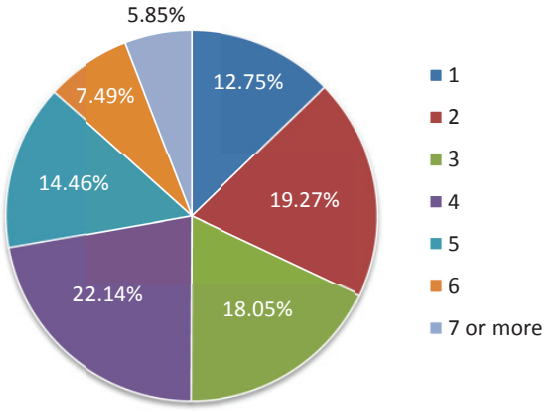


Figure 5: Percentage of Texas Families by Size



Source: Census Bureau, U.S. Census Bureau, 2000 Census Texas Data Sets: Texas Civilian Population by Percent of Poverty Income Categories by County; 2000 Census Data for Household Size (2000).

to each family size up through a family of seven. The only numbers that change are those of families in each family size group and the annual premiums. The result of each equation is then totaled so as to produce the subsidy amount for the 0-49 percent of FPL cohort. The same math is applied to find the subsidy needed for each FPL cohort. These subsidies are in turn totaled to equal the total subsidy needed to cover the entire population of those under 175 percent FPL.

The model used 95 percent of the all-funds budget for Medicaid in the 2008-2009 biennium, $43.89 billion ($21.94 billion state fiscal year), as a baseline for determining how much total money could be allocated toward TexHealth, including health insurance subsidies and wrap-around benefits for LTSS, health services for children in foster care, and potential savings to the state. Of that $43.89 billion biennium sum, $26.58 billion originates from federal income tax collection from Texans; and the remaining $17.31 billion originates in Texas general revenue funds.

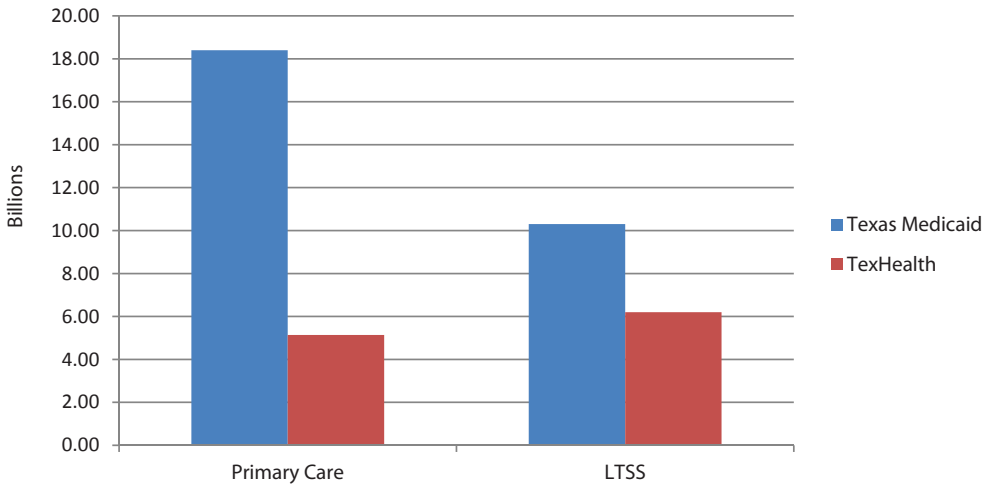
TexHealth, on these terms, would provide approximately $22.26 billion per biennium in subsidies to Texans living below 175 percent FPL per biennium. According to HHSC, the state could provide full long term services and support to the current aged, blind, and disabled population for $12.4 billion per biennium. The state then has $9.22 billion to fund indigent health care, reinsurance liability, administrative costs, maternity benefits, and savings for the state.

Indigent Care

Inevitably, TexHealth, as envisioned here, could not reach all low-income individuals needing health care. Based on historical data, these individuals are most likely to seek care in local emergency departments, where care is the most expensive. There a few ways Texas can reduce the overall cost of providing care to these individuals: enrolling them into insurance plans at time of care, reforming supplemental payments to hospitals to match services provided to funds paid, and directing them to clinics, where less expensive care can be administered.

When an individual who would qualify for a subsidy and needs emergency care arrives in the emergency room, he needs subsidized care rather than insurance. Once the individual is in the emergency room, the need for expensive health care has already arisen. At that point, the program would operate much like the CareLink program to receive negotiated rates and be connected to follow-up primary care. However, a penalty of $500-$1,000 for same-day enrollment would be assessed. If the individual decided not to enroll in the program, they would be responsible for the entire emergency department bill to the extent recovery was feasible. This measure would likely increase the collection of payments from indigent patients and reduce future use of emergency department services by making primary care accessible through enrollment in TexHealth.

Figure 6: Texas' Health Care Spending on the Low-Income Population



Source: Texas HHSC and TDI, Impact on Texas if Medicaid is Eliminated (2010) 13 Table 13 and mathematical model commissioned by Texas Public Policy Foundation.

Under Medicaid, hospitals receive supplemental payments to compensate for emergency room care for patients unable to pay. These supplemental payments include the disproportionate share hospital (DSH) payments and the upper payment limit (UPL) reimbursements. DSH payments are jointly financed by the state and federal governments; UPL reimbursements are entirely federally funded. Each biennium these hospitals receive $3.4 billion in DSH payments which are not tied to specific services provided to Medicaid-eligible individuals. This means hospitals may use DSH funds to build new facilities, hire more doctors, and other expenditures only indirectly related to providing services to indigent population.

DSH payments must be reformed so as only to compensate hospitals for uncompensated care actually rendered. Therefore, DSH payments could not indirectly fund the care of the indigent population, as through building facilities or recruiting doctors. Hospitals also receive $4 billion per biennium in UPL reimbursements, representing the difference between what Medicaid currently pays for services and what Medicare would reasonably pay for a service or the hospital charges. Under TexHealth, hospitals would no longer qualify for UPL reimbursement, however, they would receive higher payment rates from TexHealth enrollees' insurance providers than current Medicaid.

Presently, emergency departments provide an extraordinary amount of expensive primary care even though they are not required to do so. The Federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals only to provide emergency care regardless of a patient's ability to pay. Emergency care is defined as that which an average person would expect in order to prevent death or serious impairment to bodily functions or limbs.[50]

Two simple improvements would have a dramatic effect on the operation of emergency department care for the administration of primary care. First, the hospitals could be encouraged to establish clinics within the hospital or work with nearby clinics to divert non-emergency patients to receive lower cost care. Second, Texas would not reimburse hospitals for non-emergency care in amounts below $2,000, and would require prior authorization from TexHealth for any non-emergency care in excess of $2,000. Such measures would incentivize hospitals to use emergency rooms for their intended purpose—delivering emergency care. Each of these recommendations should compensate for TexHealth's inability to reach all low-income individuals and reduce the overall fiscal impact of providing health services.

Alternatives to Interstate Compact

Two other options are available to the state should formation of an interstate compact proves unsuccessful. One option provides a way to avoid participation in Medicaid; the other affords the means of working within Medicaid but without the federal mandates.

First, the Patient Protection and Affordable Care Act (PPACA) has actually given Texas one tool for accomplishing these goals: the health insurance Exchange, a federally subsidized health insurance market. Second, Texas can push for approval of a global waiver program much like Rhode Island's. One should remember that financing TexHealth under this method would limit Texas' ability to fully implement comprehensive reform.

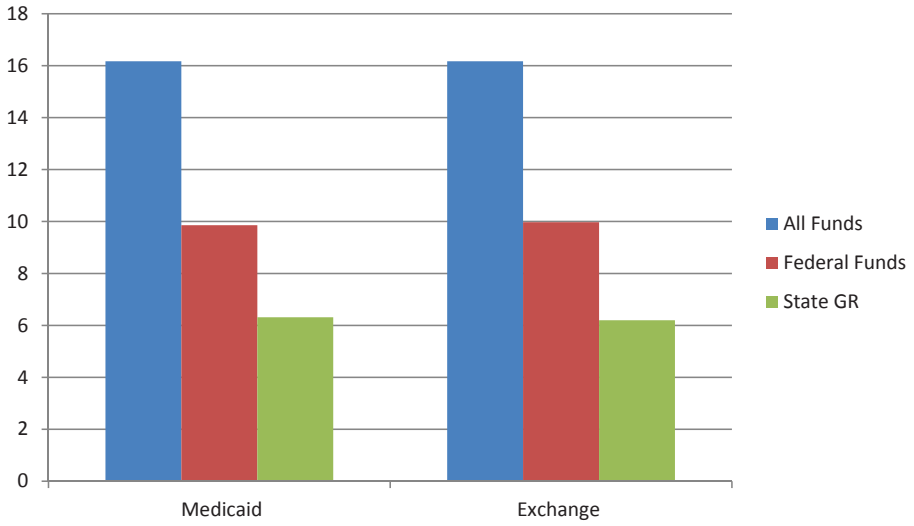
Second, Texas can push for approval of a global waiver that would return the federal funds to the state along with the flexibility to redesign the program. This approach takes some lessons learned from the welfare reform movement and pushes up reform from the state level to the federal level.

Place Medicaid Population into the Exchange

Congress provided an option for the state in the relationship between Medicaid and the Exchange under PPACA. When an individual enters the Exchange for health insurance, the Exchange automatically assesses whether the individual qualifies for Medicaid and, if he does, enrolls him. Nowhere, nonetheless, in more than 2,500 pages, does the health care act provide for a situation in which a state does not operate a Medicaid program. Therefore, while the government specifically financed the subsidy for persons between 139 percent FPL and up to 400 percent FPL, the bill does not deny a subsidy for persons below that level who are not on Medicaid. If Texas no longer operates a Medicaid program, the federal government has obligated itself to fully fund insurance for those below 139 percent FPL.

If Texas operates the Exchange, it must conform to minimum benefits under insurance plans required by PPACA and any new required benefits added by the Secretary of Health and Human Services. Texas would be less influential when

Figure 7: Texas Medicaid Client Services Expenditures
Compared to Estimated Expenditures in the Exchange, 2007



Source: Texas HHSC "Medicaid and CHIP in Perspective" (8th ed.) App. F, and authors' calculations.

it came to the amount of the federal subsidy an individual would receive as well as that individual's obligation to pay any money toward premiums. In particular, those enrolled through the Exchange would be limited to spending no more than 5 percent of their income on health care services. Nevertheless, this would free Texas general revenue funds now providing health services to the Medicaid population, saving approximately $6.86 billion per biennium.[51]

It is likely that Texas would still need to make some supplemental payments to hospitals for uncompensated care to the indigent population. Currently, hospitals receive approximately $3.4 billion per biennium to compensate for such care. However, as noted, these payments can be used for indirect provision of health services to the indigent. Under the Exchange model of funding, Texas should reform these supplemental payments to pay only for health care services actually provided, disallowing indirect uses of supplemental payments.

Because the Exchange would likely provide only for primary and acute care benefits, Texas would then use the general revenue dollars, previously allocated for the Medicaid program, to provide wrap-around benefits for long term care to the aged, blind, and disabled, as outlined above. The exact health insurance policies to be offered in the Exchange cannot be fully known, as the Secretary of Health and Human Services has not released all of the rules and guidelines. Currently, approximately 290,000 individuals receive long term services and support, including care in nursing facilities and intermediate care facilities for the mentally retarded, hospice care, and primary home care provided through traditional Medicaid and waiver programs. In state fiscal year 2009, the total cost of providing LTSS was $10.3 billion—$4.06 billion of it from state general revenues—excluding acute care and prescription drugs.[52] However, HHSC determined that to maintaining long-term services and support at the current rate—which includes providing services up to 220 percent FPL—would cost Texas $6.2 billion, or $12.4 billion per biennium.

Figure 7 considers only client services expenditures, not supplemental payments because of their complexity and the uncertainty of continuation should Texas place the Medicaid population in the Exchange. Replacing Medicaid with Exchange insurance enhanced by wrap-around benefits for LTSS is likely to be the more easily achieved option in the short term. However, the limitations and lack of flexibility in plan designs that are governed in large part by the whims of Congress may cause concern for the long term financing of health care through this model.

PPACA Amendments to Allow States to Exempt Themselves from Federal Medicaid Requirements

At the national level, Congress could make a few small changes to PPACA that would permit the states to administer Medicaid programs without federal mandates or lengthy waiting periods for approval of waiver applications. Currently section 1332(b) provides that beginning in 2017 the Secretary of Health and Human Services *may* grant waivers to the requirements with respect to the health insurance exchange, premium assistance, out-of-pocket expenditure limits, and sections of the Internal Revenue Code.*

Section 1332 (a) should be amended to include Title XIX and XXI of the Social Security Act as programs that a state may exempt themselves from federal Medicaid requirements. Then section 1332(b) should be amended from "the Secretary *may*" to The Secretary *shall* grant a waiver under subsection (a)(1) if the State certifies that a state plan:

(A) will provide coverage that is more comprehensive than the coverage available in the State on March 22, 2010;
(B) will provide improved coverage and cost-sharing protections against excessive out-of-pocket spending to its residents relative to March 22, 2010;
(C) will provide improved coverage to its residents relative to March 22, 2010; and
(D) will not increase the Federal deficit.†

Amending section 1332 of PPACA in this manner would enable states to exempt themselves from the extensive federal eligibility and benefit requirements under Medicaid and CHIP, while still receiving federal funding to administer these programs. The amendments should further provide that waivers may be granted beginning in 2013, instead of 2017. These relatively small changes to PPACA would have a large impact on a state's flexibility to provide tailored models of health care delivery to its residents.

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* *The Patient Protection and Affordable Care Act (Public Law 111-148), Title II, Subtitle A, sec. 1332 (a)(2), (b)(1) (2010) (emphasis added).*
† *Prepared by Brandon Clark, FrogueClark, LLC (Jan. 12, 2011) (emphasis added).*

Obtaining Section 1115 Waiver for a Medicaid Replacement Program

Under the Social Security Act, Section 1115 waivers allow a state to operate programs to test out policy innovations for five years, unless an extension is granted. Waivers must demonstrate no additional cost to the federal government and must be approved by Centers for Medicare and Medicaid, Office of Management and Budget, and the Secretary of Health and Human Services. Rhode Island's global waiver program procured under section 1115 of the Social Security Act, and approved in 2008, allowed for flexibility services offered to the Medicaid population without federal mandates. Even in the beginning years of the global waiver, Rhode Island has spent less on Medicaid programs and provided better care to its residents.

Through a Section 1115 waiver, Texas can outline to the federal government a sustainable program based on the TexHealth model. Texas was among the states that used the waiver process to inspire the welfare reform movement that attained federal enactment in 1996.[53]

Though the end result of Medicaid reform would be quite different from welfare reform, the methodology of pressuring Congress to take action through a Section 1115 waiver may make it the most viable option for achieving change.

By demonstrating that a free market system of health care can provide greater choice, better care, and lower costs, Texas will again have proven that the states are the incubators of change. The Medicaid funding crisis that states currently face provides the impetus for reform that is long overdue.

Conclusion

Runaway Medicaid costs are not just health insurance and health care issues; they represent a fiscal crisis that threatens the entire Texas state budget, limiting the funds available to other programs, such as education and public safety. The inherent structure of Medicaid encourages states to spend more and more money on providing care and small incremental attempts to limit costs do not resolve the fundamental problem of Medicaid spending. Medicaid as an entitlement program encourages overspending and poor health decisions by enrollees because there is no financial link between the care received and the person receiving the care.

A TexHealth program would encourage personal responsibility in enrollees through financial links to the enrollee without overburdening the most vulnerable populations through subsidized health insurance.

Allowing the free market to control health care spending after financial links are established reduces the overall demand for health care without threatening the health of individuals because individuals will take responsibility in managing their own health. Replacing Medicaid is not a choice but a necessity. ✯

APPENDIX A:

The tables below provide an estimate of an individual's subsidy for health insurance based on family size and income and assets. The monthly subsidy amounts listed below are calculated based on the average costs of health insurance plans in February of 2011. The tables were calculated by the authors based on the 2011 federal poverty index.

INDIVIDUAL

Percent FPL	Income	Premium Subsidy Percentage	Monthly Subsidy Amount	HSA Monthly Subsidy Amount	Annual Deductible Subsidy
0-49	$0 – $5,444	100%	$175	$183	$2,000
50-74	$5,445 – $8,167	90%	$158	$166	$1,800
75-99	$8,168 – $10,889	75%	$131	$140	$1,600
100-124	$10,890 – $13,612	50%	$88	$96	$1,300
125-149	$13,613 – $16,334	30%	$53	$61	$1,000
150-174	$16,335 – $19,057	10%	$18	$28	$600

FAMILY OF TWO

Percent FPL	Income	Premium Subsidy Percentage	Monthly Subsidy Amount	HSA Monthly Subsidy Amount	Annual Deductible Subsidy
0-49	$0 – $7,354	100%	$397	$416	$3,000
50-74	$7,355 – $11,032	90%	$357	$377	$2,700
75-99	$11,033 – $14,709	75%	$297	$317	$2,250
100-124	$14,710 – $18,387	50%	$198	$218	$1,500
125-149	$18,388 – $22,064	30%	$119	$138	$900
150-174	$22,065 – $25,742	10%	$40	$60	$300

FAMILY OF THREE

Percent FPL	Income	Premium Subsidy Percentage	Monthly Subsidy Amount	HSA Monthly Subsidy Amount	Annual Deductible Subsidy
0-49	$0 – $9,265	100%	$397	$416	$3,000
50-74	$9,266 – $13,898	90%	$357	$377	$2,700
75-99	$13,899 – $18,530	75%	$297	$317	$2,250
100-124	$18,531 – $23,163	50%	$198	$218	$1,500
125-149	$23,163 – $27,795	30%	$119	$138	$900
150-174	$27,796 – $32,428	10%	$40	$60	$300

FAMILY OF FOUR

Percent FPL	Income	Premium Subsidy Percentage	Monthly Subsidy Amount	HSA Monthly Subsidy Amount	Annual Deductible Subsidy
0-49	$0 – $11,174	100%	$397	$416	$3,000
50-74	$11,175 – $16,762	90%	$357	$377	$2,700
75-99	$16,763 – $22,349	75%	$297	$317	$2,250
100-124	$22,350 – $27,937	50%	$198	$218	$1,500
125-149	$27,938 – $33,524	30%	$119	$138	$900
150-174	$33,525 – $39,112	10%	$40	$60	$300

Endnotes

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[14] Ibid.
[15] The Honorable Arlene Wohlgemuth and Spencer Harris, Texas Public Policy Foundation, *The Big Squeeze* (2011) 3.
[16] *See* generally The Honorable Arlene Wohlgemuth and Spencer Harris, Texas Public Policy Foundation, *The Big Squeeze* (2011).
[17] Author's calculations based on Dr. Jagadeesh Gokhale, *Final Notice: Medicaid Failure* (2010) Tbl. 3.
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[27] Ibid at 23, 28.
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[30] Florida Medicaid, Agency for Health Care Administration, Florida Medicaid Reform: Extension Request, 1115 Research and Demonstration Waiver (June 2010) 14-16.
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[34] Ibid.
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[37] Texas HHSC & TDI, *Impact on Texas if Medicaid is Eliminated* (2010) 32.
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[39] eHealthInsurance, Inc., 2010 Fall Cost Report for Individual and Family Policyholders (2010) 5.
[40] Ibid.
[41] Texas HHSC, *Texas Medicaid and CHIP in Perspective* (8th ed. 2011) 4–15.
[42] eHealthInsurance.com search showing that for a 30 year old female, only one insurance provider, Scott & White Health Plan, offered policies that included maternity benefits.
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[45] Texas HHSC, *Texas Medicaid and CHIP in Perspective*, (7th ed. 2009) 6-8.
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[50] 42 CFR §438.114(a) (2010).
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[52] HHSC & TDI, *Impact on Texas if Medicaid is Eliminated* (2010) 13, Tbl 3.
[53] *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Pub.L. 102-193, 110 Stat. 2105. In late 1980s and early 1990s, Governor Tommy Thompson of Wisconsin began instituting welfare reform whereby state assistance was tied to employment. In 1995, Texas passed HB 1863 which applied time limits and employment requirements to welfare benefits.

About the Authors

Arlene Wohlgemuth is Executive Director and director of the Foundation's Center for Health Care Policy. She served 10 years as a state representative for district 58. During the 77th legislative session, she served as chairman of Appropriations Article II Subcommittee (Health and Human Services), vice-chairman of Calendars, CBO for Human Services, and member of the Select Committee for Health Care Expenditures. Wohlgemuth authored HB 2292, the sweeping reform of Health and Human Services which improved service delivery for the recipients, saving taxpayers more than $3.7B during its first five years. The reforms consolidated 12 agencies into five and was the largest government reform bill ever passed in the state.

Brittani Miller joined the foundation in November 2010 as a Research Associate in the Center for Health Care Policy. Her research focuses on Texas Medicaid reform based on free market principles. Prior to the Foundation, Miller represented petitioners in the Court of Federal Claims on vaccine-injury cases. She published a policy paper on the institutional disadvantages inherit to the vaccine injury compensation program. While in law school, Miller clerked for the Institute for Justice Austin Chapter. There she collaborated with the Executive Director on freedom of speech, eminent domain, and economic liberty issues. Miller received a B.S. in Communication Studies from the University of Texas at Austin, and a J.D. from George Washington University Law School.

Spencer Harris joined Texas Public Policy Foundation in 2010 as a Health Care Policy Analyst. His research focuses on identifying patient-centered, free market solutions for our state's health care challenges. No stranger to Texas public policy, Harris worked in the House of Representatives for Rep. Warren Chisum where he covered health care issues, immigration issues, and the Licensing and Administrative Committee. Harris is a native Texan, born and raised in Houston. He graduated from Texas A&M University with a degree in History and Anthropology.

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900 Congress Ave., Suite 400 | Austin, Texas 78701 | (512) 472-2700 phone | (512) 472-2728 fax | www.TexasPolicy.com