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Brief Analysis

Texas Health Care Reform

by Pamela Villarreal and Joe Barnett

Policymakers are debating changes to the state's Medicaid program — the joint federal-state health care program for the poor — and discussing ways to provide coverage to the state's large uninsured population through the private insurance market. Medicaid now takes 26 percent of the state budget, double the portion it consumed a little more than a decade ago. The federal government matches the state's Medicaid spending, which was about $7 billion in 2006. Without reform, uncontrolled Medicaid spending is on a course to swamp the state budget. Two of the changes proposed by legislators include NCPA ideas: Using indigent care dollars to subsidize the purchase of private insurance, and creating Health Savings Accounts (HSAs) for the direct purchase of medical care.

Good Idea: Encouraging Private Insurance. In 2005, 3.7 million Texans were enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP). An additional 5 million Texans (25 percent of the state's population) were without health insurance. In response to the growing number of uninsured, the state Senate passed a bill proposing a new insurance plan called Healthier Texas. Under the plan, the state would subsidize the purchase of private insurance for low-income individuals using federal and state dollars previously allocated to reimbursing hospitals and physicians that provide "free care" to the indigent and uninsured [see the figure]. The funds would be used to cover an estimated 2 million adults who do not qualify for Medicaid but whose incomes are under 200 percent of the federal poverty level. How would the plan work?

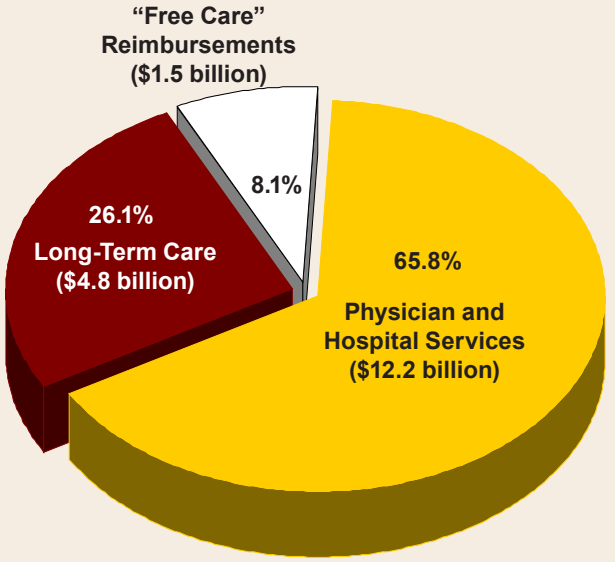
- The state would pay part of the cost of individual or employer-provided health insurance; families would pay premiums based on a sliding income scale, but all of them would be required to pay minimal deductibles and copayments for health care services.
- The state would also fund Health Savings Accounts (HSAs) that enrollees could use to pay expenses not paid by insurance.

If the plan is enacted into law, the federal government must waive current requirements for the use of the federal money.

Good Idea: Savings Accounts in the Medicaid Program. Texas legislators have also proposed reforms to the current Medicaid program, including establishing Health Opportunity Accounts (HOAs) for Medicaid patients who complete preventive health programs, such as smoking cessation and weight loss. The state would deposit funds into the HOAs, which beneficiaries could use for medical services not covered by Medicaid. Although similar to Health Savings Accounts, in that both provide funds to pay out-of-pocket costs, HOAs aim to reward recipients for making healthy lifestyle changes.

Finally, the bill recently passed by the state Senate would encourage seniors to purchase long-term care insurance to relieve the burden on the system. Some of the assets of seniors who insure would be protected from state efforts to recover nursing home costs from their estates. Four states currently have these public-private long-term care partnerships, and other states are considering them.

Texas Medicaid Spending by Service, 2005



Source: Kaiser Family Foundation, "Distribution of Medicaid Spending by Service, FY 2005," statehealthfacts.org.

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Good Idea: The "Three-Share" Proposal. Texas officials have asked for a waiver to implement a pilot "Three-Share Program" in Galveston County and have also expressed interest in expanding the program to additional areas. Three-Share programs for small employers and workers who do not qualify for Medicaid have been implemented in a few other states. Under a Three-Share Program, health care premium costs would be paid by the state (using state and/or federal Medicaid funds), the employer and the employee. The health plans offered would cost an average of $150 to $180 per month per family. The benefits would not be as comprehensive as conventional health plans, but would generally provide primary care, specialty care, drugs and limited inpatient services.

Questionable Idea: Health Insurance Exchange. Another reform, recommended by a task force appointed by Gov. Rick Perry, is for the state to establish a Health Insurance Exchange Market to bring small businesses and individual purchasers together with insurers. However, state policymakers should be careful not to imitate the Health Connector created by Massachusetts and under consideration in several other states. The Health Connector embodies the idea of managed competition, which requires insurers to charge every member of a health plan the same premium regardless of expected health care spending. This practice, known as community rating, forces insurers to charge healthy people more so sick people can be charged less. As a result, insurers cannot compete on their ability to price and manage risk. The proposed reforms are a start, and some measures similar to the Senate bill could be considered in the Texas House of Representatives, but more can be done.

Missed Opportunity: Deregulating the Insurance Market. Private insurance subsidies are useful, but the state should also cut some of its 52 cost-increasing insurance mandates, which require insurers to cover specific medical services. Nationwide, as many as one-quarter of the uninsured may have been priced out of the market by such costly regulations.

Missed Opportunity: Personal and Portable Health Insurance. Texas could create portable insurance that individuals can carry from job to job by following the NCPA/BlueCross BlueShield of Texas reform plan. Under the current system, workers often lose employer-sponsored health coverage when they switch jobs. Portable health insurance would allow consumers to keep the health plan of their choice and maintain a continuing relationship with doctors and health facilities regardless of their employment.

Missed Opportunity: Recovering Long-Term Care Costs. Long-term care costs the state about $4.8 billion annually. Texas could do more to reduce spending on long-term care. Many seniors who receive subsidized nursing home care could pay some of the cost, but many of their assets are exempt for Medicaid eligibility purposes. In addition, middle-class seniors can legally "hide" their assets by transferring them to their children through irrevocable (Miller) trusts. The effectiveness of the state's estate recovery program could be improved. It now exempts many assets from estate recovery and prohibits the state from placing a lien on property to ensure it receives a share of the proceeds of a sale. More aggressive state programs have recovered less than 2 percent of their long-term care costs, but the sums involved are significant; nationally, the median recovery per estate in 2004 was about $8,000.

Missed Opportunity: Block Grant. Texas should ask for a block grant of all federal funds, including Medicaid, SCHIP and indigent care funds. This would give the state the flexibility to combine different pots of federal money and use them more efficiently, such as tailoring benefit packages for specific Medicaid populations, subsidizing private health insurance premiums and funding community health centers. Charity care currently costs about $1,500 per uninsured person annually, or $6,000 for a family of four. As more people are covered by insurance, the need to subsidize indigent-care hospitals should fall.

Conclusion. Texas is taking some bold steps to reform its costly Medicaid program. With a quarter of its population uninsured, the key is to encourage participation in the private insurance market, with a minimal state safety net.

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