
**HOUSE SELECT COMMITTEE ON STATE HEALTH CARE EXPENDITURES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2004**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
79TH TEXAS LEGISLATURE**

**DIANNE WHITE DELISI
CHAIRMAN**

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Select Committee On
State Health Care Expenditures

November 24, 2004

Dianne White Delisi
Chairman

P.O. Box 2910
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The Honorable Tom Craddick
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Select Committee on State Health Care Expenditures of the Seventy-Eighth Legislature hereby submits its' interim report including recommendations and drafted legislation for consideration by the Seventy-ninth Legislature.

Respectfully submitted,

Handwritten signature of Dianne White Delisi in cursive script.

Dianne White Delisi

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Linda Harper-Brown, Vice Chairman

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Jaime Capelo

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Joe Deshotel

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Arlene Wohlgenuth

Linda Harper-Brown
Vice-Chairman

Members: Leo Berman, Jaime Capelo, Myra Crownover, Joe Deshotel,
Roberto Gutierrez, Sid Miller, Vicki Truitt, Carlos Uresti, Arlene Wohlgenuth

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INTRODUCTION

At the beginning of the 78th Legislature the Honorable Tom Craddick, Speaker of the Texas House of Representatives, appointed eleven members to the Select Committee on State Health Care Expenditures. The proclamation establishing the committee provided that the committee has jurisdiction over all matters pertaining to the state expenditures as a purchaser or provider of health care services, including the purchase of insurance covering health care or the purchase of products as a health care service provider. The committee's jurisdiction includes such matters as expenditures for health care under Medicaid, for state employee group insurance, for health insurance for active or retired teachers, for health care services provided by teaching hospitals and other health science centers, and for health care services for incarcerated offenders. The Committee membership includes the following: Dianne White Delisi, Chairman; Linda Harper-Brown, Vice Chairman; Leo Berman; Jaime Capelo; Myra Crownover; Joe Deshotel; Roberto Gutierrez; Sid Miller; Vicki Truitt; Carlos Uresti; Arlene Wohlgemuth.

During the interim the Committee was assigned five charges by the Speaker:

- Study the funding source of the Medicaid Disproportionate Share Hospital (DSH) Program
- Monitor the implementation of the Driver Responsibility Act
- Study the effects of “crowd out” in the Children’s Health Insurance Program and Medicaid Program
- Study current consumer-directed care models, particularly in regards to long-term care
- Identify and seek new models for the provision of health care benefits within the Employee Retirement System and the Teacher Retirement System

The Committee has completed their hearings and investigations. The Select Committee on State Health Care Expenditures has adopted and approved all sections of the final report.

Finally, the Committee wishes to express appreciation to the agencies, associations and citizens who contribute their time and effort on behalf of this report.

HOUSE COMMITTEE ON STATE HEALTH CARE EXPENDITURES

INTERIM STUDY CHARGES

- CHARGE** Monitor the implementation of the Driver Responsibility Act in respect to the collection of associated surcharges for trauma care. Specifically evaluate the funding and distribution of funds to trauma care facilities.
- CHARGE** Study the effects of “crowd out” in the Children’s Health Insurance Program and Medicaid Program to determine accurate data and to ascertain if additional policy changes are needed to prevent “crowd out” of private insurance and escalating public insurance costs.
- CHARGE** Evaluate the funding source of the Medicaid Disproportionate Share Hospital (DSH) Program and the criteria that a hospital must meet to participate in the DSH program in comparison to the balance and fairness of other state and federal funding streams.
- CHARGE** Study current consumer-directed care models that are in use by the state and look at other states’ consumer-directed care models that may benefit Texas in areas such as long-term health care and chronic health care. Place emphasis on the Program of All-Inclusive Care For the Elderly model to ascertain its true potential for both cost-effectiveness and improved health outcomes. Identify barriers to the model’s expansion in Texas.
- CHARGE** Continue to identify and seek new models for the provision of health care benefits within the Employee Retirement System and the Teacher Retirement System.

CHARGE

DRIVER RESPONSIBILITY ACT

Monitor the implementation of the Driver Responsibility Act in respect to the collection of associated surcharges for trauma care. Specifically evaluate the funding and distribution of funds to trauma care facilities.

BACKGROUND

During the 78th Regular Legislative Session HB 3588 created the Driver Responsibility Program¹ (DRP) in an effort to enhance public safety and shift some of the burden of accident related costs from the general population to those who accumulate moving violations or are convicted of certain driving related offenses. The program established the Designated Trauma Facility and Emergency Medical Services Account (DTF/EMSA) in which revenue that is generated from the DRP is deposited. This account is to support the trauma system including designated trauma hospitals, EMS providers, the Regional Advisory Councils, and the Texas Department of Health-Bureau of Emergency Management.²

The DRP addresses both traffic safety and financial issues by assessing points and/or surcharges on the licenses of people who engage in activities that cause vehicle accidents and using the revenue to reimburse medical facilities for trauma care. Funds in the account are generated through two sources. One is state traffic fines³ and the other is a DRP.

The state traffic fine is a fee of \$30 that is assessed for each traffic conviction. One-third of this fee is deposited into the DTF/EMS account, with the remainder being deposited into the credit of the undedicated portion of the general revenue. If deposits to the General Revenue Fund from the \$30 traffic fine and the Driver Responsibility Program exceed \$250 million in fiscal year (FY) 2006 or FY 2007, sixty-seven percent of the additional revenue from the \$30 traffic fine during the fiscal year would be deposited to the Texas Mobility Fund per statute, rather than the General Revenue Fund.⁴

The DRP utilizes a point system for driving infractions by assessing a surcharge on the license of a person who has accumulated six points over a specific timeframe. The points are assigned for moving violations classified as Class C misdemeanors and applies surcharges to offenders, based on the type of offense and the time period in which the citation was received. For each conviction, DPS will assign points to a person's license as follows:

- Two points for a moving violation conviction in Texas or that of another state
- Three points for a moving violation conviction in Texas or another state that resulted in a vehicle crash
- Points will not be assigned for speeding less than ten percent over the posted limit or seat belt convictions

Any points that a driver may earn for moving violations will remain on the driver's record for a period of three years. The Texas Department of Public Safety (DPS) will assess a surcharge when a driver accumulates a total of six points or more on their record during a three year period. The driver must pay a \$100 surcharge for the first six points and \$25 for each additional point.⁵

1 HB 3588, Article 10, 78th Regular Legislative Session, June 2003.

2 Texas Department of Health, Designated Trauma Facility and Emergency Medical Services Account Implementation of HB 3588, Texas Department of State Health Services, September 1, 2004.

3 HB 2, 78th 3rd Called Special Legislative Session, October 20, 2003.

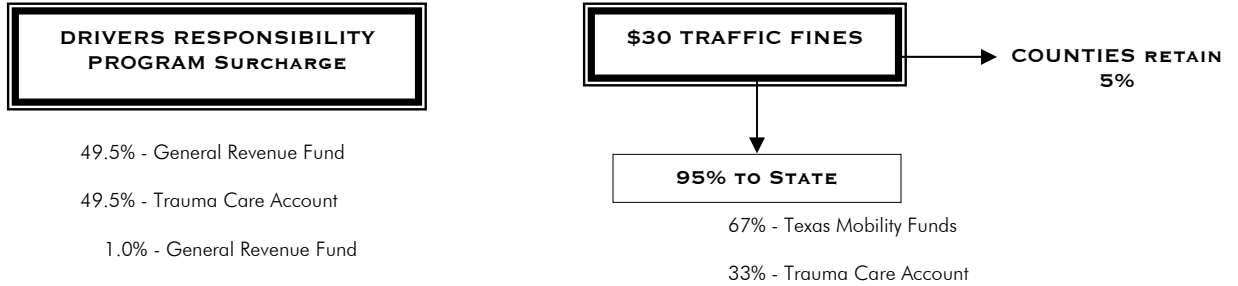
4 Ibid.

5 Texas Department of Public Safety, Driver Responsibility, Press Release, August 19, 2003.

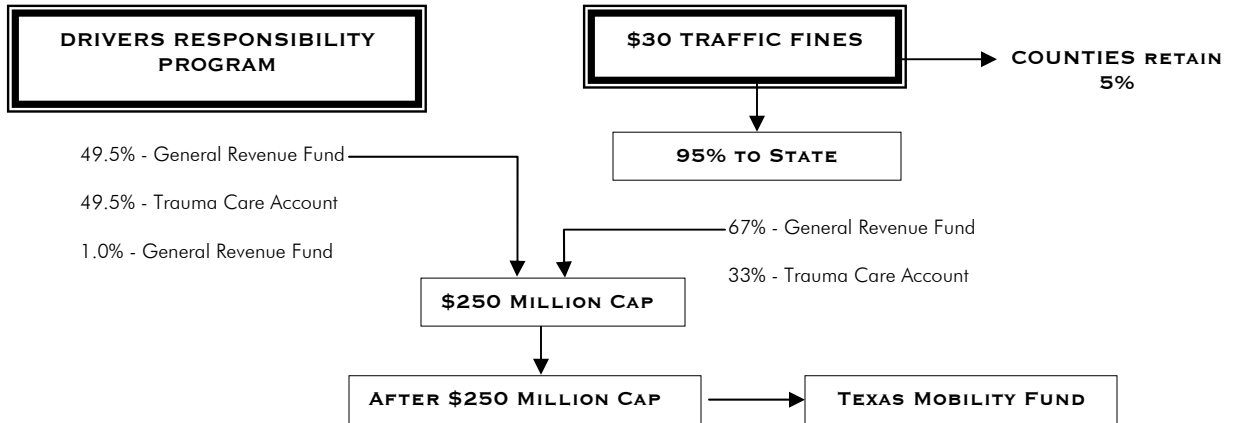
Figure 1⁶

FUNDING DISTRIBUTION BY ALLOCATION FOR THE DRIVERS RESPONSIBILITY PROGRAM (DRP) AND \$30 TRAFFIC FINE REVENUES

FY 2004-05



FY 2006-07



* As per HB 2, 78th Third Called Special Session, Articles 2 and 3 Amending HB 3588, 78th Regular Session, Chapters 10, 13, and 20.

In fiscal years 2004 and 2005, the \$30 collected for traffic fines is distributed as follows:

- 5% retained by collecting municipality or county (\$1.50)
- 95% forwarded to the state (\$28.50)
- 67% of the state's portion (\$19.10) is deposited in the Texas Mobility Fund 33% of the state's portion (\$9.40) is deposited in the Trauma Care Account

In fiscal years 2006 and 2007, the \$30 collected for traffic fines will be distributed as follows per statute:

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- 67% of the state's portion (\$19.10) is deposited in the General Revenue Fund 33% of the state's portion (\$9.40) is deposited in the Trauma Care Account

6 Funding distribution by percentage for the DPR and \$30 traffic fines allocations to the General Revenue fund (GR), the Trauma Care Account, and the Texas Mobility Fund (TMF) as per HB 3588, 78th Regular Session and HB 2, 78th Third Called Special Session. These Sections Expire September 1, 2007.

The DRP does not assign points for certain offenses. For these offenses the DRP assigns annual surcharges for certain convictions for a period of three years. These offenses are:⁷

Offense	Surcharge Amount
Driving While Intoxicated	\$1000 per year \$1,500 per year for second or subsequent conviction in a 36 month period \$2,000 if there was an alcohol concentration level of .16 or more ⁸
Driving while license is invalid (<i>suspended, revocation, cancellation or denial</i>)	\$250 per year
Driving without financial responsibility	\$250 per year
Driving without valid license (<i>expired or no license issued</i>)	\$100 per year

IMPLEMENTATION

Texas Department of State Health Services

Texas Department of State Health Services (DSHS) worked extensively with stakeholders, including the Texas Public and Not-for-Profit Hospital Association, the Texas Hospital Association's Technical Advisory Group (THA TAG), the Texas Medical Association's EMS and Trauma Committee, and the Governor's EMS and Trauma Advisory Council (GETAC) to develop a rule for implementation. After more than 25 hours of meetings, the Trauma Systems Committee voted unanimously to recommend to GETAC that the rule be forwarded to the Texas Board of Health for proposal. At the GETAC meeting on February 13, 2004, the Council voted unanimously to recommend proposal of the rule to the Texas Board of Health. The Board proposed the rule for publication in the *Texas Register* and comment at its meeting on April 15, 2004. The public comment period ran through May 2004 and the Board adopted the final rule on July 1, 2004.

The major provisions of the rule that were adopted are as follows:⁹

- Definition of uncompensated trauma care and methodology for determining costs from charge data
 - Hospitals report charges for uncompensated care
 - Medicaid cost to charge ratio is applied to total charges which results in costs
- Calculation of hospital shares of the available funds
 - Fifteen percent will be shared equally among all eligible applicants up to a maximum of \$50,000 per facility, or
 - Eighty-five percent will be based on a pro rata share of the total

7 H.B. 3588, Article 10, 78th Regular Legislative Session, June 2003.

8 This surcharge applies if it is shown on the trial of the offense that an analysis of a specimen of the person's blood, breath, or urine showed an alcohol concentration level of 0.16 or more at the time the analysis was performed.

9 Designated Trauma Facility and Emergency Medical Services Account Implementation of HB 3588, Texas Department of Health Services, September 1, 2004.

-
- uncompensated trauma care reported by eligible hospitals
 - Any collections by hospitals on previously reported uncompensated trauma care must be reported and will offset the distribution amounts for the following year
 - Provisions for return of the funds if a hospital does not meet designation requirements
 - Support of the development of physician incentive plans by hospitals
 - Specification of the distribution methodology for the other allocations (Extraordinary Emergency Fund - \$500,000; EMS – two percent; Regional Advisory Councils – one percent)

The 78th 3rd Called Special Legislative Session authorized \$108 million for FY 2004 and \$163 million for FY 2005. HB 3588 specifies the following distribution formula for the funds: \$500,000 for the Extraordinary Emergency Fund; ninety-six percent of the remaining funds to trauma facilities and hospitals in “pursuit of designation” for uncompensated trauma care; two percent to EMS providers; one percent to Regional Advisory Councils in the trauma system; and one percent for administrative costs.¹⁰

Texas Department of Public Safety

The DPS reviewed two separate implementation strategies. The alternatives were an in-house collection process with DPS collecting all fees for the duration of the program vs. a dual system in which DPS collected the fees during the start-up of the program and then transferred the collection process to a vendor. In November 2003 DPS completed its review and recommended utilizing a vendor for the collection of the surcharges.

During FY 2004 DPS began the Request for Proposal (RFP) process. Upon determining in November 2003 that an outside vendor was needed to collect the surcharges, DPS began work on the RFP for the DRP. In May 20, 2004, DPS approved and posted the RFP for bids by interested vendors. On August 26, 2004, DPS concluded the vendor selection process and signed a contract, with Municipal Service Bureau for the collection of the surcharges.

Municipal Service Bureau will charge a four percent collection fee of all surcharges. If an individual utilizes an installment plan the person pays an additional \$2.50 per payment. In addition, there is also a \$2 fee for electronic check payment by phone and \$5 fee for credit card payments. DPS indicates that current statute authorizes a fee up to thirty percent of the surcharge.¹¹ The current contract has a ceiling that prevents the vendor from collecting more than thirty percent of any surcharge.¹²

10 Designated Trauma Facility and Emergency Medical Services Account Implementation of HB 3588, Texas Department of Health Services, September 1, 2004.

11 Driver Responsibility Program Service Level Agreement, Texas Department of Public Safety, August 26, 2004, page 4.

12 Driver Responsibility Program, Request for Proposal, Texas Department of Public Safety, May 20, 2004, page 34.

FUNDING

As of August 9, 2004, DPS estimated that there are 177,792 driver records with a conviction that requires the payment of a surcharge. Processing on these pending cases will begin on October 1, 2004. According to DPS, these cases will generate surcharges totaling \$56,049,850 with the anticipated sixty-six percent collection rate of \$37,329,200.¹³ Collection of FY 2004 surcharges were deferred until FY 2005 in order for DPS to finalize selection of the vendor and in house computer programming. DPS anticipates minimal revenue loss with a FY 2005 implementation for offenses that occurred and were also convicted in September 2003. For these few convictions DPS will be unable to collect a full three years of surcharges since the legislation provides for DPS to collect surcharges for thirty-six months from the date that notices of owing a surcharge are mailed to the offender. For the next five years DPS has provided anticipated revenue figures that will be generated from the surcharges. The anticipated revenue generated is based on a sixty-six percent collection rate.

DPS Fiscal Projections ¹⁴		Anticipated Surcharge Collected @ 66%
Total Surcharge		
FY 2005	\$227,117,050	\$149,896,200
FY 2006	\$381,214,500	\$251,590,500
FY 2007	\$535,311,950	\$353,305,887
FY 2008	\$462,292,350	\$305,112,951
FY 2009	\$462,292,350	\$305,112,951

Revenue estimates range from \$100 million in FY 2004 to \$240 million in FY 2007.

As of September 1, 2003, DSHS has identified 188 hospitals that were designated as trauma facilities. Additionally, 71 undesignated facilities have met the criteria for the “active pursuit of designation” provisions of the legislation. These facilities have until December 31, 2005, to achieve designation or any funds they receive under this statute must be returned.

A total of 237 hospitals applied for the funds; three were ineligible. The applications were evaluated and hospital percentage shares of the funding determined.

On August 16, 2004, a report was received from the comptroller’s office, which provided the final FY 2004 totals in the DTF/EMS Account - \$18,964,127¹⁵ (the following table shows how this total is broken down into the various allocations). Final determination of actual hospital dollar reimbursement amounts was completed and the funds were distributed on August 30, 2004.¹⁶

13 Ibid.

14 Driver Responsibility Fact Sheet, Texas Department of Public Safety, September 8, 2004.

15 E-mail from Karen Prothero with the Texas Department of State Health Services to Kathy Perkins with the Texas Department of State Services, August 16, 2004.

16 Designated Trauma Facility and Emergency Medical Services Account Implementation of HB 3588, Texas Department of Health Services, September 1, 2004.

FY04 DTF/EMS Account Total	\$18,964,127
Hospital Allocation (96%)	\$18,231,595
EMS Allocation (2%) ¹⁷	\$352,251
Regional Advisory Council (1%)	\$189,641
Department Allocation (1%)	\$189,641

It appears that the distributions that were made in FY 2004 through the collection of traffic fines could have been substantially larger if the implementation of the DRP had progressed as smoothly as the Legislature expected. The program was not far enough along to collect revenues that were anticipated to be available in FY 2004.

RECOMMENDATION

The success of this program is dependent upon the performance of the vendor in collecting the fees. The DPS will need to perform proper diligence to assure that the vendor's performance meets or exceeds their contractual standard. The Committee recommends an audit of the performance, collection and enforcement of the driver responsibility program prior to the next scheduled distribution of funds in FY 2006.

A question has been raised over whether DPS has clear statutory authority to authorize an administrative fee in addition to the surcharge. The legislature may need to exam the statutory authority to issue an administrative fee and provide clarification to DPS. The program should also remain in its current funding distribution formula to ensure that the state's trauma system remains the beneficiary.

¹⁷ This amount was reduced from the required 2% by \$27,032 because there were counties that had no eligible EMS Provider. Those funds were included in the Hospital Allocation as required by the statute.

CHARGE

CHILDREN'S HEALTH INSURANCE PROGRAM AND MEDICAID PROGRAM

Study the effects of “crowd out” in the Children’s Health Insurance Program and Medicaid Program to determine accurate data and to ascertain if additional policy changes are needed to prevent “crowd out” of private insurance and escalating public insurance costs.

BACKGROUND

The State Children's Health Insurance Program (SCHIP or CHIP) was created under title XXI as part of the Balanced Budget Act of 1997 to address the problem of uninsured children. CHIP was designed as a health insurance program to cover children whose families earn too much money to be eligible for Medicaid, but not enough money to afford private health insurance.

CHIP is a federal/state partnership targeted to cover low-income children. A "targeted low-income child" is defined as a child residing in a family with an income below two hundred percent of the Federal Poverty Level (FPL) or a child whose family has an income fifty percent higher than the state's Medicaid eligibility threshold.

Federal Poverty Guidelines

Based on Annual Income

Family Size	100%	133%	150%	185%	200%
1	9,310	12,382	13,965	17,224	18,620
2	12,490	16,612	18,735	23,107	24,980
3	15,670	20,841	23,505	28,990	31,340
4	18,850	25,071	28,275	34,873	37,700
5	22,030	29,300	33,045	40,756	44,060
6	25,210	33,529	37,815	46,639	50,420
7	28,390	37,759	42,585	52,522	56,780
8	31,570	41,988	47,355	58,405	63,140

At 100% of poverty, for families larger than 8, add \$ 3,180 for each additional person.

Federal Poverty Guidelines, Continued

Based on Monthly Income

Family Size	100%	133%	150%	185%	200%
1	776	1,032	1,164	1,435	1,552
2	1,041	1,384	1,561	1,926	2,082
3	1,306	1,737	1,959	2,416	2,612
4	1,571	2,089	2,356	2,906	3,142
5	1,836	2,442	2,754	3,396	3,672
6	2,101	2,794	3,151	3,887	4,202
7	2,366	3,147	3,549	4,377	4,732
8	2,631	3,499	3,946	4,867	5,262

At 100% of poverty, for families larger than 8, add \$ 265 for each additional person.

Source for Guidelines: U.S. Department of Human Services.

Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

At the federal level the Centers for Medicare & Medicaid Services (CMS) administers the CHIP program. Federal matching funds from CHIP will provide \$40 billion over 10 years since becoming available on October 1, 1997. These funds allow states to expand health care coverage to uninsured children. CHIP is a state administered program with each state setting its own guidelines for eligibility and services. The U.S. Department of Health and Human Services estimates that over 5.3 million children are enrolled in state CHIP plans in the United States.¹

"Crowd Out" occurs when publicly funded health coverage (Medicaid or CHIP) is substituted for private sector health coverage. When government sponsored health coverage, including CHIP or Medicaid, becomes available individuals or families may choose to discontinue their employer or group health coverage to enroll in the government program. Crowd out becomes an issue when there is a vast expansion in publicly funded coverage, such as the implementation of CHIP.

Crowd out can occur when a previously uninsured child is enrolled in CHIP and the family chooses to maintain publicly funded that coverage when an affordable employer sponsored health insurance (ESI) is offered. Crowd out can also occur when an employer deliberately reduces or eliminates ESI for employees and their dependents with the expectation that government sponsored health programs will provide the coverage. Many times crowd out occurs as a result of a combination of employer and employee actions. For example, an employer covers too small a portion of the insurance and the employee views it as unaffordable.

¹ "SCHIP Enrollment Climbs to 5.3 Million Children in 2002," U.S. Department of Health and Human Services news release, February 5, 2003.

CHIP is intended to cover uninsured children. Thus, states and the federal government have a continuing interest in ensuring that CHIP specifically targets uninsured children, rather than children who are already covered by private sector health insurance.

Crowd out is more of a concern with CHIP than with Medicaid because CHIP families have relatively higher incomes, making them more likely to afford private health insurance. The availability and affordability of employer based or group coverage varies by state and region, resulting in differences in crowd out data.

As public coverage is expanded, some degree of crowd out seems inevitable. When parents and employers are priced out of the private insurance market, many families are forced to find publicly funded coverage. Private health insurance is considered unaffordable when the cost for coverage exceeds ten percent of the family's income.²

A study by the Robert Wood Johnson Foundation determined different scenarios that may not be considered when collecting crowd out data:³

- Families who buy individual coverage often have special health care needs and pay prohibitive premiums
- Very low-wage workers with very high premium shares for employer sponsored health insurance (ESI)
- A woman who has minimum coverage or catastrophic coverage that does not cover pregnancy benefits
- A family with unstable or seasonal employment (gains and loses access to ESI)

Title XXI of the Social Security Act includes provisions that requires state programs to include policies designed to minimize crowd out. States were instructed by the Health Care Financing Administration (HCFA) "to describe procedures in their state CHIP plans that reduce the potential for substitution." Anti-crowd out policies must be carefully designed so that they do not result in uninsured families and children. States have adopted a range of policies to prevent crowd out.

State Strategies for Limiting Crowd Out (NCSL)

States may impose a waiting period during which children must be uninsured before they can be eligible for CHIP. The waiting period is designed to discourage parents from dropping their children's private insurance. Imposing waiting periods is the most common and direct state strategy to limit crowd out. Thirty-seven states use a waiting period policy, ranging from one month to twelve months, and most states include exceptions to their waiting period policies. The exceptions to the waiting period generally relate to families losing coverage, through no fault of their own, within the specified time period (such as when an employer stopped offering dependent coverage, or an applicant loses his or her job).

Some states implement CHIP cost-sharing to create an economic disincentive for families

² Testimony submitted by Trey Berndt of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004.

³ Anne K. Gauthier, Understanding the Dynamics of "Crowd Out": Defining Public/Private Coverage Substitution for Policy and Research, June 2001.

considering substituting CHIP for private insurance. Twenty-nine states implement cost-sharing in the form of premiums, enrollment fees, and co-payments.

In a less stringent approach, states may monitor crowd out and include questions on their CHIP applications to determine eligibility and ensure that the children applying are legally entitled to benefits. Seventeen states use information about current and previous insurance coverage. These CHIP applications typically include questions about insurance status on applicant forms and some states verify insurance status before granting eligibility. Nine states collect enrollee surveys and six states use record matches. The federal government requires that all states screen children who apply for CHIP and Medicaid eligibility. Other strategies to monitor the effects of crowd out include auditing applications retrospectively, interviewing enrollees, and delegating the responsibility for measuring crowd out to third parties.

States can implement a premium assistance program for preventing crowd out by subsidizing ESI. The state would pay a portion of the employees premium in their current ESI to deter the employee from dropping the private coverage to join CHIP. This allows states to achieve the broader goal of capitalizing on private sector resources and strengthening the foundation of ESI. This strategy helps eliminate crowd out by helping employers maintain employee health benefits that employees can afford.

A final strategy to limit crowd out has been implemented by California. California has imposed legal obligations on employers and insurers to not alter their coverage policies in response to CHIP.⁴ Additionally, legislation currently being considered in California would require certain California businesses to provide health benefits to employees.

Texas Crowd Out

In 1999 SB 445 that was adopted by the 76th Legislature created the CHIP program in Texas. The Texas CHIP program provides health insurance to children nineteen years or younger who are not on Medicaid. The families net income must be at or below two hundred percent of the federal poverty level. This safety net is designed to cover the neediest children in Texas, including those who lack health insurance as their family moves from welfare to economic independence.

Texas chose to provide CHIP through contracts with private insurance carriers with premiums and co-payments established on a sliding scale fee according to family income. Texas recovers seventy-two percent of the cost of CHIP from the federal government.⁵ \$967 million is allocated for CHIP in the FY 2004-05 with funds coming from the State's tobacco settlement supplemented with three federal dollars for every state dollar.⁶

SB 445 adopted two policies designed to limit crowd out. The first established a waiting period for families who already had coverage at the time of the application. The second anti-crowd out policy

4 Amy Westpfahl and Lutzky Ian Hill, Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP (The Urban Institute) June 2001.

5 Written testimony submitted by Chris Patterson, Texas Public Policy Foundation, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 4.

6 Ibid. Page 5.

in SB 445 required families to share the cost for CHIP services. Cost sharing included point of service co-pays and enrollment fees or monthly premium cost sharing.

The 78th Texas Legislature passed HB 2292 to expand Texas' anti-crowd out policies. In HB 2292, the waiting period application was expanded to all children eligible for CHIP. New CHIP enrollees must wait for a three month period before their health coverage is effective. The waiting period is based on when the child is determined eligible:⁷

- If the child is found eligible for CHIP on or before the 15th day of a month, the waiting period begins on the first day of that same month
Example: Eligibility is determined on January 5th, waiting period is January, February, and March; health coverage begins April 1
- If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month
Example: Eligibility is determined on January 18th, waiting period is February, March and April; health coverage begins May 1

If new CHIP enrollees meet certain exceptions (in statute, HB 2292), they are exempt from the waiting period:⁸

- Parents or guardian lost employment because of a layoff or business closing
- Loss of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Loss of coverage due to a change in marital status of a parent of the child
- Loss of child's Medicaid coverage because the family's earnings or resources increased or the child reached an age at which Medicaid coverage is not available
- Other circumstances resulting in the involuntary loss of coverage
- The family terminated health coverage because the cost for the coverage exceeded ten percent of the family's income (supported at the level at which health insurance becomes unaffordable)
- The child has access to group based health benefits plan coverage and will participate in the CHIP premium assistance program administered by HHSC
- HHSC has determined that other grounds exist for a good cause exception (this gives HHSC broad authority in case of error or special needs condition)

HB 2292 also expanded anti-crowd out policies by providing HHSC with more flexibility to increase cost sharing to the federal maximum levels. As a government subsidized program, Texas CHIP is very affordable, but participating families do share in the cost of the program. As illustrated in Figure 1 and 2, families in the Texas CHIP program contribute a certain amount of the share in cost, depending on the family's total income.⁹

7 Written testimony submitted by Trey Berndt of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 10.

8 Ibid. page 11.

9 Written testimony submitted by Trey Berndt of the Health and Human Services Commission, House Select

Texas CHIP Policies - Cost Sharing

- Since it is a subsidized program, CHIP is very affordable, but it is not a free program. CHIP families share in the cost of the program.

(Note: "FPL" is Federal Poverty Level; Co-pay Caps are per six-month enrollment period):

At or below 100% of FPL	Charge
Monthly Premium	\$0
Office Visit	\$3
Emergency Room	\$3
Generic Drug	\$0
Brand Drug	\$3
Co-pay Cap	\$1.25% (of family's income)
Facility Co-pay, Inpatient	\$10
Facility Co-pay, Outpatient	\$0
101% to 150% of FPL	Charge
Monthly Premium	\$15 per mo./per family
Office Visit	\$5
Emergency Room	\$5
Generic Drug	\$0
Brand Drug	\$5
Co-pay Cap	\$1.25% (of family's income)
Facility Co-pay, Inpatient (per admission)	\$25
Facility Co-pay, Outpatient	\$0

Figure 1

Texas CHIP Policies - Cost Sharing, Continued

151% to 185% of FPL	Charge
Monthly Premium	\$20 per mo./per family
Office Visit	\$7
Emergency Room	\$50
Generic Drug	\$5
Brand Drug	\$20
Co-pay Cap	2.5% (of family's income)
Facility Co-pay, Inpatient (per admission)	\$50
Facility Co-pay, Outpatient	\$0
186% to 200% of FPL	Charge
Monthly Premium	\$25 per mo./per family
Office Visit	\$10
Emergency Room	\$50
Generic Drug	\$5
Brand Drug	\$20
Co-pay Cap	2.5% (of family's income)
Facility Co-pay, Inpatient (per admission)	\$100
Facility Co-pay, Outpatient	\$0

Figure 2

Additional policy changes were made that impacted CHIP eligibility. The elimination of income disregards such as child support payments and disabled adult care resulted in a decline in the CHIP caseload of 16,710 in November 2003. Overall, the number of CHIP enrollees in Texas has declined by 130,208 from September 2003 through April 2004. Also, the procedural change requiring CHIP participants to re-enroll every six months has resulted in a decline in CHIP caseloads. From September 2003 to April 2003, 109,913 clients chose not to re-enroll and 45,585 attempted to enroll but were determined ineligible.¹⁰

The CHIP caseload level for FY 2004 is decreasing as assumed in the Appropriations Bill (HB 1), but will not reach the levels set out in HB 1. The forecast assumes stabilization of caseload decline in FY 2005:¹¹



Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 12-13.
 10 Texas Health and Human Services Commission, Medicaid, Vendor Drug, and CHIP Caseload and Cost Update (Austin) April 23, 2004, Page 2.

11 Texas Health and Human Services Commission, Medicaid, Vendor Drug, and CHIP Caseload and Cost Update (Austin) April 23, 2004, Page 6.

**CHIP caseload and Costs:
HB 1 and Spring 2004 Forecast**

	H.B 1		Spring 2004 Forecast		Differences	
	Average Monthly Clients	\$ per Client	Average Monthly Clients	\$ per Client	Average Monthly Clients	\$ per Client
2004	380,603	\$88.54	406,760	\$96.12	26,157	\$7.58
2005	346,818	\$91.27	345,380	\$97.29	(1,438)	\$6.02

Texas Health and Human Services Commission conducted a study on CHIP enrollees from January 2003 to December 2003.¹² This included nine months under the old waiting period and three months under the new three month waiting period, as revised by HB 2292. According to the HHSC study, the average monthly enrollment from January 2003 to December 2003 was 496,094. The average monthly new enrollment during this time was 21,295.

The study determined that about one percent of new monthly enrollment was due to crowd out, whereby private coverage was dropped in order to enroll in CHIP. Children in families that applied for CHIP after dropping other health coverage had to wait out the waiting period. One half of one percent of the new monthly enrollment was exempted from the waiting period due to the cost of their employer or group insurance being over ten percent of their family income. About eight percent of the new monthly enrollment was exempted from the waiting period for other permitted reasons.

The Institute for Child Health Policy, CHIP's External Quality Review Organization, conducted a CHIP consumer survey with families who had been enrolled in CHIP in Texas for twelve months or longer:¹³

- Twenty-four percent reported access to employer based family coverage
- Eighty-one percent of those with access to employer based coverage said they could not afford that coverage
- The cost of employer based coverage was reported to be, on average, eleven percent of family income

The availability and affordability of private sector insurance must be taken into consideration when examining CHIP crowd out. The cost of health insurance has risen at an incredible rate in recent years, affecting employers ability to provide affordable health insurance. The Texas Department of Insurance (TDI) examined the question of: "How much have health insurance premiums risen over

¹² Written testimony submitted by Trey Berndt of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 15.

¹³ Ibid., page 17.

the last five years?"

As the table below shows, average annual insurance premiums are provided for single coverage (employee only) and for family coverage (employee and dependents). Rates are provided for five years, including 2001, which is the most recent year for which data is available. Average family premiums for all businesses (large and small combined) were lowest in 1998, and have since increased thirty-four percent from \$5,693 to \$7,486. Family premiums for small businesses (2-50 employees) experienced an even larger increase of forty-four percent, from \$5,534 in 1997 to \$7,974. Large businesses with more than 50 employees saw lower rate increases of thirty-three percent from \$5,590 in 1998 to \$7,423 in 2001.¹⁴

Table 1
1997-2001 Average Single and Family Premiums in Establishments
that Offer Health Insurance by Firm Size – Texas and National Data

Size of Business	Texas					United States				
	1997	1998	1999	2000	2001	1997	1998	1999	2000	2001
Average Single Premiums										
All Businesses	\$2,193	\$2,087	\$2,336	\$2,627	\$2,925	\$2,050	\$2,174	\$2,325	\$2,655	\$2,889
Small Businesses	\$2,172	\$2,270	\$2,539	\$2,955	\$3,299	\$2,107	\$2,235	\$2,475	\$2,827	\$3,031
Large Businesses	\$2,200	\$2,030	\$2,261	\$2,538	\$2,809	\$2,029	\$2,151	\$2,269	\$2,595	\$2,845
Average Family Premiums										
All Businesses	\$5,693	\$5,588	\$6,209	\$6,638	\$7,486	\$5,332	\$5,590	\$6,058	\$6,772	\$7,509
Small Businesses	\$5,534	\$5,575	\$6,486	\$6,784	\$7,974	\$5,178	\$5,441	\$6,062	\$6,868	\$7,704
Large Businesses	\$5,727	\$5,590	\$6,161	\$6,618	\$7,423	\$5,366	\$5,621	\$6,057	\$6,752	\$7,473

Source: Analysis of the 1997-2001 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Although MEPS data is only available through 2001, another annual survey of employers provides more recent information. The Employer Health Benefits Survey conducted annually by the Kaiser Family Foundation and the Health Research and Educational Trust reported average premium rate increases of 12.7 percent in 2002 and an additional increase of 13.9 percent in 2003.

Although Texas specific data is not available from this survey, discussions with Texas employers and limited rate data provided to TDI by several large insurers indicates that most Texas employers experienced significant rate increases similar to those reported in the Employer Health Benefits survey in 2002 and 2003. If TDI applies these rate increases to the Texas data listed in the table above, the average rates for 2003 would increase as follows: the average single premium for all businesses would be \$3,754; for small businesses, \$4,235; and for large businesses, \$3,606. The average family premiums in 2003 would increase to \$9,609 for all businesses combined; \$10,236 for small business; and \$9,529 for large.¹⁵

Texas Department of Insurance (TDI) also examined the question of: "What is the average out-of-

14 Written testimony submitted by Dianne Longley, Texas Department of Insurance, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 2.

15 Letter to Representative Linda Harper-Brown, Vice-Chair of House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, from Dianne Longley, Texas Department of Insurance, March 12, 2004, page 3.

pocket cost for employer coverage?"

Out-of-pocket costs paid by employees in the form of premium contributions for their insurance coverage vary widely. Most carriers require a minimum contribution from the employer, with the remainder paid by the employee. While the Department does not have access to this information for Texas employers since group insurance rates are not subject to rate regulation, the above mentioned MEPS survey and Employer Health Benefit Survey do provide some data. The most recent information is again from the Employer Health Benefit Survey which reports the average monthly premium contribution that employees must pay for family coverage increased from \$178 in 2002, to \$201 in 2003. Overall, workers are now required on average to contribute \$2,412 annually towards the cost of insurance coverage that includes children. However, the MEPS data suggest that average employee contributions are significantly higher for Texas' small businesses in particular. In 2001, the MEPS data shows that employees working for small firms were paying an estimated \$2450 for family coverage. Those costs are certainly higher now, given the significant premium increases of 2002 and 2003.¹⁶

TDI examined the role that benefits, premiums, co-payment rates, and choice of provider play in the decision to drop private coverage and enroll in public coverage:

Since the Department has no regulatory oversight of CHIP or Medicaid, a direct answer to this question can not be given. However, studies have shown that as premium costs increase, making family coverage less affordable, individuals who have a choice between a public program and a private plan are more likely to choose the less expensive public program. In focus group discussions with small employers as part of the State Planning Grant study, several employers said they have employees whose income is too low for them to afford the employer's health plan, but does allow them coverage under either Medicaid or CHIP. Employers indicated that their employees were satisfied with their public program and were not interested in or could not afford to pay for private insurance. However, others indicated that some Medicaid/CHIP enrollees would prefer to participate in an employment based health plan if it were available.¹⁷

A survey conducted by TDI found that there is an interest among employees to enroll in employer offered health insurance rather than CHIP, but most employees believe they are incapable of paying for the cost of ESI. The TDI poll asked the question: "If some of your employees have children who are covered under TexCare Partnership (State Medicaid or Children's Health Insurance Program), have any of those employees ever indicated to you that they would prefer their children be covered under an employment based health plan instead of under Medicaid or CHIP?"¹⁸

All the survey respondents, including both the employers who do offer insurance and those who do not were asked this question. The responses were as follows:

¹⁶ Ibid, page 4.

¹⁷ Ibid, page 5.

¹⁸ Ibid, page 5.

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- 69.5 percent (7,612): I do not know if any of my employee's children are covered under Medicaid or CHIP, and none have indicated that they would prefer to be covered under an employment based health plan
 - 11.3 percent (1,233): I do know that some employees have children who are covered under Medicaid or CHIP, but I have not had any discussions with my employees about their preference
 - 4.4 percent (482): Less than 5 employees have indicated to me that they would prefer to enroll their children in an employment based health plan rather than Medicaid or CHIP
 - 1.0 percent (107): Between 5 and 10 employees have indicated to me that they would prefer to enroll their children in an employment based health plan rather than Medicaid or CHIP
 - 0.3 percent (36): More than 10 employees have indicated to me that they would prefer to enroll their children in an employment based health plan rather than Medicaid or CHIP

A final question examined by TDI was: "Which plays a bigger role in consumer decision making to leave a private plan for a public plan: premium costs or provider choice?"

While the Department does not have access to any data specifically addressing this issue as it applies to the CHIP program, research under the State Planning Grant indicates that premium cost is the most important factor in most health insurance decisions. Though provider choice does play a limited role, both small and large employers report that cost is the primary factor. Although in years past there were concerns that individuals were limited in their choice of providers under some managed care plans, those restrictions have loosened significantly in recent years, with most private plans offering an out-of-network benefit that allows individuals to see any provider they choose if they are willing to pay higher costs. In some cases, individuals enrolled in public programs experience tighter restrictions regarding provider choice than those enrolled in private programs. As such, it is unlikely that many children enrolled in private plans are dropping coverage for a public plan due primarily to provider choice.¹⁹

OUTLOOK ON CROWD OUT CHIP Premium Assistance Program²⁰

In testimony to the committee, Texas Health and Human Services Commission (HHSC) promoted the CHIP premium assistance program as an anti-crowd out strategy. The CHIP premium assistance program would support employers' efforts to maintain health insurance coverage and encourage families to stay with their employer or other group coverage.

¹⁹ Presentation submitted by Dianne Longley, Texas Department of Insurance, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004.

²⁰ Written testimony submitted by Trey Berndt of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, pages 21-22.

CHIP premium assistance programs use state and federal CHIP funds to pay a portion of the cost of enrolling families who are CHIP eligible in private employer or group insurance. HHSC is using a federal Health Insurance Flexibility and Accountability (HIFA) waiver for the development of the CHIP premium assistance program. The HIFA waiver gives flexibility to the state and encourages the use of the private insurance market to provide health coverage for Medicaid and CHIP enrollees. Premium assistance, when cost effective, offers moderate savings and has the benefit of insuring additional family members through the subsidy of an "employee and children" or an "employee and family" premium.

The CHIP premium assistance program proposed by Texas HHSC is similar to an Illinois program. Any family with CHIP eligible children will be offered a flat subsidy to be used for employer offered or other group insurance. The employer will still be expected to cover the same percentage of the premium that was covered before the state premium assistance. The amount of the subsidy will be calculated by considering the average cost of insuring a family in CHIP and including a savings deduction.

Texas CHIP Premium Assistance Program as proposed by HHSC:

- If a CHIP family enrolls their children in employer or other private group coverage, they will receive a flat subsidy of about \$150 per month. At least one parent would also be enrolled, since most employer coverage offers "employee plus children" or "employee plus family" options
- A continued employer contribution to the cost of coverage will be required
- Point of service cost sharing (doctor's office, prescription copays, etc.) will be whatever the group plan requires
- A CHIP family's participation in premium assistance will be optional
- The proposal was available for public comment from November 17, 2003, to December 23, 2003. The formal waiver application was submitted to the federal government in March/April 2004 and has an estimated federal approval time of four to six months

Small Business Health Coverage

While the health insurance rate increases affect all businesses, small firms have been hit the hardest. According to the U.S. Small Business Administration, forty-six percent of Texas workers are employed by small firms. Small business employers are especially concerned about the large rate increases in health insurance. In TDI's 2001 State Planning Grant Survey, the following information was determined:²¹

- For small employers who offered insurance:
 - Twenty-seven percent reported insurance cost increases of fifty-one percent or more
 - Thirty-six percent reported cost increases ranging from twenty-six percent to fifty percent

²¹ Presentation submitted by Trey Berndt of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 2, March 24, 2004, page 19.

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- Two percent noticed a decrease in the number of employees who cover their children and were sure the decrease was due to CHIP enrollment
 - For small employers who did not offer insurance:
 - Sixty-two percent indicated that they had not purchased coverage because it was too expensive
 - Seven percent said they were willing to offer coverage, but that their employees could not afford their share of the premium
 - Four percent said they were unable to obtain coverage because one or more employees have a pre-existing condition that made the group uninsurable

According to a May 2004 survey by the National Federation of Independent Business (NFIB) trade group, health costs are the top concern for small businesses. Many small businesses are responding by dropping coverage. To alleviate the burden of health care costs to small businesses, lawmakers have focused on small employer relief on state mandates, subsidies, and buying pools.²²

Legislation providing relief on state mandates have been introduced in nine states. Such plans allow insurers to sell health plans free of state required benefits such as chiropractic care or eye care. In Idaho, a new subsidy plan allows needy workers at companies with fifty or fewer employees to tap a state fund for up to \$300 a month to pay for their children's health insurance. Congress is considering legislation that would allow buying pools called association health plans (AHPs), with companies banding together across state lines to form big groups with buying power to negotiate lower rates. AHPs would be exempt from state mandated health benefits.

California SB 2

By requiring some businesses to offer employee health benefits, California SB 2 goes to great measures to ensure that crowd out is prevented. SB 2 was signed into law by former Governor Gray Davis in October 2003. If it survives a November referendum, SB 2 of California would take effect in California by 2006. The legislation would require certain California businesses to provide health benefits to employees. Business groups are against SB 2, while organized labor supports it.

There are three important components of SB 2:²³

- Beginning January 1, 2006, companies with 200 or more workers must offer health benefits to employees and their dependents. Employers must pay at least eighty percent of the cost with workers paying the rest
- Starting January 1, 2007, companies with 50 to 199 workers must offer health benefits to employees, but they don't have to extend coverage to dependents. Employers must pay at least eighty percent of the cost with workers paying the rest

22 Jim Hopkins, "Rising benefit costs hurt small businesses' financial health," USA Today, 4 June 2004: Final Edition.

23 Ibid.

- As an alternative, companies of all sizes can avoid offering health benefits by paying a fee to the state that will go to a pool to provide state subsidized health care

HB 3484 (Goodwill Bill)

The cost of health insurance is especially high for those with disabilities. Oftentimes people with disabilities choose to keep their public health care coverage instead of giving it up to be employed. Currently in Texas there is no provision in state law for a Medicaid buy-in program. HB 3484 (Goodwill Bill) from the 78th Legislature, establishes a work group on health care options for certain persons with disabilities to study creating a Medicaid buy-in program in Texas. The work group can document the types of benefits employees with disabilities need, typical employer benefits offered, Medicaid benefits needed, and the ability of workers with disabilities to pay a portion of health care premiums.

As established by HB 3484, the work group on health care options for certain persons with disabilities will study a straight buy-in program for people with disabilities who go to work for an employer that does not provide insurance. The work group will also examine the feasibility of using Medicaid to cover certain conditions that employers' health coverage does not cover.

The funding for the work group is provided by a federal grant from the U.S. Department of Health and Human Services, Center for Medicaid Services. The name of the grant is Medicaid Infrastructure Grant to Support the Competitive Employment of People with Disabilities.

THE POLICY OPTIONS TO BE STUDIED BY THIS WORK GROUP INCLUDE	
The extent to which employers will offer health benefits to full and part-time workers	The adequacy and types of health benefits currently offered by employers related to the needs of people with disabilities.
The current utilization rate of the Medicaid Program by people with disabilities. A projection of the cost savings to Medicaid if other options were available through the employers' health benefit plans. The use of Medicaid as a supplement to employer based health insurance to cover disability related items not otherwise covered but the employers health plan will be explored.	The projected impact of the employment rate of people with disabilities with the implementation of a Buy-In option to the Medicaid Program. This option is available to states under the Work Incentives Improvement Act of 1999.
What affect would the increased use of the Health Insurance Premium Payment Reimbursement Program, or other cost sharing options, have on the ability of persons with disabilities to receive employer base health coverage? What affect would the increased use of the Health Insurance Premium Payment Reimbursement Program, or other cost sharing options, have on the ability of persons with disabilities to receive employer bases health coverage?	The current utilization rate in Texas, of existing work incentives available to people receiving Social Security benefits. If an individual's Medicaid benefits were extended to allow for their use while working, would employment increase?

CHIP Assets Test

HB 2292 implemented a policy to further prevent crowd out by tightening the assets test a family must meet in order to qualify for CHIP. The CHIP assets test ensures that the neediest Texas children have access to CHIP. It is the same assets test used to ensure eligibility for Temporary

Assistance for Needy Families (TANF) and for the food stamp program. The assets test prevents crowd out by encouraging families with sufficient finances to move forward with private insurance or employer sponsored insurance. HHSC provides the following information on the CHIP Assets Test:²⁴

Section 2.46 of HB 2292, 78th Legislature, Regular Session, authorized the Texas Health and Human Services Commission (HHSC) to establish eligibility standards for the Children's Health Insurance Program (CHIP) regarding the type and dollar value of allowable assets for a family whose gross family income is above one hundred fifty percent of the Federal Poverty Level (FPL). Legislative appropriations assumed the implementation of an assets test.

The proposed assets test rules were published in the Texas Register in a detailed form on February 20, 2004. HHSC held public hearings on the rules in Austin on March 15-16, 2004. Approximately one hundred comments were received during the public hearings and comment period, which ended March 21, 2004.

In response to public comment, the proposed rules were modified to exempt from the asset calculation:

- Retirement accounts that have penalties for early withdrawal
- Life, burial or other insurance with a cash value
- Internal Revenue Code 529 qualified college savings program accounts, such as Texas Tomorrow Fund accounts
- Educational grants and scholarships
- Vehicles modified to transport a household member with a disability

Final rules will be published in the Texas Register on May 7, 2004, and will apply to any CHIP applications and renewals that have not been fully processed before August 24, 2004.

Assets Test Policy:²⁵

Families with incomes above one hundred fifty percent FPL who are newly applying for or renewing CHIP coverage and who have not been found eligible for a new term of coverage before August 24, 2004, may not have assets that exceed specified limits after certain allowances are made. Liquid assets, such as cash and bank accounts, and certain vehicle values will be considered. Real property, such as a home, will not count as an asset. The federal poverty income levels for 2004 are outlined below:

Family Size	Monthly Federal Income Guidelines*		Annual Federal Income Guidelines*	
		150 %	200%	150%

24 Health and Human Services Commission, CHIP ASSETS TEST POLICY: Summary of Final Rules, http://www.hhsc.state.tx.us/chip/reports/042304_AssetTestPolicySum.html, 2004.

25 Ibid.

2	\$1,561	\$2,082	\$18,735	\$24,980
3	\$1,959	\$2,612	\$23,505	\$31,340
4	\$2,356	\$3,142	\$28,275	\$37,700
5	\$2,754	\$3,672	\$33,045	\$44,060

* Effective through March 31, 2005²⁶

Liquid Assets

Countable liquid assets include:

- Cash on hand
- Cash value of checking and savings accounts
- Money remaining from the sale of a homestead
- Cash value of stocks, bonds, and savings certificates

Excluded liquid assets include:

- Individual Development Accounts and other accounts, such as retirement accounts, with restricted use and penalties for early withdrawal
- Cash value of life insurance, burial insurance, or other insurance with a cash value
- Internal Revenue Code 529 qualified college savings program accounts, such as Texas Tomorrow Fund accounts
- funds received as educational grants or scholarships

Vehicle Values

The family's vehicle values will be considered in applying the assets test, but some or all of the family's vehicle values may be exempt as outlined below. Countable vehicles include any operable and licensed automobile, truck, motorcycle, SUV, van, boat, or motor home (including campers and RVs). The value of countable vehicles will be the lowest trade-in/wholesale value listed in the Hearst Corp./NAR Division Black Book.

Exemptions:

- If a family does not own any vehicles that are totally exempt, the family may exempt the first \$15,000 of the highest valued vehicle and \$4,650 of the value of each additional vehicle.
- Exempted vehicles include:
 - Vehicles owned by friends or family outside the CHIP household, but used by the CHIP family
 - Trailers, mobile homes, all-terrain vehicles, tractors, and farm equipment
 - Leased vehicles
 - Vehicles owned by a business
 - Vehicles modified to provide transportation for a household member with a disability (modifications may include lifts, ramps, hand controls, etc.)
 - Any vehicle worth less than \$15,000 and one vehicle worth \$15,000 or more if the vehicle is:

²⁶ Source: U.S. Department of Health and Human Services

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- The family's only home
 - Used more than fifty percent of the time to produce income
 - Used more than fifty percent of the time by a self-employed person to transport equipment or employees to worksites
 - Necessary to carry fuel or water

RECOMMENDATION

The committee recommends that the legislature should consider applying premium sharing to any added or restored benefits. In addition the legislature should consider codifying exemptions for asset calculations. To encourage individuals and families to save for their future healthcare needs the legislature should consider exempting any cash that may be deposited in a Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), or Flexible Spending Account (FSA), when determining CHIP eligibility. HHSC should require the CHIP application to ask applicants to both verify whether they have access to private health insurance through their employer and to report its cost. Continue to monitor and seek to expand the use of the CHIP Premium Payment Assistance Program; this will include working closely with the Office of State Federal Relations in pursuit of a waiver.

CHARGE

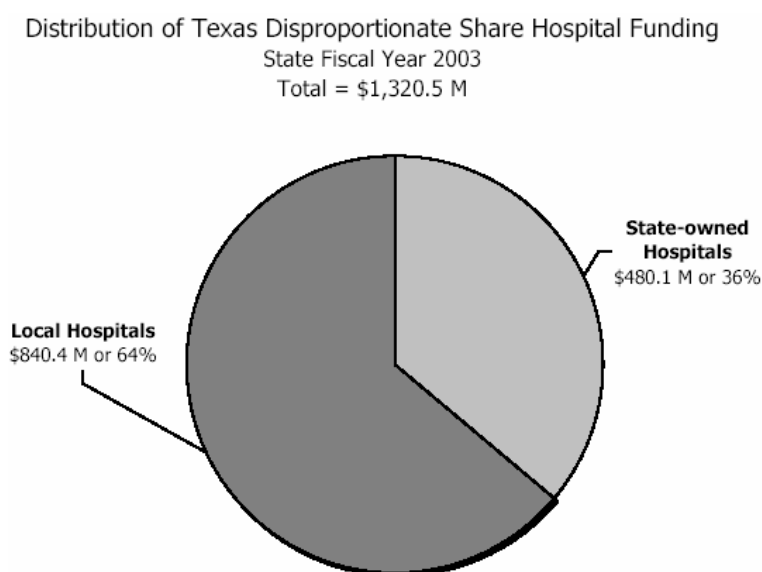
MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

Evaluate the funding source of the Medicaid Disproportionate Share Hospital (DSH) Program and the criteria that a hospital must meet to participate in the DSH program in comparison to the balance and fairness of other state and federal funding streams.

BACKGROUND

The Disproportionate Share Hospital (DSH) Program reimburses hospitals providing care to patients who are unable to pay. The federal government, through the U.S. Department of Health and Human Services, provides matching funds to the states to provide payments to hospitals.

In Texas the DSH Program provides payments to approximately 181 hospitals each year. For FY 2003, this included 167 non-state public and private hospitals and fourteen state owned hospitals. The DSH funds help the participating hospitals offset losses on uninsured patients and the shortfall in Medicaid reimbursement. In FY 2003, the 167 non-state hospitals in the Texas DSH program received approximately \$840.4 million¹ in DSH payments. The fourteen state owned hospitals received approximately \$480.2 million in DSH funds.²



Sources: Legislative Budget Board; Health and Human Services Commission.

Figure 1³

Under the Omnibus Budget Reconciliation Acts of 1980 and 1981 states were allowed to access federal funds to reimburse hospitals in the form of DSH payments. The funding was directed toward hospitals providing large volumes of care to low income populations, including both Medicaid and uninsured patients. These hospitals lose money due to low Medicaid reimbursement rates and uncompensated indigent care and must shift the burden to state and local taxpayers.

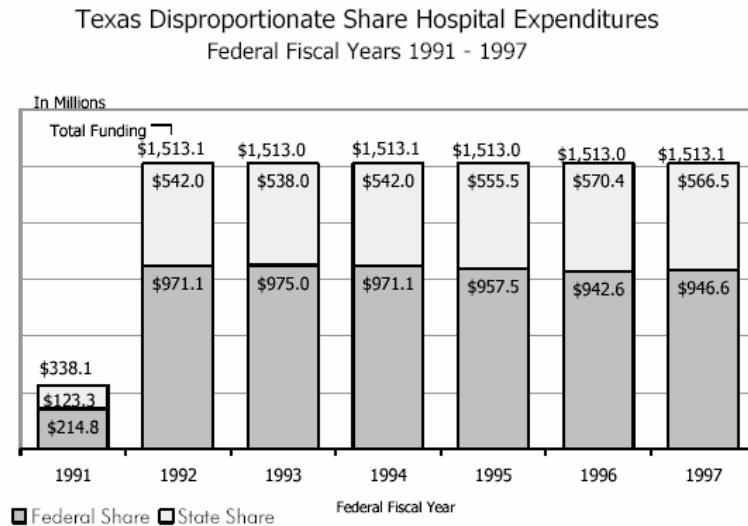
Texas was one of only a few states to participate in the DSH program in the early 1980's. In 1985 federal regulations were passed allowing states to generate matching funds through provider taxes and donations. As a result, DSH participation dramatically increased among other states. The DSH

1 Testimony submitted by Scott Reasonover of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures, February 11, 2004, page 4.

2 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 13.

3 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 15.

program grew in federal and state spending from less than \$1 million in FY 1989 to over \$16 billion in FY 1993.⁴ This included an increase in federal and state DSH expenditures of \$5.3 billion to \$17.5 billion from FY 1991 to FY 1992. In Texas, the total funding for the DSH program grew from \$338.1 million to \$1.5 billion from FY 1991 to FY 1997.



Sources: Centers for Medicare and Medicaid Services and Legislative Budget Board.

Figure 2⁵

The explosive growth in the DSH program was partly due to some states exploiting the program through creative financing arrangements that sometimes financed activities with DSH funds that were normally paid from the state's general revenue. To combat this, federal law was amended multiple times during the 1990's to tighten restrictions on the DSH program.

In 1991 Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments to curb the significant increase in DSH payments. These amendments banned provider donations, capped provider taxes, and proposed provider tax criteria. DSH payments were also capped at FY 1992 levels or twelve percent of the state's total Medicaid expenditures.

In response, the states turned to Intergovernmental Transfers (IGTs) as a revenue source to draw down federal DSH funds. IGTs involve exchanges of funds between different governmental entities. In the case of DSH, public hospitals transfer funds to state Medicaid agencies so that the state can draw down federal funds and make DSH payments to these public hospitals. Texas modified its DSH program so that nine large public hospitals provided the state matching funds through IGTs. This IGT mechanism is still in use today.

The Omnibus Budget Reconciliation Act of 1993 (OBRA) placed further restrictions on the DSH program by limiting participation to hospitals with at least a one percent Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the facility's total number of inpatient days attributed to Medicaid patients by the total number of inpatient days for that facility. Additionally,

4 Carey Eskridge, Disproportionate Share Hospital (DSH) Program: Your Questions Answered, The Texas Legislative Council, Facts at a Glance, March 2003, page 1.

5 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 5.

OBRA capped DSH payments to eligible hospitals at an amount equal to the cost of providing unreimbursed care to Medicaid or uninsured patients.

The Balanced Budget Act (BBA) of 1997 contained significant expenditure cuts for the DSH program. The BBA of 1997 reduced the federal allotment to state DSH programs through a five year schedule of restrictions from 1998-2002, with the aim of achieving a balanced federal budget by 2002. For Texas the BBA cap was set at \$806 million for FY 2000, dropping to \$765 million in 2001 and 2002.⁶ The total amount of DSH funds for Texas was reduced from \$946.6 million in FY 1997 to \$776.4 million in FY 2003.⁷ After 2002 federal DSH expenditures would be the previous year's allocation, adjusted for inflation. The state allotment would be subject to a cap of twelve percent of the state's total annual Medicaid expenditures.

Additionally, the BBA imposed limitations on DSH payments to state mental hospitals. DSH payments to Institutions for Mental Diseases (IMDs) are capped at the lesser of either the state's total 1995 DSH amount for IMDs (All Funds) or the product of a state's current total DSH amount and the percentage that IMD DSH funds comprised of total 1995 DSH Funds (All Funds).⁸

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 increased state allotments for FY 2001 and FY 2002, a two year reprieve from the BBA reductions. BIPA increased states' total DSH allotments for FY 2001 by freezing allotments at FY 2000 levels and adjusting the amounts for inflation. For FY 2002 the amount would be the FY 2001 allotment, also adjusted for inflation. States' total DSH reimbursements are still subject to the existing twelve percent cap. Under the provisions of BIPA, DSH allocations for FY 2003 were again capped at the amounts specified by the Balanced Budget Act (BBA) of 1997.

BIPA also extended a special DSH provision to all states that raised the hospital specific cap for state owned hospitals. For FY 2003 and FY 2004, state owned hospitals may be reimbursed for up to one hundred seventy-five percent of the hospitals' uncompensated care costs. With the DSH reimbursement cap increased, Texas had the option to maximize the DSH allotment to state owned hospitals.

BIPA further mandated new DSH reporting requirements. States are required to submit an annual report providing the amount of compensation each DSH hospital received and also submit an annual, independent certified audit. The audit must demonstrate the state's compliance with the DSH payment cap, including the methodology used to calculate unreimbursed care costs, and the records maintained by the state concerning claimed costs, expenditures, and payments.

In 2000 the Texas Senate Finance Interim Subcommittee on Graduate Medical Education was charged by then Lieutenant Governor Rick Perry with the task of reviewing the state's Medicaid DSH program with an emphasis on the formula and criteria used to distribute the funding to hospitals. During the late 1990's there was a "delinking" of the historical relationship between Medicaid service levels and indigent care. In 1999 the large urban hospitals that provide the IGTs to draw down federal dollars requested a change in the DSH formula to increase their DSH dollars.

6 Legislative Budget Board, Staff Performance Report to the 78th Texas Legislature, January 2003, page 4.

7 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004.

8 Legislative Budget Board, Staff Performance Report to the 78th Texas Legislature, January 2003.

Under the formula at that time the large urban contributing hospitals received the lowest level of reimbursement in relation to their burden of care.

"Average Net DSH/CAP Ratio"

Hospital Category	Current Formula FY 00
Large urban publics	21%
Children's hospitals	100%
Other urban	63%
Rural	51%
Average, all hospitals	38.39%

Figure 3⁹

In response to requests by the contributing hospitals, the Texas Health and Human Services Commission (HHSC) proposed a formula to increase the weights for the large urban public hospitals by a factor of 0.5, by equalizing the importance of indigent care and Medicaid in the DSH allocation formula. The Texas Senate Finance Interim Subcommittee on Graduate Medical Education worked with HHSC, the Texas Department of Health (TDH), and representatives from the hospital associations to create more equitable funding for all types of hospitals providing uncompensated care.

The Texas Senate Finance Interim Subcommittee on Graduate Medical Education recognized the critical role of the large public contributing hospitals as traditional safety net providers for indigent care as well as the unique role of rural hospitals in providing critical health care in underserved areas. On April 20, 2000, the subcommittee unanimously adopted the following recommendation:⁹

For the FY 2001 allocation of Disproportionate Share funds, the Health and Human Services Commission should proceed with its proposed rule change, making adjustments to the proposed rule to mitigate the impact on rural hospitals. Prior to allocation of subsequent fiscal years' Disproportionate Share funds, the Commission should make necessary changes to further emphasize uncompensated indigent care in the distribution formula. At least every two years the Commission should evaluate the Disproportionate Share Hospital Funding Program and make necessary rule changes to ensure the program's emphasis on uncompensated care and provision of care in under served areas of the state.

The HHSC implemented several changes for FY 2001 and subsequent years in response to these recommendations. The HHSC added weights so that transferring hospitals would receive more money and increased the dollars used to reimburse hospitals for treating low income patients. Also, HHSC set aside a minimum of 5.5 percent of DSH toward reimbursing rural hospitals. For FY 2002 and subsequent years, the commission expanded DSH eligibility to include hospitals in small urban areas. This change allows more hospitals in Abilene, Bryan, Longview, Lubbock, Midland, San Angelo, and Tyler to qualify for and receive funding.

⁹ Senate Finance Interim Subcommittee on Graduate Medical Education, Final Report on Medicaid Disproportionate Share Hospital Funding, May 15, 2000, page 20.

On December 8, 2003, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Act addressed the DSH program by increasing the DSH allotment to all states by sixteen percent over the FY 2003 amount. Federal DSH payments for FY 2004 are estimated to total \$8.2 billion. Texas will receive \$900.7 million in DSH payments for FY 2004, which represents an increase of \$124.2 million over FY 2003. This annual allocation of \$900.7 million continues through 2010 and may be readjusted by the Consumer Price Index in 2011.

DSH Program Funding

DSH payments are made in addition to other Medicaid reimbursements to hospitals that serve large numbers of Medicaid and uninsured low income patients. These payments are based on formulas devised by the states, subject to certain federal requirements. Federal law requires states to reimburse qualifying hospitals based on what the hospital would normally receive under the Medicaid program for inpatient services. The state determines which hospitals qualify for DSH payments, subject to the federal minimum standard of at least a one percent Medicaid utilization rate. Federal standards also require DSH eligible hospitals (children's hospitals exempted) to have at least two physicians with admitting privileges who accept Medicaid and provide non-emergency obstetrical services to Medicaid clients.

The state also determines, within federal guidelines, the amount of DSH payments made to the qualifying hospitals.

Medicaid DSH payments are subject to the same federal-state matching rules that apply to Medicaid payments. DSH payments are subject to the Federal Medical Assistance Percentage (FMAP), which is based on a state's three year average per capita income relative to the national per capita income. (The enhanced FMAP does not apply to the DSH program).¹⁰

In Texas the matching rate is 60.87 percent federal funds to 39.13 percent state funds in FY 2004.¹¹ DSH payments are different from other Medicaid payments because DSH does not reimburse for specific patient's services. While the Medicaid payments consider inpatient, outpatient and ambulatory care, DSH payments employ a lump sum approach.

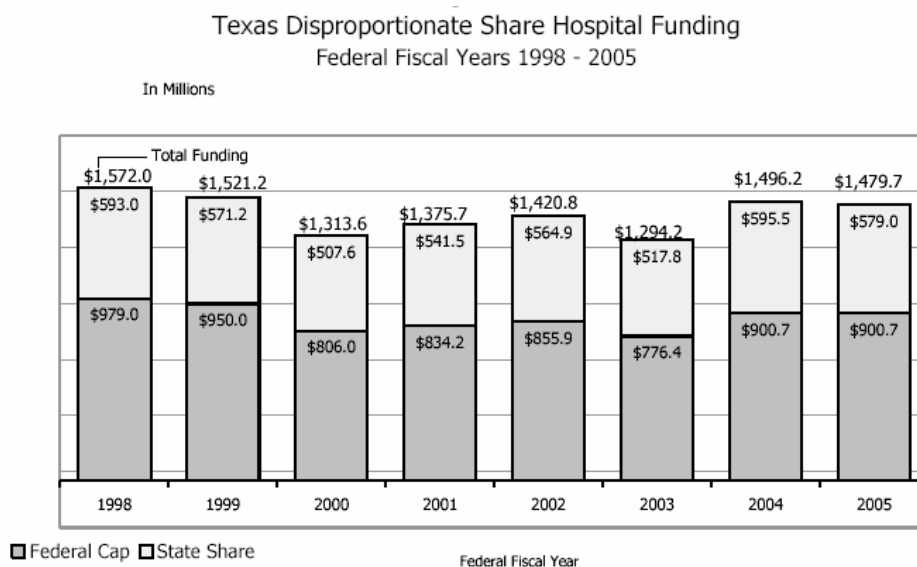
There is wide variation among states in regards to non-federal financing. Among the different states non-federal DSH revenues are derived from state, county, and local funds, as well as provider taxes.

10 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004.

11 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 3.

Texas DSH Program

The DSH Program in Texas provides payments to both state and non-state hospitals that provide care to large numbers of the uninsured, Medicaid clients, and patients unable to pay for their care. These facilities are commonly called safety net hospitals and include public and private hospitals, children's hospitals, university hospital systems, and long-term mental health care institutions. DSH payments are a critical source of funding for safety net hospitals in alleviating the financial burden of providing uncompensated care. The table below highlights the amount of DSH funds that Texas has received since 1998 and shows the estimated DSH funding for Texas through 2005:



Sources: Centers for Medicare and Medicaid Services and Legislative Budget Board.

Figure 4¹²

Both the state and non-state DSH programs use Intergovernmental Transfers (IGTs) to supply the non-federal share of Medicaid funding.

State owned Hospitals

The fourteen state owned hospitals transfer GR in an amount equal to one hundred percent of their unreimbursed costs for Medicaid and uninsured patients to the HHSC. The transferred funds are then used to draw down federal matching funds for distribution. The HHSC withholds from distribution back to the hospitals a sum equal to the federal funds obtained, which is then returned to GR.

The following flow chart shows how the transfer arrangement operated in FY 2003:

¹² Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 7.

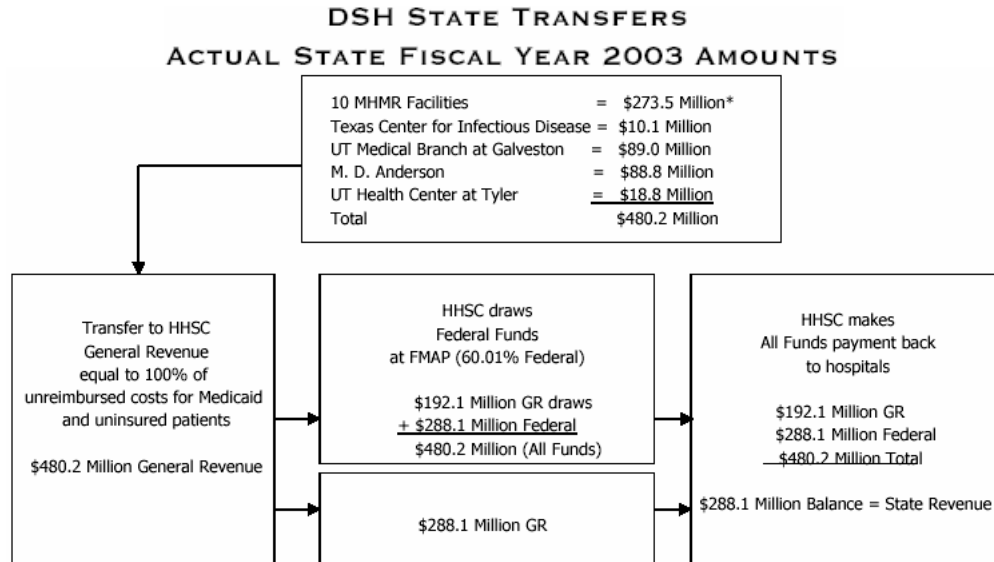


Figure 5¹³

The fourteen state facilities providing IGTs in the DSH program include the University of Texas Medical Branch at Galveston, the University of Texas M.D. Anderson Cancer Center, the University of Texas Health Center at Tyler, the Texas Center for Infectious Disease (TDH's Hospital in San Antonio), and 10 state owned or funded mental health facilities. (Two mental health facilities in Vernon and Wichita Falls, have merged into one entity but are considered separate facilities for DSH purposes) The distribution of DSH funding by these fourteen facilities in FY 2003 is shown in the following chart.

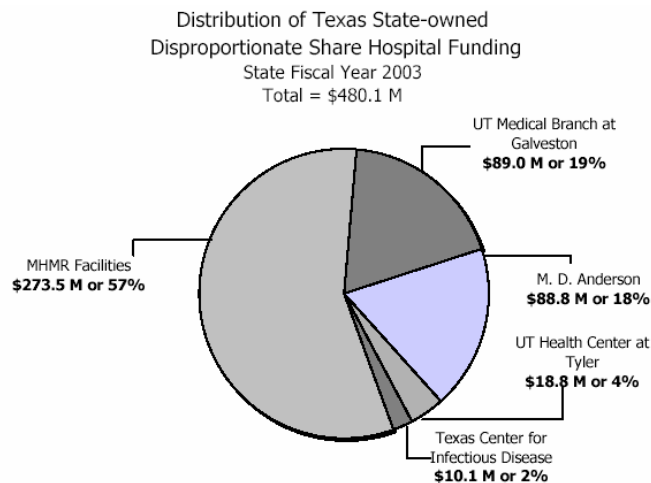


Figure 6¹⁴

In distributing DSH payments, the state first makes payments to the state owned hospitals and then provides payments from remaining federal funds to non-state hospitals.

In Texas, state owned hospitals are reimbursed for one hundred percent of their hospital specific

13 Testimony submitted by Maria Hernandez of the Legislative Budget Board, House Select Committee on State Health Care Expenditures, February 11, 2004, page 13.

14 Ibid, page 14.

limit, or DSH cap. Federal law allows the DSH reimbursement cap to be increased to one hundred seventy-five percent for state owned hospitals, however Texas currently does not use this higher cap. The federal government also has limitations on DSH payments to IMDs. If the payments to the state mental hospitals exceed the IMD limit, then the payments are adjusted proportionately to bring total IMD payments under the limit. After reimbursing state hospitals any remaining DSH funds are available for payment to non-state DSH hospitals.

Non-state Hospitals

Nine large volume Medicaid public hospitals provide the IGTs that equal the state match portion to draw down federal Medicaid funds for non-state hospitals. These federal funds are used as DSH payments directed at urban hospitals, rural hospitals, and children's hospitals. The nine large urban public hospitals participate in the IGT voluntarily under an arrangement negotiated with HHSC. For FY 2003, the nine transferring hospitals were University Health System Bexar County, Parkland Memorial Hospital, Medical Center Hospital, R. E. Thomason General Hospital, Harris County Hospital District, University Medical Center-Lubbock, Spohn Memorial Hospital, John Peter Smith Hospital, and Brackenridge Hospital.¹⁵

The large public transferring hospitals put up a combined total of approximately \$336.1 million in IGTs.¹⁶ This drew down approximately \$504.3 million in federal funds for a total of \$840.4 million in combined state-federal DSH funds. The large public transferring hospitals were then compensated in DSH payments in excess of the amount they transferred to the state. The nine hospitals that provided the IGTs received a total of \$540.3 million (\$336.1 million state match and \$204.1 million federal) through the DSH reimbursement formula for FY 2003.¹⁷ This was an overall net gain of approximately \$204.1 million for all of the transferring hospitals combined.

The federal DSH money that is drawn down by the IGTs from the nine large public hospitals is used to reimburse DSH eligible non-state hospitals. In FY 2003, the state used these DSH funds to reimburse 167 non-state hospitals, including the large public transferring hospitals.¹⁸ The 158 non-state hospitals that were not involved in IGTs received approximately \$300.2 million in DSH funds. This included seven children's hospitals that received a combined \$52.8 million, 87 rural hospitals being paid a combined \$46.2 million, and 64 non-transferring urban hospitals in receipt of a combined \$201.0 million.¹⁹

Texas' DSH program provides DSH funds to both public hospitals and private hospitals that meet certain criteria established by the Texas Health and Human Services Commission, pursuant to federal guidelines. To qualify for DSH funding, a hospital must meet one of the following three criteria:²⁰

15 Testimony submitted by Scott Reasonover of the Health and Human Services Commission, Final SFY 2003 Medicaid DSH House Select Committee on State Health Care Expenditures, February 11, 2004.

16 Testimony submitted by Scott Reasonover of the Health and Human Services Commission, House Select Committee on State Health Care Expenditures, February 11, 2004, page 4.

17 Ibid., page 4.

18 Testimony submitted by Scott Reasonover of the Health and Human Services Commission, Final SFY 2003 Medicaid DSH House Select Committee on State Health Care Expenditures, February 11, 2004.

19 Ibid.

20 Memo to Chairman Dianne White Delisi of House Select Committee on State Health Care Expenditures, from

1. Medicaid Inpatient Utilization Percentage

- Any Medicaid hospital can qualify for DSH if its Medicaid inpatient utilization percentage is above the average for all Medicaid hospitals, plus one standard deviation. This percentage is calculated by taking the number of inpatient days attributable to Medicaid and dividing it by the total number of inpatient days
- A rural Medicaid hospital can qualify for DSH if its Medicaid inpatient utilization percentage is above the average for all Medicaid Hospitals

2. Medicaid Inpatient Days

- Any Medicaid hospital can qualify for DSH if the number of its Medicaid inpatient days is above the mean number of Medicaid days, plus one standard deviation for all Medicaid hospitals
- Medicaid hospitals in counties that are under 250,000 in population and defined as urban by the Federal Office of Management and Budget can qualify if their number of Medicaid inpatient days is above the mean number of Medicaid days for that group of hospitals, plus seventy-five percent of one standard deviation for that group of hospitals

3. Low Income Utilization Rate (determined by adding two ratios as follows):

$$\begin{array}{c} \text{Low Income Utilization Rate} \\ = \\ \frac{\text{Medicaid and State and local funding}}{\text{Total Cost}} \\ + \\ \frac{\text{Total Charity Charges} - \text{Total state and local revenue}}{\text{All inpatient revenue (charges)}} \end{array}$$

Figure 8

- Medicaid hospitals qualify for DSH if the Low Income Utilization Rate is twenty-five percent or greater

After HHSC has used the above described state criteria, it must complete the steps listed in Figure 9 to select which hospitals actually will receive a DSH payment:²¹

Hospitals are designated on an annual basis as qualifying for DSH payments and then receive monthly payments during the years in which they qualify. Federal rules set out payment limits for DSH hospitals. The Medicaid disproportionate share cap serves as a ceiling to the amount of DSH monies a hospital can receive in a state fiscal year. Each hospital's annual DSH funds are limited to the sum of the hospital's Medicaid shortfall and its cost of services to uninsured patients as updated for inflation. The Medicaid shortfall is determined each year by its two year prior cost report.

PROCESS FOR SELECTING DISPROPORTIONATE SHARE HOSPITALS	
STEP/ACTION/RESULT	
STEP 1	Medicaid service rates for all applying hospitals listed in descending order Hospitals with Medicaid service rates greater than an annual calculated percentage above the average Medicaid service rate for all Medicaid hospitals are selected
STEP 2	Rural hospitals' Medicaid service rates are listed in descending order Hospitals with Medicaid service rates greater than the average Medicaid service rates are selected
STEP 3	Remaining hospitals have their low-income patient service rates listed in descending order Hospitals with a low-income patient services rates greater than 25% listed in descending order.
STEP 4	Remaining hospitals have their total number of Medicaid inpatient days listed in descending order Hospitals with total Medicaid inpatient days greater than annual calculated percentage above the average Medicaid inpatient days for all Medicaid hospitals are selected
STEP 5	The total Medicaid inpatient days of the remaining hospitals are listed in descending order Hospitals located in urban counties with population of 250,000 persons or less whose total Medicaid inpatient days are less than 75 percent of annually calculated percentage above the average Medicaid inpatient days for all Medicaid hospitals are selected
Source: Texas Administrative Code, Section 355.8065	

Figure 9

21 Legislative Budget Board, Staff Performance Report to the 78th Texas Legislature, January 2003, page 8-9.

COMMITTEE INQUIRIES

The committee requested information from HHSC on the amount of unreimbursed healthcare costs that are not covered by DSH payments in rural hospitals.²²

The committee also inquired about the DSH payments to the three state owned teaching hospitals, including M.D. Anderson, U.T. Medical Branch at Galveston, and U.T. Tyler. The following information was provided by the Legislative Budget Board:²³

- FY 2003 payments to state owned teaching hospitals are based on the amount of uncompensated care a hospital provided in FY 2001. The uncompensated care charges for the three state owned teaching hospitals totaled \$253.4 million in FY 2001 (after deducting patient revenue collected). The table below lists the corresponding number of clients that were provided uncompensated care at each of the three teaching hospitals in FY 2001

FY 2001 (in Millions)	Inpatient Uncompensated		Outpatient Uncompensated	
	Charges	Clients	Charges	Clients
M.D. Anderson	\$60.3	1,438	\$65.8	22,875
U.T. Medical Branch at Galveston	51.9	3,940	56.3	184,031*
U.T. Tyler	14.2	848	4.9	4,731
Total	\$126.4	6,226	\$127.0	

* Number of outpatient days.
Sources: Health and Human Services Commission, M.D. Anderson Cancer Center, The University of Texas Medical Branch at Galveston, and The University of Texas Health Center at Tyler.

Figure 11²⁴

For FY 2003 a total of \$196.6 million in General Revenue funds was transferred from the three state owned teaching hospitals to HHSC for the DSH program. These General Revenue funds accounted for 50.3 percent of the total General Revenue appropriated to the three state owned teaching hospitals. The table below compares DSH payments to appropriated General Revenue for each state owned teaching hospital in FY 2003.²⁵

FY 2003 (in Millions)	General Revenue	DSH Payment	DSH Payment % of General Revenue
U.T. Medical Branch at Galveston	\$221.7	\$89.0	40.1%
M.D. Anderson	136.9	88.8	64.9%
U.T. Tyler	32.4	18.8	58.0%
Total	\$391.0	\$196.6	50.3%

Source: Legislative Budget Board.

22 Memo to Chairman Dianne White Delisi of House Select Committee on State Health Care Expenditures, from Sharon Carter with the Health and Human Services Commission, February 26, 2004.

23 Memo to Chairman Dianne White Delisi of House Select Committee on State Health Care Expenditures, from Maria C. Hernandez with the Legislative budget Board, May 14, 2004.

24 Memo to Chairman Dianne White Delisi of House Select Committee on State Health Care Expenditures, from Sharon Carter with the Health and Human Services Commission, February 26, 2004, page 1.

25 Ibid. page 2.

DSH Outlook

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

On December 8, 2003, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) into law. Title X of the MMA includes a provision that affects Texas' Medicaid DSH program. The provision increases the DSH allotment to all states. Beginning in FY 2004, state DSH allotments increase by sixteen percent without regard to a current cap. This will ensure that states will not draw down DSH funds in excess of twelve percent of their total spending on medical assistance. Texas will receive an estimated \$900.7 million in DSH payments for FY 2004. This represents an increase of \$124.2 million over Texas' DSH allotment for FY 2003. This annual allocation of \$900.7 million continues through 2010 and may be readjusted by the Consumer Price Index in 2011.²⁶

The MMA also created a new program to assist states with paying for uncompensated medical care for undocumented aliens. The law establishes an annual \$250 million fund, which will be allotted among the states each year between FY 2005 and 2008. Two-thirds of this money (\$167 million) will be distributed based on the relative percentages of undocumented aliens in each state. Under this provision of the MMA, Texas is estimated to receive an allotment of \$24.8 million for FY 2005.²⁷

The remaining one-third of the federal fund will be allotted to the six states with the largest number of undocumented alien apprehensions, based on data from the U.S. Department of Homeland Security. Under this provision, Texas is expected to receive an additional \$25 million for eligible hospitals in FY 2005.²⁸

The MMA requires United States Health and Human Services to directly pay hospitals, doctors, and other providers for their uncompensated costs of providing emergency health care to undocumented aliens.

County Indigent Healthcare Program

Under the County Indigent Health Care Program (CIHCP), a county is eligible to receive state assistance once it has spent eight percent of its General Revenue tax levy on mandatory indigent health services. The 78th Legislature appropriated \$11.2 million for the FY 2004-2005 Biennium (\$5.6 million per year), to Strategy E.2.1, Support of Indigent Health Services. The allocation is divided into two categories:²⁹

1. Eighty-five percent (or \$4,335,000) of funds go to counties that received money the previous year
2. Fifteen percent (or \$765,000) of funds go to counties that are new to the program

26 Board, Federal Funds Watch, Volume 9, Issue 3 December 10, 2003.

27 Ibid.

28 Ibid.

29 Texas Department of Health, County indigent Health Care Program Update, May 10, 2004, page 4.

Each county participating in the program receives a proportion of the total fund based on a formula that considers:

1. Indigent health care in the past year
2. Population of county below fifty percent of the poverty line

The County Indigent Healthcare Program is similar to DSH, in that, both programs reimburse uncompensated services provided by a hospital. In the County Indigent Health Care Program, the state money is distributed to the counties which then distribute the funds to the eligible hospitals. These funds are only designated to counties without a public hospital or hospital district.

Intergovernmental Transfers (IGTs)

President Bush's FY 2005 budget request for Centers for Medicare & Medicaid Services (CMS) proposes a restriction on the use of certain IGTs and caps federal payments to individual state and local providers. This proposal was made to "help stem the tide of rising costs in the Medicaid program."³⁰ The budget proposal curbs "IGTs that are in place solely to undermine the statutorily determined Federal matching rate. The budget proposes to cap Medicaid payments to individual State and local government providers at the cost of providing services to Medicaid beneficiaries and restrict the use of certain intergovernmental transfers. The proposal is expected to save the Federal Government \$1.5 billion in FY 2005 and \$9.6 billion over five years".³¹ The IGT revisions are being analyzed by Texas' HHSC to determine their possible impact on the DSH program.

Upper Payment Limits

Upper Payment Limits (UPLs) stipulate that federal Medicaid reimbursements are capped at the same rate as the federal government could be reasonably expected to pay for Medicare. This limit went into effect in 2001 and it applies separately to state, private, and county owned facilities. The limit applies to the entire class of providers (state, private, or county). Thus, an individual facility could be paid more by Medicaid than the Medicare cap, but another facility in the same class would therefore have to be paid less than the cap. The goal of UPLs is to prevent states from inflating federal Medicaid reimbursements above actual costs in order to acquire additional federal funds. According to the President's FY 2005 budget, the federal cost of UPL arrangements over the next five years is \$9.2 billion.³² Texas' Medicaid costs are currently reimbursed less than comparable Medicare costs.

HHSC proposal to increase DSH payments to state owned hospitals

State owned hospitals may be provided for up to one hundred seventy-five percent of the hospitals' uncompensated care costs for FY 2003 and FY 2004 under current federal law. Texas' HHSC is considering an increase in DSH payments to state owned acute care hospitals up to one hundred sixty percent of uncompensated care for FY 2004 and 2005. This change would free up an additional \$120 million for the state General Revenue. Under this consideration, the DSH formulas would be

30 US Dept of Health and Human Services, Budget in Brief FY2005, Washington, March 1, 2004, page 50.

31 Ibid p. 66.

32 Ibid.

adjusted so that non-state hospitals would be "held harmless" to the amount due without the accelerated payment (increase of sixteen percent) from the MMA. Of the \$120 million in new state revenue, \$74.7 million would be used toward the estimated Medicaid/Children's Health Insurance Program (CHIP) shortfall, \$20.3 million would go toward restoring Medicaid eligibility for pregnant women to one hundred eighty-five percent of the Federal Poverty Level (FPL) for FY 2005, and \$25 million would be used to establish UPL payments to urban, non-public hospitals.³³

RECOMMENDATION

The DSH program is essential for hospitals solvency considering the demographics of Texas. The Legislature needs to continue to monitor the activity of the DSH program at the federal level, particularly in regards to retaining the legitimate use of IGTs as a tool to secure matching funds. Also, the legislature should attempt to coordinate a percentage of new or restored funds under GME into the DSH process in order to draw down additional federal matching dollars. The DSHS and Legislature should evaluate the County Indigent Health Care Program in an effort to encourage all counties to increase participation in the indigent health care system.

³³ Presentation by the Texas Health and Human Services Commission to the Senate Finance Committee, May 24-25, 2004.

CHARGE

CONSUMER-DIRECTED LONG-TERM CARE MODELS

Study current consumer-directed care models that are in use by the state and look at other states' consumer-directed care models that may benefit Texas in areas such as long-term health care and chronic health care. Place emphasis on the Program of All-Inclusive Care For the Elderly model to ascertain its true potential for both cost-effectiveness and improved health outcomes. Identify barriers to the model's expansion in Texas.

BACKGROUND

Consumer Directed Care in Other States

Measuring the number and types of consumer-directed programs is challenging, however there is a general sense of the size and scope of consumer-direction. One inventory of both Medicaid and non-Medicaid programs conducted by the National Council on Aging (NCOA) in September 2001 found 139 consumer-directed service programs operating in all states except Tennessee and the District of Columbia. Fifty-eight percent of those programs served less than 1,000 individuals, but nationally about 500,000 individuals received services in these 139 programs.¹

In 2000 an estimated 9.5 million people in the United States required long-term care, including six million elderly and 3.5 million non-elderly.² This segment of the population is highly diverse, ranging from young people suffering from incapacitating illnesses and injuries to older citizens afflicted with Alzheimer's or debilitating effects of aging, such as strokes or hip fractures. These citizens often rely on others to aid them with even the most basic aspects of daily life, such as bathing, dressing, and eating, or more instrumental activities, such as preparing meals and managing their finances. In addition, many of these citizens depend on publicly funded health care programs like Medicaid or Medicare to help pay for their care.

In 2002 Medicaid accounted for forty-three percent of the \$139 billion spent on long-term care in the United States,³ and Medicaid and Medicare combined were the primary source of payment for seventy-three percent of all nursing home residents.⁴ The traditional agency operated, case managed system of public assistance, however, often leaves these clients with little influence over the nature or scheduling of the care provided to them, the selection of workers providing that care, or the setting in which the care is received. Challenging this traditional arrangement, younger clients of these publicly funded programs began advocating for greater control over the resources needed for their long-term care during the 1970s. The concept of consumer direction in this country originated from these disability rights and independent living movements.

The most commonly accepted definition of "consumer direction" was first published in "Principles of Consumer-Directed Home and Community-Based Services" by the National Institute of Consumer-Directed Long-Term Care Services in 1996. That definition reads, in part:

Consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumer direction ranges from the individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services.⁵

1 Karen Tritz, Long-Term Care: Consumer-Directed Services under Medicaid, CRS Report for Congress, February 6, 2004.

2 Ellen O'Brien and Risa Elias, Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-Term Care" (May 2004), 1.

3 Ibid., 2.

4 Ibid., 4.

5 Mark R. Meiners, et al., "Consumer Direction in Managed Long-Term Care: An Exploratory Survey of Practices

Consumer direction is not a single model of service delivery but an approach to health care that encompasses a broad range of strategies to shift greater responsibility for decision making in a person's health care to the person actually receiving the care. These strategies are philosophically related to the idea of "consumer choice" and such private sector arrangements as health reimbursement accounts or medical savings accounts that link a consumer's medical decisions to the financial consequences of those decisions. Consumer direction, however, should be distinguished from consumer choice in that its focus is in meeting nonmedical, personal care and daily living needs associated with long-term and chronic health care. Consumer-directed care allows an individual with a disability or chronic illness to function as independently as possible with the added advantages of being provided more personalized service in a more cost effective setting than a nursing or long-term care facility.

Consumer-directed care models in public health care span a continuum represented on one end by direct pay and on the other by professional case management. Under the direct pay or direct cash approach, the state establishes a total dollar value for services needed by an individual, and that amount is paid directly to the consumer. This model gives the consumer the greatest flexibility to use funds to meet the consumer's particular needs. The consumer can purchase assistive technology to maintain independence; make modifications to a home or vehicle to avoid institutional housing; purchase necessary services from a formal vendor; or recruit, hire, train, and manage a direct care worker to provide services. Often with direct pay, the consumer is considered the employer of record and is responsible for payroll and tax considerations. In the professionally managed services model, the state establishes the dollar value for services and contracts with an organization, such as a Medicaid provider, or a professional care manager to administer a consumer's budget and develop a care plan to meet the needs of the client. The extent of consumer direction in this model is determined by the discretion given the client within that budget to select from a list of available services and personal care workers provided by the state contractor. This model differs very little from traditional case-managed or agency operated publicly funded home care services.

Consumer direction has its roots in patient advocacy, but the concept has gained momentum among federal and state policymakers for three other important reasons: health care workforce shortages, cost, and the *Olmstead* decision by the United States Supreme Court.

In 2002 the United States Department of Health and Human Services (HHS) reported that nine of every ten nursing facilities in the United States lacked adequate staff to care properly for their residents.⁶ This shortage in the long-term care workforce includes nurse aides, orderlies, attendants, home health aides, and personal and home care aides. The United States Bureau of Labor Statistics has projected that Texas will need 37,650 additional direct care workers through 2008.⁷ The consequence of such a shortage in available long-term care workers to a client's quality of life is obvious. Many agency operated Medicaid programs allot a certain number of service hours considered appropriate to meet the needs of a patient living in an institution. Without sufficient staff, these standards cannot be met. Consumer-directed care models can help alleviate this workforce shortage without compromising quality of care by allowing clients to hire a family member, friend,

and Perceptions," *The Gerontologist* 42, no. 1 (February 2002): 32-38.

6 Susan Harmuth, "The Direct Care Workforce Crisis in Long-Term Care," *North Carolina Medical Journal* 63, no. 2 (March/April 2002): 88.

7 *Ibid.*, 89.

or neighbor to provide nonmedical direct care services. For some patients who are institutionalized only because they require daily living assistance, this allowance means the freedom to return to the community. The benefit of this approach extends beyond improved quality of care and independence for the consumer to include cost savings for publicly funded long-term care programs.

Public funding through Medicaid and Medicare accounted for more than sixty percent of total nursing home expenditures in 2002.⁸ The costs associated with providing long-term care and the impending retirement of 77 million Americans of the "baby-boom generation" beginning in 2011 have encouraged state governments to explore alternative approaches to the delivery of Medicaid and Medicare services.⁹ In federal FY 2002, Texas ranked third nationwide in total amount of Medicaid spending with more than \$13.6 billion.¹⁰ More than nineteen percent of that amount (approximately \$2.6 billion) was spent on institutional long-term care (care provided in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR)).¹¹

Perhaps the most important reason for increased interest in consumer-directed care models, however, is the 1999 United States Supreme Court ruling in *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999), which held it a violation of Title II of the Americans with Disabilities Act (ADA) for states to provide services in an institution to a disabled person if they could be better served in a community-based setting. This decision compelled states to develop comprehensive working plans for placing qualified candidates in less restrictive settings and to assure that those on waiting lists for services would be served within a reasonable period of time.

According to the Kaiser Commission on Medicaid and the Uninsured, the vast majority of Americans who receive long-term care do so at home, with only twelve percent residing in nursing homes or other institutional facilities, and more than eighty-seven percent of people with long-term care needs remain living in the community.¹² In spite of this, three-fourths of all long-term care spending is for care administered in nursing homes, and more than sixty percent of nursing home care is publicly funded.¹³ In addition, of Medicaid's fifty million beneficiaries, more than seven million are "dual eligibles," low-income elderly and individuals with disabilities who are enrolled in both Medicare and Medicaid.¹⁴ These observations have brought considerable interest to the idea of consumer direction in both the Medicare and Medicaid programs.

Program of All-Inclusive Care for the Elderly (PACE)

Authorized by the Balanced Budget Act of 1997, PACE is a comprehensive system of long-term care service delivery that integrates Medicare and Medicaid financing. The model is based on the premise that offering consumers a comprehensive package of services that includes all of the

8 O'Brien et al., 3.

9 Erin Madigan, "Long-term health care costs loom large for governors," *Stateline.org* (July 16, 2004), www.stateline.org.

10 The Henry J. Kaiser Family Foundation, "Total (Federal and State) Medicaid Spending FFY2002," *State Health Facts Online*, www.statehealthfacts.org.

11 Ibid., "Texas: Distribution of Medicaid Spending (Federal and State) on Long Term Care, FFY2002."

12 The Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role in Long-Term Care" (March 2001).

13 Ibid.

14 The Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries" (January 2004).

benefits covered by Medicare and Medicaid (as well as additional services available at community care facilities) will lower costs by reducing use of more expensive hospital and nursing home services. A 1998 study conducted by Abt Associates, Inc., concluded that participation in PACE could be associated with a significant decrease in the number of inpatient hospital and nursing home admissions and length of stays, suggesting that the preventive and rehabilitative services emphasized by PACE reduce the need for institutional care.¹⁵

PACE which is based on an integrated primary, acute, and long-term care services for the vulnerable elderly was developed in the 1970's by On Lok Senior Health Services in the Chinatown community of San Francisco. The program incorporates an interdisciplinary team of professionals and paraprofessionals who assess a client's needs, develop care plans, and deliver services with the goal of providing cost efficient care in the most appropriate setting. Social and medical needs are provided primarily in community adult day health centers and are supplemented by in-home services.

PACE is a capitated benefit of the Medicare program and can be included as an optional benefit in a state's Medicaid service plan. Capitating the financing permits PACE providers to deliver a broader range of services, including services outside the list of benefits covered by traditional Medicare and Medicaid. To participate in the PACE program, a beneficiary must be at least 55 years old, live in a PACE service area, and be eligible for nursing home care under Medicare or Medicaid. Medicare eligible participants who are not eligible for Medicaid may take part in PACE but are required to pay monthly premiums equal to the Medicaid capitation amount.

Seventeen states currently have approved PACE providers: California, Colorado, Florida, Kansas, Massachusetts, Maryland, Michigan, Missouri, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Washington, and Wisconsin. Louisiana and New Mexico have PACE applications pending with the Centers for Medicare & Medicaid Services (CMS). Growth of the program is limited to no more than twenty new program provider agreements nationally per year.

SB 908, enacted by the 77th Texas Legislature, directed the Texas Health and Human Services Commission to develop and implement the PACE program in Texas. Currently, the Texas Department of Aging and Disability Services (DADS) is the administering agency for Texas' two approved PACE sites: Bienvivir Senior Health Services in El Paso and the Jan Werner Adult Day Care Center in Amarillo. Bienvivir Senior Health Services began its participation in the demonstration phase of PACE in 1992 after Congress increased the limit on the number of sites for program replication. Program enrollment at Bienvivir has increased from 469 in 2001 to almost 680 in 2004.¹⁶ In state FY 2002, the average monthly cost per enrollee at Bienvivir was \$2,385.72.¹⁷ The Jan Werner Adult Day Care Center opened as a PACE site in March 2004 and currently serves approximately 65 enrollees.

In November 2003 the National Rural Health Association and the National PACE Association

15 Alan J. White, Yvonne Abel, and David Kidder, "Evaluation of the Program of All-Inclusive Care for the Elderly Demonstration: A Comparison of the PACE Capitation Rates to Projected Costs in the First Fiscal Year of Enrollment. Final Report" (October 27, 2000), 1.

16 Phone conversation with Gerardo Cantu, Texas PACE program administrator, August 23, 2004.

17 Texas Department of Human Services, 2003 Reference Guide, "Integrated Service Delivery," 35.

announced a one year initiative with the United States Department of Health and Human Services Health Resources and Services Administration known as the Rural PACE Technical Assistance Program. The initiative organized seven work groups to develop strategies for adapting and expanding the PACE model to rural communities, with one group assigned to each of the following issues: staffing, financing, infrastructure, technology, provider network development, risk management strategies, and community needs assessment. The final conference among the working groups was scheduled to take place in September 2004.

CMS awarded a four year contract to Mathematica Policy Research, Inc., to evaluate PACE and assess the program's effects on its participants and on the Medicare and Medicaid programs at large. The objective of the evaluation is to assess participants' health, use of services, and satisfaction with care; PACE capitation rates as compared to fee-for-service expenditures; for profit PACE programs as compared with nonprofit programs; and the influence of local issues, such as availability of nursing homes or community care programs, on variations in results across sites. The final report from this evaluation was scheduled to be released in September 2004.

Medicaid Options for Consumer-directed Care

Various forms of consumer direction have been permitted under Medicaid for many years. It may be offered as part of the state's Medicaid service plan or as a managed care program. Another alternative is to offer it under either a home and community-based or research and demonstration waiver. The type of waiver sought is determined by the specific program elements offered. Several states have designed and implemented consumer-directed care models under Medicaid waivers that subsequently served as the basis for broader national initiatives. In the following pages are brief discussions of how consumer direction can be featured through a state's Medicaid service plan, various waiver programs, and new federal initiatives.

State Plan Services

CMS permits consumer direction of certain personal care services as part of a state's traditional Medicaid program. The CMS State Medicaid Manual provides that "Medicaid beneficiaries may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider." Under this option, the state Medicaid agency is responsible for monitoring the service provider to guarantee service delivery by qualified providers. Funds are not dispersed directly to a consumer but are managed by the state agency.

Some states allow non-legally responsible family members (a family member who is not a parent or spouse) or friends of the client to be hired as providers, either as employees of the state Medicaid agency or as independent Medicaid providers. As a state employee, the provider must complete the agency's training and can be assigned to provide care for unrelated clients. Independent providers are required to comply with the state's licensure or certification requirements. In 2002 nearly one half of the independent Medicaid providers in the Washington and Michigan state personal care programs were family members.¹⁸

18 Karen Tritz, Congressional Research Service Report for Congress, "Long-Term Care: Consumer-Directed Services Under Medicaid" (February 6, 2004), 12.

A very limited option for consumer direction in a state's Medicaid plan is the mandatory home health benefit for individuals who qualify for nursing facility services. Although states can cover therapeutic services under this benefit, historically it has provided skilled medical services in the home as opposed to personal assistance services. Furthermore, federal certification requirements for home health providers are very specific and restrict consumers' ability to direct their own care and hire nontraditional providers.

Section 1115 Waivers

Section 1115 of the Social Security Act authorizes the secretary of the United States Department of Health and Human Services (HHS) to waive certain requirements of the Social Security law, including some requirements of the Medicaid program. Section 1115 permits the secretary to approve research and demonstration projects to test substantially new policies that expand Medicaid coverage without committing additional federal resources. Nearly one-fifth of all Medicaid spending falls under Section 1115 waiver authority.¹⁹ This authority is especially effective for consumer-directed care programs as states may get approval for direct cash payments to consumers, reimbursement for care provided by legally responsible relatives, modifications of Medicaid eligibility requirements, and waivers of requirements relating to Medicaid provider agreements. Section 1115 waiver projects are generally approved to operate for a five year period and are required to be budget neutral for the life of the project. In February 2004 the Congressional Research Service reported there were four states providing consumer-directed services through Section 1115 waivers: Arkansas, Florida, New Jersey, and Oregon.

In August 2001 HHS announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative under which guidelines for a new Section 1115 waiver process were released. The purpose of HIFA is to promote coverage expansions using existing Medicaid and Children's Health Insurance Program (CHIP) resources. The HIFA guidelines waive a number of Medicaid requirements and offer states several opportunities to save costs. These include enrollment and benefit limits; premium assistance (for individuals covered by private or employer sponsored insurance); cost sharing through enrollment fees, premiums, deductibles, or copayments; greater flexibility to set Medicaid and CHIP program rules that increase private health coverage options; and improved accountability to ensure that funds are being used to increase health insurance coverage, including substantially more private coverage options such as employer sponsored insurance.

The HIFA guidelines identify three groups of beneficiaries eligible for the waiver project. Mandatory populations comprise individuals who are required to be covered by the state's Medicaid plan, including those most likely to require long-term care such as the elderly and disabled who receive social security income. Optional populations comprise individuals who can already be covered under Medicaid without a waiver and include elderly and disabled individuals with incomes over the mandatory eligibility levels. Expansion populations include individuals not eligible for Medicaid or CHIP coverage without a Section 1115 waiver, such as childless, non-disabled adults under age 65.

¹⁹ Cindy Mann, Kaiser Commission on Medicaid and the Uninsured, "The New Medicaid and CHIP Waiver Initiatives" (February 2002), 1.

Home and Community-Based Services/Section 1915(c) Waivers

In 1981 the United States Congress created the Home and Community based Services (HCBS) waiver program by enacting Section 1915(c) of the Social Security Act. The program provides support services to clients eligible for care in a hospital, nursing facility, or ICF/MR to allow the participants to stay in their homes or elsewhere in the community. As of February 2004 there were more than 275 HCBS waiver programs in operation nationwide.²⁰ Between 1997 and 2002, state and federal HCBS waiver program expenditures nearly doubled from \$8.2 billion to \$16.3 billion.²¹ The target population of HCBS programs ranges from the elderly, to individuals with developmental disabilities, to victims of HIV/AIDS, to medically fragile children. As a result states have significant flexibility in designing their HCBS programs to offer a broad range of services that supplement the state's traditional Medicaid plan.

Cash and Counseling Demonstration Program and New Freedom Initiative

In February 2001 the Bush Administration announced the New Freedom Initiative, a multi-agency federal effort to reduce obstacles to full integration into the community of people with disabilities. One part of the initiative, the Independence Plus waiver program, assists states in further developing consumer-directed care programs by streamlining the waiver process in much the same way as the HIFA guidelines specifically delineated federal policy with regard to the Section 1115 waiver process. The initiative included the release of the Independence Plus template in 2002 and the establishment of a minimum set of program features that states are required to document for a consumer-directed program to receive CMS approval for the waiver. These features include a person centered planning process, an individualized budget, fiscal intermediary services, a support broker who serves at the direction of the consumer, a quality assurance and quality improvement system, and consumer protections such as an emergency backup system.

The Independence Plus initiative is a modification and expansion of the Cash and Counseling Demonstration Program established in 1996 by the HHS with the financial support of the Robert Wood Johnson Foundation. Three states implemented the initial Cash and Counseling program: Arkansas, Florida, and New Jersey. Under the Cash and Counseling demonstrations, individuals with disabilities and the elderly were directly paid a monthly allowance to purchase personal assistance services and related goods. Participants were allowed to purchase services from a family member, friend, or Medicaid agency provider. Counselors aided individuals in developing a cash plan; recruiting, training, and managing workers; gaining access to community services; and developing a backup plan.

The Independence Plus initiative is designed to provide personal assistance to individuals and families so that people who require long-term care services and support can remain in their own homes. Independence Plus programs operate under Section 1115 demonstration waivers or Section 1915(c)/HCBS waivers. Independence Plus templates have been designed for programs under both waivers. The type of template used depends on the specific objectives of a state's program. A state

²⁰ Tritz, 2.

²¹ Gary Smith and Beth Jackson, prepared for the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Disabled and Elderly Health Programs Group, "Summary of Results: National Quality Inventory Study of HCBS Waiver Programs" (January 2004), 1.

must submit a waiver application under Section 1915(c) to provide services through an individualized budget managed by a Medicaid provider or to allow participants to direct home and community based waiver services only. If the state wishes to provide direct cash to consumers, permit pay to legally responsible relatives, change Medicaid eligibility requirements, permit use of non-Medicaid providers as direct care workers, or allow consumer direction of any state plan or waiver service, the state must submit its application under Section 1115.

As with any Section 1115 demonstration project, states have much greater flexibility in designing Independence Plus programs under Section 1115 authority. These programs must be voluntary for participants, be budget neutral, and include adequate support resources for participants directing their own care. States are given discretion:

- Over whether the program operates statewide
- To set enrollment caps
- Whether to permit the legally responsible family members to qualify as providers
- Whether unspent funds can be saved by participants to finance the purchase of adaptive equipment or environmental modifications

Independence Plus programs operating under HCBS waiver authority are limited in the same way as other Section 1915(c) waiver programs. Participants in these programs must meet level-of-care requirements and consumer direction is limited to HCBS waiver approved services. States can require beneficiaries receiving community based services to participate in an HCBS Independence Plus program. Unlike participants in Section 1115 programs, individuals participating in an HCBS program do not receive direct payments of their individualized budgets. Instead, a third party contracts with the state to manage finances and arrange for payments. However, the program also must be budget neutral and states must maintain certain beneficiary protections.

Another major component of the New Freedom Initiative is the Systems Change Grants for Community Living. In 2001 when the New Freedom Initiative was announced, the Systems Change grants included four distinct grant opportunities: the Nursing Facility Transitions grants; the Community integrated Personal Assistance Services and Supports (CPASS) grants; the Real Choice Systems Change grants; and the National Technical Assistance Exchange for Community Living grants. As the initiative has evolved a number of additional grant opportunities have developed. All of these grants are sorted into three broad categories that determine how the funds may be used: Feasibility Studies and Development grants; Research and Demonstration grants; and Technical Assistance to States, State Advisory Committees, and Families grants. Specific grant opportunities within those categories currently include: Respite for Adults, Respite for Children, and Community based Treatment Alternatives for Children (Feasibility Studies and Development category grants); Quality Assurance and Quality Improvement in Home and Community based Services, the "Money Follows the Person" Rebalancing Initiative, the Independence Plus Initiative, and CPASS (Research and Demonstration category grants); and the National State-to-State Technical Assistance Program, the Technical Assistance for Consumer Task Forces, and the Family-to-Family Health Care Information and Education Centers (Technical Assistance to States, State Advisory Committees and Families category grants). Four of these grants may provide funding for direct services: up to twenty percent of total funds awarded under the Independence Plus Initiative and the CPASS grants and up

to ten percent of total funds awarded under the Quality Assurance and Quality Improvement in Home and Community based Services and the "Money Follows the Person" Rebalancing Initiative grants may be used to provide direct services to individuals with a disability or long-term illness.

Approximately \$158 million from CMS's research appropriation was dedicated to Real Choice Systems Change grants for federal fiscal years 2001 through 2003 and given to states to improve access to community living for individuals of any age with a disability or long-term illness.²² CPASS grants have been awarded to programs that augment consumer-directed personal assistance services offering maximum individual control, conduct outreach to existing consumer-directed programs, evaluate the expansion of consumer direction, build support networks for individuals participating in consumer-directed services, and improve recruitment and retention of direct care workers. In FY 2001, nine states and one territory were awarded CPASS awards totaling \$7.6 million: Alaska, Arkansas, Guam, Michigan, Minnesota, Montana, Nevada, New Hampshire, Oklahoma, and Rhode Island. In FY 2002, seven states (Colorado, Hawaii, Indiana, Kansas, North Carolina, Tennessee, and West Virginia) and the District of Columbia received CPASS awards totaling \$6 million. In FY 2003, Arizona, Connecticut, Louisiana, Massachusetts, Nebraska, Oregon, Texas, and Virginia received CPASS funds totaling \$4.5 million.²³

In July 2004 Texas had five active programs operating with funds awarded under the Real Choice Systems Change Grants initiative. The Texas Health and Human Services Commission (HHSC) administered two grant programs: the Texas Real Choice: Creating a More Accessible System for Real Choices in Long-term Care Services and Community based Treatment Alternatives for Children programs; DHS administered the Money Follows the Person and Community integrated Personal Assistance Services and Supports programs; and the Texas Department of Mental Health and Mental Retardation (MHMR) administered the Quality Assurance and Quality Improvement for Home and Community based Services program. As of September 1, 2004, community care and nursing home services programs of DHS and mental retardation programs of MHMR, including these grant programs, were consolidated into the Department of Aging and Disability Services (DADS).

The Texas Real Choice program is in its second year of operation. The program consists of two projects, one in the Heart of Texas region and the other in the Texoma region, that are testing the use of "system navigators" who help to guide individuals requiring long-term care with coordinating their care across agencies and available programs. The Heart of Texas model is testing the use of these navigators in multiple points of access throughout its region, while the Texoma model is testing a single point of access and software known as ServicePoint. At the conclusion of the second year, HHSC will conduct an evaluation on both models. The Community based Treatment Alternatives for Children program has used its grant to fund a research specialist at HHSC to conduct a feasibility study and develop an implementation plan for community based services, such as intensive in-home treatment, for children with severe emotional disturbances. The study is intended to produce at least one solution for using a Section 1915(c) waiver to integrate funding, coordinate services, and develop a comprehensive provider base for these children to receive treatment at home.

22 Centers for Medicare and Medicaid Services, "Real Choice Systems Change Grants Fact Sheet" (May 2004), www.cms.hhs.gov/systemschange.default.asp.

23 Tritz, 21-22.

The Money Follows the Person and the CPASS programs have entered into contracts with coordinators for their respective programs. The Money Follows the Person program has contracted with the Center on Independent Living to establish transition workgroups to assist individuals transitioning from institutional living to their homes and communities. The CPASS program is currently recruiting service providers for the Service Responsibility Option pilot project in the Lubbock and Amarillo areas.

The Quality Assurance and Quality Improvement for Home and Community based Services grant administered by MHMR is designed to improve the information gathering capability of the department and integrate the agency's waiver program quality assurance and improvement reporting mechanisms into a comprehensive system. The department created a task force that in June 2004 unanimously recommended the use of the National Core Indicators tool to measure participants' experiences in Texas' MHMR waiver programs. A business analyst has also been hired to begin design of the information gathering system.

In May 2004 CMS announced the availability of approximately \$31 million in additional funding for nine grant opportunities under the Real Choice Systems Change grant category: the Quality Assurance & Quality Improvement System in Home and Community based Services grant; the Integrating Long-term Supports with Affordable Housing grant; the Portals from Early Periodic Screening, Diagnosis, and Treatment to Adult Supports grant; the Comprehensive Systems Reform Effort grant; the Mental Health Systems Transformation grant; the "Money Follows the Person" Rebalancing Initiative grant; the Living with Independence, Freedom, and Equality Account Feasibility and Demonstration grant; the Family-to-Family Care Information and Education Centers grant; and the National State-to-State Technical Assistance Program for Community Living grant.²⁴ Under this latest round of grant funding availability, MHMR applied for a Mental Health System Transition grant. The grants will be awarded before September 30, 2004, and will have a budget period of thirty-five months. If awarded to Texas, the grant program will be administered by DADS.

Medicaid Managed Care

With managed care typically representing an approach in which case managers or provider staff make service decisions, consumer direction and managed care appear inconsistent. However, studies indicate that managed care organizations are incorporating into their models features consistent with consumer direction, such as permitting clients to hire and fire their direct care workers, including friends and relatives. Opportunities for consumer direction can be found in cost savings created by managed care organizations that select and pay service providers. These savings can be used to enhance client benefits and promote greater independence.

Self-directed Support Corporations

Some states permit a non-legally responsible family member or friend to be hired as a service provider, either as an employee of a Medicaid agency or as an independent Medicaid contractor. The Medicaid program also permits friends and family of consumers with significant cognitive disabilities to organize as a Self-Directed Support Corporation (SDSC). The SDSC is a legally recognized organization that assists the consumer in coordinating and receiving care as an

²⁴ *Federal Register*, 69, no. 96, (18 May 2004), 28133-28141.

alternative to the traditional agency based system. If a state permits, the SDSC operates as a licensed provider of Medicaid services or as a third party agent that employs and directs a certified Medicaid provider. Maryland, Michigan, Missouri, Tennessee, and Oregon are active in developing SDSC programs, and Tennessee has formed an association to assist and train interested individuals and family members.

Other Medicaid Research and Demonstration Projects: The Self Determination Initiative and Independent Choices

In 1997 the Robert Wood Johnson Foundation established a program similar to the Cash and Counseling Demonstration Program known as the Self Determination Program for People with Developmental Disabilities that funded 19 programs with operational features similar to those of the Cash and Counseling demonstrations. The states receiving funding under this program were Arizona, Connecticut, Florida, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Michigan, New Hampshire, Minnesota, Ohio, Oregon, Pennsylvania, Texas, Utah, Vermont, Washington, and Wisconsin. These states' projects were developed by consumers and support groups with budgets controlled by the consumers. The states provided monitoring and administrative support, but provider contracts were between the projects' governing boards, which were comprised of consumers, members of their support groups, and service providers.

Also in 1997, the Robert Wood Johnson Foundation funded thirteen projects coordinated by the National Council on Aging (NCOA) that tested a variety of consumer direction strategies for different groups of disabled persons. In 2002 the foundation awarded additional funding to the NCOA and the National Association of State Units on Aging to further assess the role of consumer direction in states' long-term care systems, including Medicaid and non-Medicaid programs, and to identify barriers to the expansion of consumer direction in those programs.

Consumer-directed Care in Texas

The Texas Legislature and relevant state agencies have long supported efforts to integrate long-term care services and improve access to alternative forms of care available in the community. These efforts date to the 1970's and the significant work performed by two joint committees created by the Legislature. In 1976 the 64th Legislature established the Joint Advisory Committee on Government Operations to review the structure of state government and administrative processes. The committee organized the Subcommittee on Health and Welfare to study the reasons for the dramatic increases in nursing facility costs during that period. As part of its report, the subcommittee included a "Background Report on the Nursing Home and Alternate Care Programs Administered by the Department of Public Welfare." This report concluded that the admissions process for nursing facilities did not consider community alternative forms of care. Continuing the work, the 65th Texas Legislature directed the Joint Committee on Long-term Care Alternatives to evaluate the scope and effectiveness of state agencies providing health related services, including agencies that provided care to the elderly and disabled. Among the committee's recommendations were preadmission assessment of Medicaid applicants for nursing facility care, expansion of services available through the Medicaid home health benefit, development of congregate housing, and establishment of adult day care services.

The 72nd Legislature passed SB 377 directing HHSC to revise, update, and review the long-term care state plan for the elderly. The HHSC responded by creating the Long-term Care Task Force in 1993. The task force was charged with preparing "a broad cross agency vision for a comprehensive system of long-term supports for people with functional limitations due to age or disability" to guide HHSC in its implementation of the long-term care state plan. The task force issued its final report and recommendations to the commissioner in August 1994. The work of the task force eventually led to the passage of SB 374 by the 76th Texas Legislature. SB 374 consolidated all long-term care programs (except programs relating to clients with mental disabilities) administered by the Texas Department of Human Services (DHS) and the Texas Department on Aging (TDA) into a new agency on aging and disability services. The bill required HHSC, DHS, and TDA to assist communities in developing community-based systems for long-term care service delivery and to provide related resources and assistance at the request of a community. SB 374 also required HHSC to evaluate the feasibility of establishing an integrated local system of access and services for the elderly and disabled and to study the feasibility of a subacute care pilot project.

Related legislative efforts continued to expand community-based long-term care services and included such Medicaid initiatives as the Frail Elderly program, the Personal Care Option, and the Community-based Alternatives and Medically Dependent Children waiver programs. National recognition for Texas as a leader in consumer direction, however, is due in large part to two specific initiatives: the Voucher Fiscal Intermediary Model Pilot for Personal Assistance Services and the Promoting Independence Initiative and Rider 37 to the General Appropriations Act from the 77th Legislature (2001).

Voucher Fiscal Intermediary Model Pilot for Personal Assistance Services

HB 2084, passed by the 75th Legislature, required DHS to develop and implement a pilot project in which vouchers were used as a payment option for long-term care, personal assistance, and respite services. The pilot project was designed so the consumer controlled the selection, management, and dismissal of direct care workers providing services, but was not responsible for payroll or tax considerations. In March 1999 the Comptroller of Public Accounts released an annual Texas Performance Review, "Challenging the Status Quo: Toward Smaller, Smarter Government." The report recommended that the voucher program be extended to appropriate programs of DHS, Texas Department of Health (TDH), the Texas Rehabilitation Commission (TRC), and MHMR, including appropriate Medicaid waiver programs. The 76th Legislature responded to the comptroller's recommendations by enacting SB 1586, which directed HHSC to implement the voucher payment program in certain programs of DHS, TRC, MHMR, and TDH. The bill also created a voucher payment program work group to assist the commission in its endeavor.

SB 1586 prompted HHSC to develop a consumer-directed services (CDS) model that permits a consumer or the consumer's guardian or designated representative to be the legal employer of record for direct care service providers. In 2002 Texas received permission from CMS to implement the CDS delivery model in several Medicaid HCBS waiver programs and in the Medicaid state plan. Texas' earlier efforts to establish a CDS model preceded the 2002 release of the Independence Plus template, and four state programs implemented consumer-directed delivery models in 2001. As a result, the state did not use the Independence Plus waiver template to secure CMS approval for the CDS option. However, CMS modified HHSC's consumer-directed care waiver amendments to more closely reflect the template's requirements before granting Texas permission to use the CDS option,

and CDS implementation in Texas has been consistent with federal guidelines. The consumer-directed services developed by HHSC are currently available through six programs. Five of these programs are administered by DADS: the Community Living Assistance and Support Services (CLASS) program, the Deaf-Blind-Multiple Disability Waiver program, the Consumer Managed Personal Assistance Services (CMPAS) program, the Primary Home Care (PHC) program, and the Community Based Alternatives (CBA) program. MHMR administers the only other program that offers a CDS option, the In-Home and Family Support program. MHMR is also awaiting approval for the Texas Home Living Program waiver.

The 78th Texas Legislature enacted two pieces of legislation that affect the coordination and implementation of consumer-directed services in Texas. SB 153 renamed the Voucher Payment Program Workgroup as the Consumer Directed Services Workgroup and charged the group with assisting HHSC in the continued implementation of consumer-directed care services in the state. HB 2292 requires HHSC to report annually to the legislature regarding the effectiveness of consumer-directed services in the state. The commission issued its first report as required by HB 2292 in February 2004. HHSC reports that utilization rates for the six programs that offer CDS options range from a low of less than one percent in the CBA and PHC programs to a high of twenty-eight percent in the CLASS program.²⁵ HHSC explains that the variation in these rates may be attributed to the fact that concerted efforts were made to educate enrollees of the CLASS program about consumer-directed options. In preparing for its 2005 annual report the commission has pledged to consult with the CDS workgroup to further evaluate client participation and utilization trends and cost-effectiveness of the CDS option.

Promoting Independence Initiative and Rider 37

On September 28, 1999, then Governor George W. Bush, responding to the Supreme Court's *Olmstead* decision, filed executive order GWB99-2 relating to community-based alternatives for people with disabilities. The order directed HHSC to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. HHSC was further directed to analyze the availability of existing community-based alternatives for people with disabilities and to focus on the removal of barriers to community placement of this population. As a result of this order, HHSC formed the Promoting Independence Advisory Board that developed the first Promoting Independence Plan, presented to the legislature in January 2001. In turn, the 77th Legislature enacted SB 367 and renamed the advisory board as the SB 367 Interagency Task Force on Appropriate Care Settings for Persons with Disabilities.

SB 367 was the central legislative element of the state's response to the *Olmstead* decision and the Promoting Independence initiative. The bill required HHSC to implement a comprehensive plan to provide a system of services and support that promotes independence and creates genuine opportunities for a person with a disability to live in the most integrated setting. A number of other bills were passed by the 77th Legislature that were relevant to implementation of the Promoting Independence Plan, including SB 368 (relating to permanency planning for children in institutional care), HB 1478 (relating to the Children's Policy Council), and HB 966 (relating to redirection of money to follow an individual leaving institutional care).

The 77th Legislature also attached Rider 37 to the General Appropriations Act. Rider 37 reads as

25 Texas Health and Human Services Commission, "Effectiveness of Consumer Directed Services: First Annual Update as Required by HB 2292. Report to the 78th Texas Legislature" (February 2004), 2.

follows:

37. Promoting Independence: It is the intent of the legislature that as clients relocate from nursing facilities to community care services, funds will be transferred from Nursing Facilities to Community Care Services to cover the cost of the shift in services.

The implementation of Rider 37 began with a pilot project to provide Community Awareness and Relocation Services (CARS). Contracts were awarded to three sites, two of which were collaborative efforts among various organizations serving different regions of the state. Originally, the contracts were for one year, but these were extended for an additional six months through November 2003. The Rider 37 implementation plan also included two means of financial assistance for certain participants making the transition from a nursing facility to the community. First, the Texas Department of Housing and Community Affairs received 35 set aside Section 8 housing vouchers available for participants under age 62. These vouchers came to the state through a special allocation from the federal government for a demonstration project known as Project Access. Second, DHS offered transition grants of up to \$2,500 to certain individuals. To participate in the Rider 37 program, an individual had to be eligible for a DHS Medicaid community care program and eligible to receive Medicaid assistance for nursing facility services. The implementation of Rider 37 was subject to Rider 7b, also attached to the General Appropriations Act by the 77th Legislature. Rider 7b stipulated, with some exceptions, that the costs of community services provided under Rider 37 could not exceed either the average Medicaid nursing facility reimbursement rate or the participating individual nursing facility rate, whichever was greater. Rider 37 became effective in September 2001 and by August 31, 2003, more than 2,000 persons had moved out of nursing facilities using Rider 37 funds.²⁶

In April 2002 Governor Rick Perry issued executive order RP13 further refining the state's response to the *Olmstead* decision and requiring HHSC to revise the Promoting Independence Plan to "(1) update the analysis of the availability of community-based services as a part of the continuum of care; (2) explore ways to increase the community care workforce; (3) promote the safety and integration of people receiving services in the community; and (4) review options to expand the availability of affordable, accessible and integrated housing." As HHSC prepared its revision, the task force recommended that the revised plan include specific data relating to the fiscal methods used to achieve the objectives of Rider 37 and information such as the age, disability, and length of time in a nursing facility before transition to the community for beneficiaries of the Rider 37 funding. The task force also recommended that Rider 37 be made a permanent funding mechanism for transitioning eligible individuals from institutional care to community-based care. The 78th Legislature continued the Rider 37 initiative for a second biennium in the form of Rider 28 attached to the General Appropriations Act.

Consumer-directed Care in Other States

CMS has provided states with increasing flexibility to design consumer-directed care programs and

26 Jay Klein, et al., "Strategies and Challenges in Promoting Transitions from Nursing Facilities to the Community for Individuals with Disabilities: A Pilot Study of the Implementation of Rider 37 in Texas" (February 2004), 5.

has offered technical assistance and grants to help states redesign their long-term care systems to incorporate home and community-based care. Changes to health care delivery systems at the state level typically develop through a process of states learning from other states' experiences. Although the majority of states continue to spend their Medicaid long-term care and support funding for care provided in nursing home and ICF/MR facilities, most states that have introduced consumer-directed care have done so through agency operated home and community-based service programs. These community-based care initiatives have generally been implemented as the result of one of three types of strategies: legislative action, market-based approaches, and fiscal and programmatic coordination. These approaches are not mutually exclusive, and states usually employ a combination of strategies to effect system wide change. What follows are descriptions of other states' consumer-directed care efforts. The first three focus on home and community-based service options, and the states are grouped according to the method by which the states initiated their programs. The final group summarizes the systematic approaches applied by three states and includes consumer-directed care initiatives outside of a nursing facility to community-based care transition programs.

Vermont and Utah

State legislative efforts generally focus on "money follows the person" initiatives that transition Medicaid clients from the institutional setting to home and community-based care. In 1998 Utah enacted the Portability of Funding for Health and Human Services law that created an open enrollment process allowing Medicaid beneficiaries institutionalized at an ICF/MR to move to the community and use HCBS waiver services. Six percent of the total number of people who were in state institutions or private ICF/MR facilities in 2000 transitioned to the community during fiscal years 2000 and 2001 under this waiver program. The program ended in 2002.

In 1996 Vermont passed Act 160 and specifically linked increases in funding for community-based care with reductions in the projected growth rate of nursing facility expenditures. The act provided that in each year that the state spent less than the projected amount of nursing facility expenditures, the savings could be spent to finance community-based care options. The nursing facility share of Vermont's Medicaid long-term care expenditures decreased from ninety to seventy-five percent between 1997 and 2000.²⁷ The act also added self-directed service options and created a statewide system of Long Term Care Community Coalitions to improve the infrastructure and coordination of local long-term care systems.

New Jersey

Market based approaches to consumer direction provide participants with the option to choose home and community-based care over institutionalization. In the late 1990s New Jersey's Department of Health and Senior Services, Division of Aging and Community Services, implemented a number of programs to provide older residents comprehensive information about health and social services available in the community. The department also offered more long-term care support options for individuals choosing to stay in a home or other residential setting in the community. These increased benefits reduced waiting lists for home and community-based services and reduced the number of

²⁷ Suzanne Crisp, et al., Medstat: Research and Policy Division, prepared for the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Disabled and Elderly Health Programs Division, "Money Follows the Person and Balancing Long-Term Care Systems: State Examples" (September 2003), 4.

Medicaid funded nursing facility residents by ten percent between 1997 and 2002.²⁸ The community support options included self-directed care and assisted living services as well as traditional in-home services, all covered under a new Medicaid HCBS waiver. The state also began a state-funded in-home services program for clients not eligible for Medicaid in which participants pay a sliding-scale fee for self-directed care and other in-home services.

Maine

Fiscal and programmatic coordination links funding streams, such as provisions that link decreases in spending for institutional care with increases in community-based programs, or system-wide processes, such as person centered planning, to provide comprehensive sets of services that can meet the unique needs of program participants. Maine transformed its long-term care delivery system in 1993 by reducing institution utilization and introducing community-based services. Savings from the decreased institutional spending afforded the expansion of several home and community-based options in the state's Medicaid plan services, as well as waiver programs and programs funded by state general revenue. Between 1995 and 2002 the proportion of state and Medicaid long-term support that was spent on home and community-based services increased from sixteen to thirty-nine percent while the number of Medicaid nursing home residents decreased by eighteen percent.²⁹

California, Oregon, and Washington

California has the largest and oldest consumer-directed care program in the United States. The California In-Home Supportive Services (IHSS) program serves more than 200,000 consumers.³⁰ The program permits payment to a wide range of caregivers, including family members. IHSS operates two very different models of delivery of care: a consumer-directed model and a provider-managed model. The consumer-directed model permits clients to hire, fire, schedule, train, and supervise their own personal assistance service providers. The program caps the maximum amount of service hours funded per month at 283 (for the most seriously impaired clients) and imposes a monthly spending cap per client that is calculated by multiplying the maximum number of hours by the state minimum wage.³¹

Oregon and Washington have developed consumer-directed care programs through Medicaid personal care and home and community-based care waivers. These consumer-directed programs now serve more clients than the conventional agency operated home care programs.³² Both states have demonstrated significant long-term care cost savings by reducing nursing facility utilization and relying on alternatives such as assisted living and adult foster homes.³³

RECOMMENDATION

The State of Texas must continue to explore opportunities to expand and enhance its consumer-

28 Ibid., 5.

29 Ibid., 7.

30 Larry Polivka and Jennifer R. Salmon, Florida Policy Exchange Center on Aging, "Consumer-Directed Care: An Ethical, Empirical, and Practical Guide for State Policymakers" (June 2001), 11.

31 Ibid., 12.

32 U.S. Department of Labor, Employment Standards Administration Wage and Hour Division, "Minimum Wage Laws in the States," www.dol.gov/esa/minwage/America.htm.

33 Polivka, 14.

directed care programs as this service delivery model has demonstrated itself to be a cost-effective way to provide enhanced services to clients.

The legislature should evaluate: the expansion of the service responsibility option (pending a successful pilot); the separation of service coordination from service provision through the consumer directed services model; the expansion of the provider base to Independent Living Centers and Area Agencies on Aging; the integration of adaptive technology as a means to achieve independence; the use of Health Savings Accounts as a new a tool for the delivery of consumer-directed care.

CHARGE

EMPLOYEE RETIREMENT SYSTEM AND THE TEACHER RETIREMENT SYSTEM

Continue to identify and seek new models for the provision of health care benefits within the Employee Retirement System and the Teacher Retirement System.

BACKGROUND

Consumer Directed Health Care

According to health economists, one essential element in the rising cost of health care is the rapid increase in the prevalence of third party payments. Currently eighty-five percent of health care costs are paid by third parties such as government entities, employers, or insurance companies. The proportion of health care paid directly by consumers has been falling for several years. In 1960 consumers paid about fifty-six percent of health care directly. By 1980 the proportion had fallen to about twenty-eight percent. Today consumers pay for only about fifteen percent of their health care costs – and most of what is paid directly is for over-the-counter (OTC) drugs, vision care, dental care and cosmetic surgery.¹

Critics of third-party payments point to several areas of concern, to include rising prices, limitations on patient choice, and seeming incentives for wasteful utilization. The limitations imposed upon access by third party payers may seem to patients to at times be tantamount to rationed care. The administrative costs of the third parties may also be higher because of review procedures designed to ensure that only appropriate care is provided and that claims are not fraudulent. The essential complaint posed by detractors of third party payment arrangements is that it reduces patients' incentive to be wise consumers of medical services by removing the ability to express preferences and make value trade-offs similar to other areas of their lives. As a result the consumer faces no real encouragement to avoid wasteful health care utilization. Indeed, third party payments may actually create an incentive to purchase as much health care as the final payer is willing to cover.

One emerging strategy to both moderate health care spending growth and improve the quality of outcomes is to have consumers become much more involved in decisions regarding their own care. The underlying premise of consumer directed health care is that the individual receiving the service knows best what they want and will – if provided the opportunity and sufficient information – generally use good judgment to purchase those services.

Consumer driven health care plans were developed in the late 1990s and promoted by a small number of new health industry companies. By January 2004 most major managed care and health insurance companies had developed consumer driven plan options, primarily for use in employer-sponsored health benefit programs. In a consumer directed health care plan, employees are educated on the true costs of medical services and held more responsible for their medical purchase decisions. As health care consumers become financially responsible for more of the real cost of health care services, the rising cost of health care could be significantly reduced.

Through defined contribution health insurance, employers attempt to connect employees with health care decision making. Under this method, the employer "defines" its contributions while the employees choose among a menu of policy option. An employee wanting richer coverage may contribute more personal funds to cover the difference between the employer's payment and the cost of the policy. On the other hand, employees choosing less expensive (typically high deductible) health plans may have the option of depositing the remaining employer funds into a personal health

¹ Testimony submitted by Devon M. Herrick Statement of Devon M. Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis, House Select Committee on State Health Care Expenditures, March 24, 2004.

account. There is a growing body of research data now indicating that extending employees more control over their health care can indeed lead to overall lower medical costs.

Consumer Directed Care Models

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a tax favored program that allows employees to set aside pre-tax money from paychecks to pay for a variety of eligible expenses. With FSAs, workers are able to draw on the money set aside to pay health care costs that are not covered by insurance, using money remaining in their paycheck after federal (and often state and locality) taxes are deducted. In effect, health care costs are lowered by paying with untaxed dollars (the worker's tax rate is typically fifteen percent to thirty percent).²

In 2003, the IRS eased restrictions so that FSA dollars can be used for over-the-counter drugs. Even with the restrictions eased, it remains difficult for employees to hold costs down. While there is no legal limit on the size of FSA accounts, most employers impose their own maximums.

- FSAs cover eligible health care expenses not reimbursed by any medical, dental, or vision care plan a worker or dependents may have
- Eligible dependents for this account include anyone claimed by the worker on her federal income tax return as a qualified IRS dependent and/or jointly file taxes
- Insurance premiums, including those for FEHB premiums, Long Term Care, private insurance premiums and supplemental insurance premiums, are NOT eligible for reimbursement

A major problem with FSAs is a "use it or lose it" requirement. Employees with an FSA account decide how much they think they will need at the beginning of the year, and the money left in the account at the end of the year is forfeited by the employee. This often leads to a wave of spending on health related items at the end of end of the year as workers realize their money will be forfeited if they don't use it. Often times workers choose to buy something they don't really need rather than lose the money altogether.

Medical Savings Accounts (MSAs)

On August 21, 1996 President Bill Clinton signed into law the Kassebaum-Kennedy bill that allowed Americans to open a Medical Savings Account (MSA). The new law became effective January 1, 1997 and it restricted the number of people who can open an MSA to 750,000 persons who are self-employed or who work for a small business (50 or fewer employees).³

Medical Savings Accounts (MSAs), later called Archer MSAs, are tax deferred investment accounts, similar in many respects to an IRA. MSAs are used in conjunction with a qualified high deductible health plan (HDHP). It is a tax advantaged arrangement that allows earnings and deductible contributions to grow tax deferred. MSAs are used to save for qualified medical expenses.

² Albert B. Crenshaw, Untangling 'consumer-driven' care plans, The Washington Post, April 25, 2004, Final Edition.

³ Sue A. Blevins, Medical Savings Accounts (MSAs) Give Patients Power, Institute for Health Freedom, www.forhealthfreedom.org/Publications/HealthIns/MSAs.html

MSA contributions are deductible from gross income on federal income tax returns for the tax year for which the contributions are made. Earnings grow on a tax deferred basis. Contribution and earnings dollars may be withdrawn tax free for medical expenses at any time. At age 65, or upon disability, withdrawals from MSAs can be made for any reason without a penalty; however, they will be taxed as ordinary income.

Either an employer or employee can contribute to an MSA; however, both generally cannot contribute to the account in the same tax year. Contributions to MSAs can be made from January 1st through the tax filing deadline for the year, generally April 15. Distributions made for qualified medical expenses are tax free. Distributions made for non-qualified medical expenses prior to age 65 are subject to income taxation and a fifteen percent penalty tax.

2004 HDHP/Contribution Rates⁴

	HDHP Minimum Deductible	HDHP Maximum Deductible	HDHP Out-of- Pocket Limit	Percentage Deductible that may be contributed to on MSA	of Maximum Contribution based on Deductible	Maximum Contribution based on Deductible
Self Only Coverage	\$1,700	\$2,600	\$3,450	65 percent	\$1,105.00	\$1,690.00
Family Coverage	\$3,450	\$5,150	\$6,300	75 percent	\$2,587.50	\$3,862.50

A person must meet one of the following categories in order to be eligible for an MSA:

- Self-employed (or the spouse of a self-employed person) and maintain a qualified high deductible health plan (HDHP) for yourself or your family
- An employee (or the spouse of an employee) of a qualified small business that maintains a qualified HDHP
- A qualified small business owner with a qualified HDHP

MSAs have been supplanted by Health Savings Accounts (HSAs). While existing MSAs may be continued, new ones may not be established. MSA accounts can be rolled over into HSAs.

Health Reimbursement Accounts (HRAs)

HRAs were officially unveiled on June 26, 2002, by the U.S. Treasury Department. With an HRA, the employer sets up an "account" for the employee and credits it with a certain amount of money. The HRA is used to pay for eligible health care expenses typically covered under the medical plan. HRAs are defined contribution health care plans, not defined benefit plans. As an incentive to employees to use their personal HRA wisely, unused funds can be carried over to the next year to cover future health care expenses. If funds are exhausted, the employee is responsible for satisfying the remaining deductible before the plan begins to pay. No employee money may be contributed to an HRA account.

Employer contributions can be any size, limited only by the employer's budget. Many employers are

⁴ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for inflation-related adjustments to the minimum and maximum deductibles and out-of-pocket limitations. The increases are determined by the annual cost-of-living adjustments based on the consumer price index (CPI).

offering an HRA instead of regular insurance for retirees, thereby enabling workers to accumulate money that would be available in retirement to supplement Medicare.

HRAs offer tax savings to both the employer and the employee. Employer contributions are not taxed, nor are withdrawals by employees to pay for medical expenses. An average employee spends about \$1000 per year in out-of-pocket health care expenses including, dental, vision, prescription drugs, deductibles and co-payments. The wage taxes on this amount are typically about \$400. Since health care expenses are not subject to wage taxes, these plans save a total of about \$400 for each \$1000 of benefit provided through an HRA.⁵

HRAs combine high deductible health insurance with a cash reimbursement for employees who incur smaller expenses. For most employees with typical health care expenses, this creates a plan that provides one hundred percent coverage at a lower overall cost for the employer. Most plans include some employee co-payments as a cost-savings measure, but most employees are unlikely to be affected by these features.

HRAs do not require that employers advance claims payments to employees or health care providers during the early months of the plan year. With HRAs employers are permitted to reduce health plan costs by coupling the HRA with a high deductible (and usually lower-cost) health plan. HRAs even the playing field between the group purchasing power of larger employers and smaller employers.

Employers favor HRAs because they are simple and clearly define the employer's cost. Unlike Medical Savings Accounts, the employer has full control of the funds and directly saves money if the employees have few claims. But if the claims are high, the employer's cost is limited to the amount specified in the plan. Employees like HRA plans because they offer full freedom of choice in choosing medical providers without the need for referrals or network restrictions. Finally, benefit plan advisers prefer HRA plans because they are more flexible and less expensive to administer than other types of health plans. HRAs are available in all fifty states regardless of the type of health insurance plan used.

Health Savings Accounts (HSAs)

Health Savings Account (HSAs) were created by a provision in the Medicare reform bill signed into law by President George W. Bush on December 8, 2003, and became effective on January 1, 2004. In a nutshell, an HSA is a tax favored account that individuals covered by high deductible health plans can use to pay for certain medical expenses.

To be eligible for an HSA, an individual must:

1. Be covered by a high deductible health plan (HDHP)
2. Not be covered by another health plan that is not an HDHP (certain coverage is disregarded for this purpose, including coverage for dental or vision care and certain permitted insurance)
3. Not be claimed as a dependent on another person's tax return

⁵ <http://www.medsave.com/articles/Introducingpercent20Healthcarepercent20Reimbursementpercent20Accounts.htm>

For self-only policies, a qualified health plan must have a minimum deductible of \$1,000 with a \$5,000 cap on out-of-pocket expenses. In the case of family policies, qualified health plans must have a minimum deductible of \$2,000 with a \$10,000 cap on out-of-pocket expenses. Preventable care services, as well as coverage for accidents, disability, dental care, vision care, and long-term care is not subject to the deductible. In the case of a "network plan," the annual deductible for services provided outside the network is disregarded and the annual out-of-pocket limitation for such expenses will not cause the plan to fail to be treated as an HDHP.

HSA contributions can be made by both the employer and the employee. Contributions to HSAs are deductible if made by an eligible individual or his family member. Such contributions are excludable from gross income and from wages for employment tax purposes if made by an eligible individual's employer. If an employer makes an HSA contribution, he must make available comparable contributions on behalf of all "comparable participating employees" during the same period. The employer receives a tax deduction on business expenses.

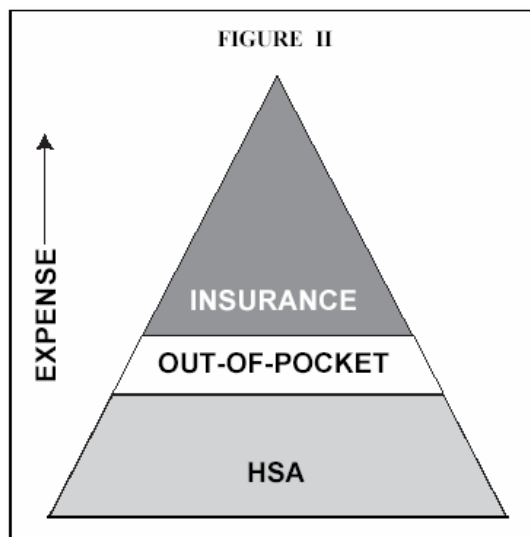
Individuals may contribute up to one hundred percent of the health plan deductible. The maximum annual contribution is \$2,600 for self-only policies and \$5,150 for family policies. Individuals age 55-65 may make additional "catch-up" contributions of up to \$500 in 2004, increasing to \$1,000 annually in 2009 and thereafter. A married couple can make two catch-up contributions as long as both spouses are at least 55. The account balances can earn interest or be invested in stocks or mutual funds, and they will grow tax free.

The legislation also provides that HSAs can be offered under a cafeteria plan. Thus, HSAs may be funded with pre-tax salary reductions and/or flex credits. Rollovers can be made into an HSA from another HSA or from an Archer MSA. Individuals who are entitled to Medicare benefits are not eligible to contribute to an HSA. The funds will be held in a trust administered by a bank, insurance company, or other approved administrator.

HSA distributions are tax-free if they are used to pay for qualified medical expenses including prescription drugs, qualified long-term care services and long-term care insurance, COBRA coverage, Medicare expenses, and retiree health expenses for individuals age 65 and older. The money in the HSA can be used to pay for non-medical expenses, but is then subject to income tax and a ten percent tax penalty. The ten percent penalty is waived in the case death or disability as well as for distributions made by individuals age 65 and older. Upon death, HSA ownership may transfer to the spouse on a tax-free basis.

In a typical HSA plan, when individuals enter the medical marketplace, they will first spend from their HSA. If they exhaust their HSA funds before reaching the deductible, they will then pay out-of-pocket. Once they reach their deductible, insurance pays all remaining costs. The advantage of insurance only covering the highest costs is that it makes health insurance become true insurance, not just pre-paid medical care.⁶

⁶ Health Savings Accounts Will Revolutionize American Health Care, National Center for Public Policy Analysis, Brief Analysis No. 481, January 15, 2004, p. 2.



The State of Florida has recently undertaken a major initiative to expand the use of HSAs within their state as part of their new "Affordable Healthcare for Floridians Act", which was signed by Governor Jeb Bush on June 14, 2004. Further information on HSA promotional activities within Florida is located at: <http://www.saveforyourhealth.com/>.

Employee Retirement System (ERS)

ERS offers the State of Texas Health Plan to employees and their dependants, retirees of state agencies, higher education (except UT/A&M), elected state officials, and the judiciary. Under this health plan, the state makes a one hundred percent contribution for health care for employees and retirees and a fifty percent contribution for their dependants. Under ERS' State of Texas Health Plan, \$1.5 billion in health care expenditures by the plan and \$500 million in health care expenditures by the participants in FY 2004. According to ERS, the projected FY 2004 expenditures per participant are \$3,875 total, including \$2,887 by the plan and \$988 by the participant.⁷

Under the State of Texas Health Plan, HealthSelect is a self-funded point of service plan administered by Blue Cross Blue Shield of Texas (Medical) and Medco Health Solutions (Pharmacy). 462,000 participants (ninety-two percent) are in HealthSelect. The Plan also includes five HMO's, with 42,000 total participants (eight percent) of the total ERS health plan participant population. The average age of participants is 49.9 years.⁸

⁷ Testimony submitted by Sheila Beckett, Executive Director, Employees Retirement System of Texas, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 5, March 24, 2004.

⁸ Ibid.

	SKIP					Total	Percentage
	Employees	Retirees	Dependents	Dependents	Other		
HealthSelect	179,162	61,855	199,308	15,860	5,842	462,027	91.7%
HMOs	16,407	3,152	20,099	1,980	212	41,850	8.3%
TOTAL	195,569	65,007	219,407	17,840	6,054	503,877	100%

The State of Texas Health Plan currently offers TexFlex, an FSA for health care and dependent care. There are 19,433 participants in these voluntary health care accounts, contributing a total of \$25 million. Under TexFlex there is an estimated \$23.9 million social security tax savings for the state and \$70.6 million estimated tax savings for state employees.⁹

ERS prepared two options of consumer driven health plans for FY 2005. These options provide insight into how a consumer driven health plan would look under a state plan. With Option A, ERS proposed a high deductible plan with an HRA. The state contribution to the HRA for each employee and retiree under this option would be about \$923.¹⁰

Consumer Driven Health Plan for FY05	
Option A	
High Deductible Health Plan with Health Reimbursement Account	
Assumptions:	
A. Fiscal Year 2005 appropriated funding level.	
B. Plan design for the high deductible plan (HDHP) as described below.	
C. State would continue to fund 100% of the cost of member coverage and 50% of the cost of dependent coverage under HDHP.	
D. Excess of available budget over cost of HDHP used to fund health reimbursement account (HRA) for each member. All employees and retirees receive the same HRA contribution without regard to dependent coverage.	
Determination of State Contribution to HRA: (Amounts are ALL FUNDS)	
1. Expected average enrollment for FY05 based on January 2004 enrollment (excluding surviving spouses and COBRA).	260,385
2. Projected average monthly state contribution for FY05	\$376.02
3. Available budget for FY05 ((2)*(1))	\$1,174,918,961
4. Projected state contribution for HDHP (described below) for FY04/05	\$934,621,761
5. State contribution available to fund HRA	\$240,297,220
6. FY05 state contribution to HRA for each employee and retiree - no additional contribution for dependents.	\$923
All members would be enrolled in one high deductible plan (HDHP) with the following benefits:	
A. Actives and retirees not eligible for Medicare:	
1. \$2,500 annual medical services deductible per participant, \$5,000 per family.	
2. Medical benefits payable at 70% in network, 50% out of network after deductible, subject to \$2,500 per participant, \$5,000 per family annual coinsurance maximum, then medical benefits payable at 100%. \$5 million lifetime maximum.	
3. \$350 annual prescription drug deductible per participant.	
4. Prescription drug copays of \$10/\$25/\$40, after deductible.	
B. Medicare-eligible participants:	
Benefits reduced 30% from current levels thru the use of deductibles, copays and coinsurance.	

With Option B, ERS proposed a high deductible plan with an HSA. The state contribution to the HSA for each employee and retiree under this option would be about \$1,160. This number is higher than the HRA contribution of \$923 because the HSA does not have a prescription drug plan.

9 Ibid.

10 Ibid. page 11.

Consumer Driven Health Plan for FY05	
Option B High Deductible Health Plan with Health Savings Account	
Assumptions:	
A. Fiscal Year 2005 appropriated funding level.	
B. Plan design for the high deductible plan (HDHP) as described below.	
C. State would continue to fund 100% of the cost of member coverage and 50% of the cost of dependent coverage under HDHP.	
D. Excess of available budget over cost of HDHP used to fund health savings account (HSA) for each member. All employees and retirees receive the same HSA contribution without regard to dependent coverage.	
Determination of State Contribution to HSA: (Amounts are ALL FUNDS)	
1. Expected average enrollment for FY05 based on January 2004 enrollment (excluding surviving spouses and COBRA).	260,365
2. Projected average monthly state contribution for FY05	\$276.02
3. Available budget for FY05 ((2)*(1))	<u>\$1,174,918,081</u>
4. Projected state contribution for HDHP (described below) for FY04/05	\$872,907,152
5. State contribution available to fund HSA	\$302,011,789
6. FY05 state contribution to HSA for each employee and retiree - no additional state contribution for dependents.	\$1,160
All members would be enrolled in one high deductible plan (HDHP) with the following benefits:	
A. Actives and retirees not eligible for Medicare:	
1. \$2,500 annual deductible per participant, \$5,000 per family. Deductible applicable to all services including prescription drugs.	
2. Benefits payable at 70% in network, 50% out of network after deductible, subject to \$2,500 per participant, \$5,000 per family annual coinsurance maximum, then benefits payable at 100%. \$2 million lifetime maximum. Coinsurance applies to all services.	
3. Prescription card provides discounts, but member pays 100% at time of service; may submit to claims administrator for reimbursement, subject to deductible and coinsurance.	
B. Medicare-eligible participants:	
Benefits reduced 35% from current levels thru the use of deductibles and coinsurance applicable to all services including prescription drugs.	

An HSA can be offered with a prescription drug plan. In order to do so the prescription drug benefit must be part of the high deductible plan.

Teacher Retirement System (TRS)

The TRS was established in 1937 as a program of retirement benefits for educators throughout the state of Texas. Article 16, Section 67, of the Texas Constitution charters TRS to provide retirement and related benefits for those employed by the public schools, colleges, and universities supported by the State of Texas. TRS is authorized to offer a health insurance program for active public school employees and retirees. In 2001, TRS was given the responsibility of administering a new statewide health care program for eligible public school employees and dependents called TRS-ActiveCare.

TRS-Care is retiree health care coverage program administered by TRS. TRS-Care began in 1986 with an original funding structure estimated to last about ten years. Since FY 2001, TRS-Care has operated on a pay-as-you-go basis. The funding sources for TRS-Care include:¹¹

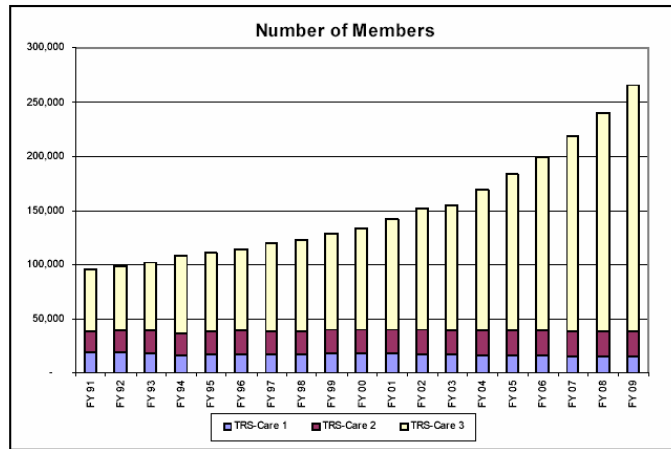
- State regular contribution: 1 percent of employee pay
- Employee contribution: 0.5 percent of pay
- District contribution (after Medicare): 0.4 percent of employee pay
- Participant premiums
- State supplemental contributions

TRS-Care includes three levels of coverage. TRS-Care 1 provides free coverage for TRS retirees without Medicare. TRS-Care 1 includes a \$4,500 annual deductible and \$9,500 annual out-of-pocket limit. TRS-Care 2 provides free coverage for TRS retirees with Medicare. TRS-Care 2 includes an annual deductible of \$1,800 and an annual out-of-pocket limit of \$6,800. Finally, the TRS-Care 3 program is available to retirees covered by Medicare. TRS-Care 3 includes a \$240 annual deductible and a \$5,240 annual out-of-pocket limit. As shown by the following graph, TRS Care has experienced a tremendous growth in enrollment and is expected to continue growing at a rapid pace.¹²

¹¹ Testimony submitted by Ronnie Jung, Executive Director, Teachers Retirement System of Texas, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 5, March 24, 2004.

¹² Ibid. Page7.

Enrollment Growth



In its presentation to the Committee, TRS identified several **cost drivers and cost containment options**:¹³

Cost Drivers	Cost Containment Options
Increase in number of retirees <small>- More retirees younger than Medicare age (15% growth in non-Medicare Care 3 retirees)</small>	Limit eligibility <small>- Specific age requirements - Service based contributions</small>
Increase in medical costs	Reduce utilization; restrict payment for certain procedures
Increase in Rx cost	Reduce utilization; limit access to or restrict payment for high cost drugs
Maintaining access and choice in managing providers	Tighten network; deeper provider discounts and reduced choices
Increased utilization due to aging population	Limit payments to certain covered procedures

TRS-ActiveCare is a health care coverage program offered by TRS to certain active school employees. TRS-ActiveCare includes three plan levels and several HMO options. TRS-ActiveCare is a self-funded, managed care program with an enrollment of 153,459 employees and 94,632 dependents. The funding to assist employees in health care coverage includes:

- District contribution: \$150/month per employee
- State funding: \$75/month per employee through school finance formula to districts
- State supplemental compensation per employee: \$500/year full-time, \$250/year part-time
- Under current structure, future increases in costs will be covered by premiums paid by school employees

¹³ Testimony submitted by Ronnie Jung, Executive Director, Teachers Retirement System of Texas, House Select Committee on State Health Care Expenditures: Subcommittee on Interim Charge 5, March 24, 2004. Page 9.

In 2003 the 78th Texas Legislature passed HB 3257, which provides for a Health Reimbursement Arrangement (HRA) program, TRS-HRAccount. TRS-HRAccount is a payment and distribution to public school employees of the state supplemental compensation for health care. The HRA account offered by TRS was to be used to pay and/or reimburse qualified health care expenses. The account has a tax deferred status and unused amounts would roll over year after year. Should the public school employee leave employment with one ISD to work at another ISD the account would follow that individual. If the public school employee leaves employment with an ISD the money will stay in the account until the employee has exhausted the funds for their health care needs.

The table below represents the savings to the public school employee by using an HRA account. For an employee that receives \$500 they would pay \$100 in taxes a year if taxed at twenty percent. Once the cost of the administrative fees are removed, the employee would see a savings of \$70.00 a year. For a part-time employee that receives \$250 they would pay \$50 in taxes a year if taxed at twenty percent. Once the cost of the administrative fees are removed from the overall savings the employee would see a savings of \$20 a year.

HRA Account Amount	Fees	Taxes Paid			Savings / (Cost)		
		15 percent	20 percent	25 percent			
\$500	\$2.50 a month/ \$30 a year	\$75	\$100	\$125	\$45	\$70	\$95
\$250	\$2.50 a month/ \$30 a year	\$37.50	\$50	\$62.50	\$7.50	\$20	\$42.50

On June 17, 2004, the Board of TRS authorized the TRS to continue the evaluation of this legislation and to temporarily suspend implementation of the TRS-HRAccount program until July 15, 2004.

On July 9, 2004, Representative Dianne White Delisi, author of HB 3257, wrote House Appropriations Committee Chairman and Legislative Budget Board (LBB) member Talmadge Heflin with the recommendation that the implementation of the TRS HRA program be delayed by having the LBB remove the funding for the program. Chairman Delisi based her recommendation upon both the higher than estimated administrative costs and the emergence of a superior health savings program option via HSAs.

On July 23, 2004, the Board of TRS approved a contract with Aetna to administer the TRS-HRA program. On August 12, 2004, Gov. Rick Perry sent a media release announcing his support for having the LBB direct that the state, not teachers, pay the administrative costs. Perry further indicated support for having the matter being brought back before the Legislature in the 2005 Regular Session.

The HRA program went into effect on September 1, 2004. However, on September 17, 2004, Speaker Tom Craddick and Lt. Gov. David Dewhurst directed the TRS to replace the school employees HRA program with a direct \$500 stipend, effectively reverting to the prior distribution system. Attorney General Greg Abbott had earlier determined that conflicts in the HRA statute allow the funding to be distributed as a cash supplement directly to teachers. Specifically, Abbott determined that the General Appropriations Act lacked specific funding for the HRA account.¹⁴

¹⁴ Letter to Ronnie Jung, Teachers Retirement System, from Lt. Governor David Dewhurst and Speaker Tom Craddick, Legislative Budget Board, September 16, 2004, page 1.

RECOMMENDATION

The State of Texas, through the ERS, should offer its employees the option of establishing an HSA, to include having readily available the required HDHP. The State of Texas should also establish to its various health care vendors that those using an HSA will be provided access to the same negotiated discounts for products and services as those state employees found within the standard benefits package.

The State of Texas should allow teachers within both the TRS-Care and TRS-ActiveCare programs to also have the option of an HSA and direct the TRS to offer a HDHP option that is compatible with an HSA. The TRS should also establish to its various health care vendors that those using an HSA will be provided access to the same negotiated discounts for products and services as those state employees found within the standard benefits package.

The State of Texas should also examine the TRS HRA program in the 79th Regular Session to determine whether the implementation of HSAs offer a more effective means of providing teachers with a tax shielded means of paying for both their health care and retirement needs.