Continuing the search for a uniquely Texas solution

Are Private Options like those in Arkansas, Indiana, Iowa, and Michigan a viable option for closing the Coverage Gap in Texas?

Benefits over Medicaid Expansion

Private option approaches offer many features that fit Texas' needs and values better than traditional Medicaid:

- **Control**- States have more control over the parameters of their private options than with traditional Medicaid expansion; private options are more flexible
- **Opt-out**– States can choose to opt out of the expansion at any time
- **Small government**– Many states find using private options appealing because they use a market-based approach; private option health plans do not have to be government-run
- **No free riders**– Private option features like premiums and cost-sharing (payments to health savings accounts or co-pays) mean everyone has a stake in their health care
- **No paying for bad behavior–** Incentives like lower premiums for those who get a health screening, and higher cost-sharing for non-emergency use of the ER mean private options can help shape health behavior
- **No starting from scratch**– Private options can build on existing state health system reforms like Texas' current 1115 Waiver

In fact, many Texans already recognize these benefits. Groups like the **Texas Hospital Association**, **Texas Impact**, and the **Texas Association of Business** have put their stamp of approval on developing a Texas-specific private option.

For example, the Texas Hospital Association's "Texas Way" plan for expansion would feature subsidies for private market insurance coverage based on ability to pay, penalties for inappropriate use of the emergency room, incentives for work, and require cost-sharing. And one of the Texas Association of Business' 2015 Legislative Priorities is to "Support a private insurance model that includes copays and a sliding scale in order to reduce the number of uninsured Texans".

Aligning our state's priorities for a private option with those of CMS may prove a challenge, but it is a challenge worth exploring as a means to reduce the high cost of caring for the uninsured that counties, hospitals, and individuals currently face. It's estimated that Texas would receive over $100 billion in funds over 10 years were the state to close the Medicaid Coverage Gap, generating an estimated $276 billion in business activity. However, failure to close the Coverage Gap is costly: Texas hospitals spent over $1.8 billion in charity care costs in 2010 alone, and cities, counties, and hospital districts spend over $2.5 billion annually in local property taxes to care for low-income, uninsured patients. By building on the successes and learning from the lessons of other states' private option models, Texas has the chance to design an option for closing the Coverage Gap in a way that is consistent with our state's values, heritage, and unique health system issues.

Sources: Cross-Call, Jesse and Solomon, Judith, "Approved demonstrations offer lessons for states seeking to expand Medicaid through waivers", Center on Budget and Policy Priorities, 2014; Hart, Patricia, "Wanted: Doctors to treat Medicaid patients", Houston Chronicle, February 9, 2013; "Jobs for Texas: 2015 Legislative Priorities," Texas Association of Business, November 2014; "Medicaid Expansion and Section 1115 Waiver Demonstrations," National Association of Community Health Centers, State Policy Report #52, March 2014; "Medicaid Expansion in Indiana", Kaiser Family Foundation, February 2015; Rudowitz, Robin, Artiga, Samantha, and Musumeci, MaryBeth, "The ACA and Medicaid Expansion Waivers", Kaiser Family Foundation, Issue Brief, February 2015; "Texas Impact 2015 Legislative Agenda," Texas Impact, available at: http://texasimpact.org/content/texas-impact-2015-legislative-agenda. "The Texas Way: A program to get Texas covered and healthy", Texas Hospital Association, October 2014.

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Eliminating the Healthcare Coverage Gap:

Finding a Path for Texas

Issue Brief 1501: Exploring the private option
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UTMB Center to Eliminate Health Disparities

Many states that have not opted to expand Medicaid under the Affordable Care Act (ACA) are choosing to eliminate their coverage gaps through a strategy known as a "private option".

With a private option, states support the purchase of private health insurance in the state's health insurance market by offering premium assistance to low-income individuals and families who would otherwise be eligible for Medicaid in expansion states.

In this issue brief, we will focus on key features of private options and lessons learned from other states should Texas choose this option.

Private option features

States choosing the private option have built on their own state-specific reforms, and they have sought approval for their option to be considered an alternative to Medicaid expansion by applying for an 1115 Waiver from the Center for Medicare and Medicaid Services (CMS). 1115 Waivers are a means by which states can make changes to their Medicaid programs with the goal of fostering innovation and reducing costs.

In some ways, States' private options are similar to traditional Medicaid, but private options also possess some special features that set them apart:

Similar	• Cost neutral (a private option can't be more expensive to CMS than Medicaid expansion) • Must offer patients the same benefits as Medicaid
Different	• Use private market insurance carriers to provide coverage • All family members can be on the same insurance plan, making it easier to coordinate their care • Individuals pay part of their premiums, and they also pay co-pays for certain services. Co-pays can be waived for participating in healthy behaviors. However, patients will not lose coverage if behavior conditions are not met • Since premium assistance can operate on a sliding scale, private options prevent "churning", where fluctuations in income cause individuals to leave and return to Medicaid, suddenly losing coverage when their income crosses above the eligibility threshold

However some special features states proposed have been rejected by CMS. For example, states cannot impose employment requirements in order to be eligible for coverage. There are also limits on co-pays.

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Exploring the private option: *Lessons from other states*

This table compares some of the features of private options approved by CMS in other states, and some of the lessons learned by these states in seeking approval for their private options.

	Number of newly eligible	Eligibility	Financing approach	Premiums and cost sharing	Special features	Lessons learned
Arkansas	Estimated 200,000 beneficiaries	All newly eligible adults with income up to 138% FPL Childless adults 0-138% FPL Parents 17-138% FPL	Premium assistance model with mandatory enrollment through private Market-place plans	Monthly contributions to health savings account take the place of cost-sharing (can't be higher than 5% of income) Premiums for beneficiaries with income 101-138% FPL (equal to ~2% income)	Limits on coverage for non -emergency medical transportation	Waiver must have clear demonstration purpose that promotes objectives of Medicaid program
Indiana	Estimated 350,000 beneficiaries	All newly eligible adults with income up to 138% FPL No retroactive eligibility	Premium assistance model with optional enrollment for adults with access to employ-er-sponsored insurance	Premiums for beneficiaries with income 101-138% FPL (equal to ~2% income); monthly health savings account con-tributions for income 0-138% FPL Coverage available starting after first premium payment (rather than on date of application); Cannot re-enroll for 6 months if dis-enrolled for unpaid premiums	Healthy behavior incentives Higher cost sharing for non-emergency use of ED Better benefits if premiums paid	Cannot have a work referral as a condition of eligibility
Iowa	Estimated 36,000 beneficiaries	All newly eligible adults with income up to 138% FPL	Premium assistance model with mandatory enrollment through private Marketplace plans	Premiums for beneficiaries with income 101-138% FPL (equal to ~2% income) 90 day grace period before unpaid premiums become collectible debt Premiums can be waived for completing healthy behav-ior activities	Healthy behavior incentives (premiums waived if healthy behaviors met) No coverage for non-emergency medical transporta-tion	Beneficiaries can't be dis-enrolled for non pay-ment of premiums
Michigan	300,000- 500,000 beneficiaries	Newly eligible adults with income 100-138% FPL (Adults 0-100% FPL en-rolled in Medicaid man-aged care)	Individuals receive coverage through Michigan's existing network of managed care organizations	Premiums for beneficiaries with income 101-138% FPL (equal to ~2% income) Payment of premiums not a condition of eligibility Cost-sharing into health savings accounts; amounts based on past 6 mos. of co-pays	Healthy behavior incentives (cost-sharing reduced if healthy behaviors met)	CMS must approve a sepa-rate protocol to implement a healthy behavior pro-gram (e.g. to specify health behaviors, measurement criteria, etc.)

Other states are also pursuing private options and awaiting approval by CMS, including New Hampshire and Utah. Still others are contemplating a policy shift from non expansion to private option. There is no deadline for Medicaid expansion.

Data sources: Cross-Call and Solomon (2014); National Association of Community Health Centers (2014); Kaiser Family Foundation (2015); Rudowitz, Artiga, and Musumeci (2015)