

**MAKING AN IMPACT:
REFORMING HEALTH CARE SERVICES
IN TEXAS**



**TEXAS CONSERVATIVE COALITION RESEARCH INSTITUTE
LIFT Task Force on Health and Human Services**

February 2001

TEXAS CONSERVATIVE COALITION RESEARCH INSTITUTE

February 7, 2001

Dear Friends:

After the 76th Legislative Session, the Texas Conservative Coalition Research Institute formed a Task Force to study a variety of health issues. One of the Task Force's primary goals was to provide a resource containing detailed, concise information about health care issues as well as the Task Force's recommendations for effective reform.

It is our hope that the content of the *Making an Impact: Reforming Health Care Services in Texas* enables you to understand, in depth, the many issues facing health care in Texas. We believe you will find this report helpful.

We would like to extend our thanks to those dedicated supporters who have made this effort possible. We look forward to continuing efforts in this important public policy issue.

Sincerely,

Warren Chisum
President, TCCRI

Making An Impact: Reforming Health Care Services in Texas

Texas Conservative Coalition Research Institute Report of the LIFT Task Force on Health and Human Services February 2001

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With Much Appreciation

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DISCLAIMER

The contents of this manual do not reflect the views of any one individual. Due to the diversity of the task force participants there may be some policy issues or recommendations that individual task force members will be unable to support. We recognize and respect their positions and greatly appreciate the work of everyone involved with the Task Force.

Executive Summary

During the last ten years, Texas' spending on health and human services has nearly tripled; however, in that same period of time, the number of people in Texas without health insurance has risen. If current population trends continue and fundamental changes are not made in how health and human services are delivered in Texas, the state will face the stark choice of raising taxes to continue funding an inefficient system or cutting other areas of spending in the budget to fund such growth. Fortunately, Texans may not have to face these choices if we, as a State, decide to focus on spending health care dollars more efficiently through innovative reform.

Unfortunately, health care policy today simply invites everyone to build a better mouse trap. Much of the effort focuses on modifying the system or, worse yet, simply creating or expanding a government program to address current needs. This is not to dismiss the efforts of many policy makers to improve the health and quality of life. It is, however, a realization that real solutions will demand more focus and a long-term perspective. Policy makers must first acknowledge and then craft a health care system that recognizes the individual primarily responsible for his health. In practical terms, this means fortifying not only the patient-doctor relationship as it relates to care, but also re-instituting the patient-provider relationship as it relates to payment. This does not, however, suggest an end to private or public insurance. Rather, it implies designing a system that encourages better health outcomes through the use of financial incentives like medical savings accounts (MSAs), co-payments, deductibles, experience rebates, discounts, etc. Ultimately, policy makers must seriously heed the call to not only satisfy an immediate concern but to also address the more complicated issue of designing a system that improves people's health.

The Texas Conservative Coalition Research Institute LIFT Task Force on Health & Human Services was formed after the 76th Legislative Session to study a variety of health issues. The purpose of the Task Force is to study health issues from a conservative perspective with the goal of providing free market, limited government solutions. Such an undertaking is necessary as the health care field is becoming increasingly funded and controlled by the government. It is the position of the Task Force that government funded health care not only conflicts with the principle of limited government, but also produces a system of health care delivery that is inefficient, overly-regulated, rationed, and delivers poorer health outcomes.

The Task Force enters the health care debate knowing that major reform of the health care system is a time consuming process and that the Task Force must also look for solutions to current health care problems within the framework of today's system. While free market solutions are ideal, the Task Force also labored to develop policy initiatives to improve programs such as Medicaid and CHIP, which are government subsidized programs. Essentially, the Task Force is committed to finding affirmative, long-lasting answers to health care needs.

The Task Force studied numerous topics during its meetings, including:

- Health care expenditures in Texas
- Demographics in Texas
- Uninsured Texans
- Medicaid
- CHIP
- Transitional benefits
- Federal tax and policy issues
- Privacy
- Fraud
- Hospitals in Texas
- Indigent care
- Rural health
- Medical personnel
- Pharmaceuticals
- Disease management
- Employer health plans
- Insurance mandates
- Nursing homes

While this list is not complete, it indicates the breadth of material studied by the Task Force. The following is a summary of the findings of the Task Force.

Overview

Health and human services is an important issue in Texas for a variety of reasons. For starters, health and human services is the second largest budget item in the state at over \$27 billion for the 2000-01 biennium, and that number is quickly growing. The health and human services budget has increased by over 250% during the last decade.¹ The majority of the state's surplus, at least \$600 million, will be used to cover cost overruns in health and human services.² Efforts to expand the state's Medicaid program could increase the state's cost to \$20 billion a year. Texas

¹Texas Comptroller of Public Accounts. Texas Expenditure History by Function, 1978-2000.

²Testimony of Texas Health and Human Services Commissioner Don Gilbert to the House Committee on Appropriations. January 24, 2001.

has one of the highest rates of people without health insurance, as nearly one in four Texans under the age of 65 does not have health insurance on any given day. Increased demands for health and human services funding means that funds needed for other priorities like teacher health insurance, pay raises for state employees, grants for higher education, transportation, border infrastructure, reducing waiting list for services to the disabled, and taxpayer returns are all jeopardized. The changing demographics in Texas, both age and ethnic, demand that Texas reassess priorities for health and human services funding. The large increases in health care expenditures have not produced better health outcomes or reduced the number of uninsured. Almost half of the children born in Texas are delivered courtesy of Medicaid.³ These are among the reasons that health and human services is such an important issue.

While fundamental reform of the health care system is important, it is also a long, arduous process. Short-term solutions are needed as well. The nursing home crisis in Texas, for instance, will require immediate attention from the Legislature.

Health and Human Services Spending

Health and human services spending represents almost 30% of the state budget⁴. Almost all of this spending is driven by Medicaid. Medicaid is a state -federal program that provides funding for long-term care services and health insurance to low-income people. Because Medicaid is the major component of health and human services spending, the Task Force dedicated a significant amount of time towards studying the implications of the explosive growth's potentially dire consequences for state budget planners.

Out of the \$27 billion spent on health and human services, Medicaid accounts for \$20 billion.⁵ Additionally, the majority of the state's budget surplus, at least \$600 million, will be used to fund cost overruns in Medicaid. As the state attempts to deal with the overruns, efforts to expand Medicaid are being made that will cost at least \$1 billion.⁶ Since Medicaid is an entitlement program, the state cannot limit the number of eligible enrolled or the amount of money spent on services. This further adds to the budget uncertainty. Expanding Medicaid eligibility will result in one of two possibilities. Either the state must increase taxes to raise more revenue or the state must ignore other funding priorities.

³Texas Medicaid in Perspective. Texas Health and Human Services Commission. February 1999.

⁴Texas Expenditure History by Function.

⁵Texas Fiscal Size Up. Legislative Budget Board. January 2000.

⁶Cost-Outs of Medicaid Eligibility Simplification. Legislative Budget Board. April 2000.

One of the reasons Medicaid is so costly is the exorbitant package of benefits it offers. The Task Force heard testimony from insurers indicating that a health plan providing the benefits of Medicaid is not offered on the market because the cost of such a package would be so large that no one would purchase it. Much like the pre-reform welfare system, Medicaid offers little incentive to leave government dependence.

One of the fallacies associated with health and human services spending is that the state can either spend more to provide more, or it can spend less and provide less. In fact, Texas can spend more efficiently. Texas can avoid expansion of entitlement programs in favor of subsidizing private insurance, shape Medicaid to mirror private market benefit options, focus on the chronic illnesses that account for a large percentage of health costs, and fund health and human services based upon improved health outcomes.

One of the policy recommendations of the Task Force is to expand the use of the Health Insurance Premium Payment System (HIPPS). This program allows the state to use funds to subsidize, rather than replace, private insurance. Other recommendations of the Task Force include a resolution to the United States Congress encouraging them to block grant Medicaid funds to the state.

Demographics

Health and human services is also important because Texas must prepare now for its future. The number of elderly people in Texas is expected to double during the next thirty years. While the elderly make up a relatively small percentage of the current population in Texas, they are the major consumer of health care services. Within the Medicaid program, the elderly and disabled represent less than one quarter of enrollees, but account for nearly two-thirds of the Medicaid expenditures.⁷ The elderly are also living longer today thanks to advances in medical technology and research that is being driven by the private sector with significant funding from the federal government. The combination of a rapidly expanding senior population, increased life expectancy, and disproportionate use of health services going to the elderly demands that Texas give priority to developing a plan to deliver long-term care services.

Texas must, as a first step, deal with the nursing home crisis in Texas. As almost half of the elderly will spend some time in a nursing home, it is vital that Texas ensure a stable, high quality nursing home industry. While Texas has stringent accountability and regulation of nursing homes, it offers among the lowest reimbursement rates in the nation. Furthermore, litigation in Texas is a problem for nursing homes; the average lawsuit award against a nursing home in Texas is more than four times the national average. This has also affected the ability of nursing homes to attain liability insurance, exacerbating an already difficult situation.

Among the Task Force recommendations are increased nursing home funding, tort reform to limit the amount of punitive damages that can be recovered while still recognizing the frailty of the elderly and the need to protect them from bad actors, and finally a method of reimbursing nursing homes that funds based upon performance and health outcomes.

The Safety Net

⁷Texas Medicaid in Perspective.

Texas spends a large portion of its budget to ensure that the poor and medically indigent receive health care. In addition to Medicaid funding and CHIP, hospitals and counties in Texas spend almost \$5 billion a year in charity care.

Spending, however, does not always equal results. One of the unanimous opinions expressed by Task Force members was the need to provide some type of safety net to the indigent. The current system has provided health care, but it is inefficient, costly, and has not produced better health outcomes for the participants. As mentioned earlier, despite tripling Texas' health and human services budget, the state has not reduced the number of uninsured.⁸ During the same time period in Texas, rates of sexually transmitted diseases, diabetes, asthma, low-birth weight infants and other diseases have actually increased.⁹ Health insurance, private or public, does not equate to health care or good health.

Increased provision of government health insurance has exerted many pressures on the health care system and created administrative problems for many providers. While the Legislature has many powers, it cannot eliminate the law of supply and demand. Health care is a commodity. When government intercedes to provide free health care it creates increased demand and a shortage of supply. The inevitable result is the rationing of health care such as is commonly experienced in European nations, including Great Britain. Rationing can take the form of increased costs or decreased quality, but without an infinite and unlimited supply of money it will be rationed. Additional attempts to control costs have produced managed care, where costs take precedent over care.

It is easy to decry the use of government health insurance or claim that the safety net is not effective. The current system, however, was created to address very real problems that need solutions. What is the right way to reform the safety net? Much like the federal government needs to allow states flexibility, states need to allow local communities flexibility. The state can do this by allowing communities flexibility in administering government programs such as Medicaid and CHIP. Additionally, the safety net should exist to plug holes, not to designate the government as the provider of health care.

Among the recommendations of the Task Force is the need to petition Congress to provide Medicaid funds to the state as a block grant. This would give the states flexibility in designing their programs while also assuring that funds are used to provide health care to the poor and medically indigent.

Conclusion

⁸Demographic Profile of the Texas Population Without Health Insurance Coverage. Texas Health and Human Services Commission. May 2000.

⁹Testimony of Texas Department of Health staff to LIFT Task Force. May 2000.

Delivery of health and human services is vital to the wellbeing of the citizens of Texas. Yet it is most important because a person's health and well being, in many ways, defines the quality of their lives and their hopes for the future.

Many of the Task Force recommendations are focused on long-term solutions, but others recognize the importance of dealing within the system as it is structured today. The state faces the very real possibility of a funding crisis for health and human services in Texas. While such funding issues are potentially dangerous, they also offer an opportunity for policy makers to implement true reform. It is a fundamental principle of the Task Force that government does not exist to provide all health services to all people. Much of the reform needed in health and human services entails redefining government funded health care as a true safety net, not as an entitlement to every citizen, many of whom receive adequate to excellent care through private alternatives.

This may seem like a daunting task. However, the recent example of welfare reform serves as a beacon. Through bi-partisanship and discussion, Congress and the states successfully reformed welfare to serve as a transitional support system rather than a way of life. Using this model, Texas should take the lead in reforming health care to deliver services where needed while recognizing that the best health care system is delivered by the private sector with government filling in the gaps, not the other way around.

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Health Insurance Mandates & Issues

Introduction

As the number of people living without health insurance remains high across the country, policymakers struggle to understand the underlying issues relating to health insurance such as individual behavior, tax policy, health insurance premium cost, employment, and utilization.

When examining the cost of health insurance, significant discussion has centered on the issue of health insurance mandates. Though the definition may vary, mandates usually take the form of a law that guarantees certain health benefits under an insurance policy. Some claim that these mandates are necessary to deliver on the promise of health insurance and guarantee that people receive the kind of coverage they need and would otherwise not receive. The counter argument is that these mandates impose costs upon employers and that, ultimately, employees pay for these additional benefits through reduced wages or loss of coverage altogether.

Past studies of insurance mandates offer no definitive conclusions. For example, the Texas Department of Insurance (TDI) recently determined that a cost analysis of the same mandate by two different firms produced a variance of nearly 500%¹⁰.

Data collection also complicates analysis. Measuring the benefit of a mandate is very difficult. Accurate analysis requires that utilization be monitored over a number of years. Regardless, the imposition of a mandate does not account for the effect it may have on employers to not offer insurance. Effect on employers that do not offer health insurance is especially important for Texas due to the very large number of small employers. Finally, any discussion of health insurance mandates requires a general knowledge of the two major federal laws effecting health insurance issuance and administration- the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

A Brief History of Health Insurance Mandates

Employers have used health insurance benefits as a tool to attract employees since World War II. Because of price and wage controls enacted during the War, employers used the lure of health

¹⁰Health Insurance Regulation in Texas: The Impact of Mandated Health Benefits. Texas Department of Insurance. Report to the Texas Legislature. December, 1998. p 25.

insurance as a recruiting tool. As employer based health benefits have become more common, state legislatures have become more involved in regulating health care plans. The following passage offers some insight:

States subsequently became more conscious of the cost of health care as they took on the role of a major provider of health care services under Medicaid. As the cost of Medicaid gradually increased, concern over the uninsured also grew. Within a few years, state lawmakers began enacting the first mandated benefit requirements in an effort to expand availability of health insurance and the scope of services provided.¹¹

Whether one opposes or supports mandates, it is clear that during the last 35 years the number of health insurance mandates has increased significantly. In fact, since the early 1980's state governments have considered over 1000 mandates and have passed upwards of 800.¹² Texas, depending upon which source is consulted, has anywhere from 20 to 63 mandates on the books. Depending upon the source, individual mandates drive up the cost of premiums anywhere from less than 1% to over 20%. As the percentage of people without insurance has increased, many states have reviewed their process for imposing mandates to determine their cost effectiveness. In Texas, the Joint Committee on Health Benefit Mandates has met during the past interim to consider the issue.

ERISA

The Employee Retirement Income Security Act, or ERISA was passed in 1974 to regulate the administration of employee benefit plans. ERISA effectively prevents states from regulating self-funded employer health plans of large multi-state corporations while allowing states to regulate health insurance plans sold in the state. While it prevents states from regulating self-funded employer plans, ERISA does impose its own requirements upon such plans. These requirements include:

- Providing information on the plan to the Department of Labor;
- Requirements that participants have access to information about the plan;
- Fund management requirements;
- Procedural requirements (like an appeal process for denied claims);¹³

¹¹*Ibid.* p 14.

¹²Report on the Cost of Health Care System Mandates. J. Allen Seward & James W. Henderson. Baylor University. January, 1999.

¹³Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA. United States General Accounting Office. July 1995.

The protections provided by ERISA, however, relate to the administration of a plan by an employer rather than the benefits that are provided. ERISA offers some major benefits to employers. Plans that are self-funded, and therefore covered under ERISA, are not subject to state premium taxes or high risk pool assessments. ERISA also offers employers substantial protection from lawsuits. While an individual may bring a lawsuit against an employer forward, the potential for success in such lawsuits rarely merits moving forward, and the limitation on recovery of punitive damages is a further deterrent.

While many consumer advocates and state lawmakers have expressed frustration over ERISA preemption, the statistical evidence suggests that most self-insured plans covered under ERISA provide most of the benefits mandated by states.¹⁴ Furthermore, a survey of employers in Texas revealed that very few choose to self-fund in an attempt to avoid mandates (less than 15%) and that most chose to self-fund because of the premium savings, freedom in plan design, and lower administrative costs.¹⁵ One of the problems under the current system is that the involvement of the courts has produced a multitude of decisions that have “muddied” the water. As noted in a recent United States General Accounting Office (GAO) report, “distinguishing between self-funded and fully insured plans is growing more difficult as the health market changes.”¹⁶

¹⁴Health Insurance Regulation in Texas: The Impact of Mandated Health Benefits. Texas Department of Insurance. Report to the Texas Legislature. December, 1998.

¹⁵*Ibid.* P. 45.

¹⁶Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA. United States General Accounting Office. July 1995.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) “sets standards for access, portability, and renewability that apply to group coverage- both fully insured and self-funded- as well as to individual coverage.”¹⁷ Some of the features of HIPAA:

- Provides people losing group coverage the right to guaranteed access to coverage in the individual market regardless of health status;
- Does not permit issuers to cancel coverage of individuals once they become eligible for Medicare;
- Requires that all insurance carriers sell any of their small employer plans to a small employer that applies. Does not extend this provision to the large group or individual markets;
- Requires that certain individuals leaving group coverage be guaranteed access to coverage in the individual market. No similar guarantee for those in the individual market who may lose it in the future;
- Requires all issuers who operate in the individual market to offer eligible individuals at least two health plans;
- Grants states the ability to use high risk pools and other means to ensure guaranteed access.¹⁸

In 1997, the Texas Legislature passed legislation in order to conform with the requirements of HIPAA. Texas now provides for guaranteed issue and guaranteed renewability of small employer plans. Small employers are defined as those companies with 2-50 employees. Additionally, all health plans in Texas must limit exclusions based upon pre-existing health conditions to 12 months.¹⁹ Texas also created the Texas Health Insurance Risk Pool in 1997. The Risk Pool is intended to provide health coverage to certain individuals who are considered to be “medically uninsurable” or those who are guaranteed coverage under the portability requirements in HIPAA.

¹⁷Health Insurance Standards: New federal Law Creates Challenges for Consumers, Insurers, Regulators. United States General Accounting Office. February 1998.

¹⁸*Ibid.* P. 2-4, 6. Listed provisions are direct quotes from the GAO report.

¹⁹Information Provided to the Blue Ribbon Task Force on Uninsured Texans. Texas Department of Insurance. December, 1999. P.3.

To be eligible for coverage under the Risk Pool an individual must provide:

- 1) a notice of rejection or refusal to issue substantially similar insurance for health by one insurer;
- 2) a certification from an agent that states that the agent is unable to obtain substantially similar insurance;
- 3) an offer to issue substantially similar insurance only with conditional riders;
- 4) a refusal to issue substantially similar insurance except at a rate exceeding the pool rate;
- 5) evidence of the individual's maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days;
- 6) diagnosis of certain conditions (cancer, diabetes, AIDS, etc.).²⁰

Premiums for the Risk Pool may not exceed 200% of the cost of similar health coverage. Since the premiums are controlled and may not cover the cost of insuring participants, the Risk Pool is also funded through annual assessments on insurers and HMO's. According to TDI, the pool had approximately 7,000 participants as of December 1, 1999.²¹

Health Insurance Mandates in Texas

Mandates in Texas generally fall under three categories:

- 1) mandates that require coverage for certain illnesses, procedures, or treatments (e.g.-

²⁰Texas Statutes. Insurance Code. Chapter Three- Life, Health, and Accident Insurance. Art. 3.77 Texas Health Insurance Risk Pool. Sec. 10(a)(1-6)

²¹Information Provided to the Blue Ribbon Task Force on Uninsured Texans. Texas Department of Insurance. December, 1999. P. 11.

mammography);

2) mandates that require coverage of certain persons (e.g.- adopted children)

3) mandates that require coverage of certain providers (e.g. chemical dependency treatment providers).

According to TDI, there are about 30 mandates in Texas. Most of these cover the first type of mandate listed above, those that apply to certain treatments and illnesses.

However, “the number of mandates increase to over 57 if the practitioners’ mandate(s) is/are viewed as 18 instead of one.”²² This, again, reveals that much of the debate surrounding the cost of mandates is based upon methodology and which definition of the term mandate one chooses to use. A recent report issued by Baylor University professors J. Allen Seward and James Henderson found that “Texas mandates concerning only mammography, complications of pregnancy, contraceptive services, coverage of newborn and handicapped children, and chemical dependency have been estimated to add slightly more than 17% to the cost of premiums.”²³ The report also concludes that as a direct result of the cost increases associated with mandates, approximately 275,000 Texans have become uninsured, and that 18% of Texas firms have chosen to self-insure.

A separate study by the actuarial firm of Milliman & Robertson Inc., commissioned by TDI, found that a total of thirteen mandates would raise premiums anywhere from 15-30%.²⁴ Other major findings of the Milliman & Robertson report include:

- If the mandates did not exist, a large majority of small and large group insurance plans would still cover the benefits at some level.
- The treatments associated with many of the mandated benefits are expected to result in fewer sick days and lower disability benefits for the employer.
- The elimination of the mandates studied would probably have an insignificant impact on the number of uninsured in Texas. This is because the number of uninsured appears to be as dependent, if not more dependent, on the income and/or available resources of individuals and/or employers than it is on the cost of health care. On the other hand, each incremental cost increase due to additional mandates may drive some employers to

²²J. Allen Seward & James W. Henderson. P.25-26.

²³*Ibid.* P. 5.

²⁴Cost Impact Study of Mandated Benefits in Texas: Report #1. Susan K. Albee, et al. July 21, 2000. Texas Department of Insurance.

choose not to offer coverage.

- Most of the rate differences expected between the Basic and Catastrophic and market plans are due to cost sharing differences (deductible and coinsurance percentages) rather than the removal of mandated benefits.

Small Employer Plans

One important aspect of health mandates is the different impact they have upon small and large employers. Large employers are better able to deal with new mandates because of the existing infrastructure they have and the larger pool to which they will spread costs. In recognition of this fact, Texas and more than 40 other states have passed legislation to make health insurance more affordable and easier to manage for small employers.

Texas allows small employers to purchase plans that exclude many of the mandated benefits. Unfortunately, those plans, according to TDI statistical and survey information, are not widely utilized. In 1998, for example, only 25 of the reduced benefit plans were sold in Texas.²⁵ While this should not be taken to mean that these plans are bad public policy, it is certainly worth noting that the number of plans sold is so low. One of the reasons mentioned by a number of Task Force members for the poor performance of the reduced benefit plans is that insurers and insurance agents have little incentive to sell such plans.

Cost/Benefit Analysis

Some states have chosen to review their policies with respect to health insurance mandates. Many states, Texas included, have considered legislation that would require a cost/benefit analysis to be performed before a mandate was introduced into law. A cost/benefit analysis would measure the costs imposed by the mandate versus the benefit supplied by it. As is the case throughout, this process can be as much art as it is science. Cost/benefit is an important part of any debate on public policy. The integrity of the data is paramount. While a mandate may impose a small increase in premiums, small percentages can mean the difference between \$50 and \$100 co-pays. Similarly, any discussion of cost/benefit must aim to measure the long term benefits provided. While the imposition of a mandate to cover mammographies may impose a cost, the benefit of detection must be considered.

²⁵Information Provided to the Blue Ribbon Task Force on Uninsured Texans. Texas Department of Insurance. December, 1999. p. 4.

CONCLUSION

Health is a very personal issue that is not easily addressed in the maelstrom of emotional and political rhetoric. Moreover, principles of limited government and free market often are discarded or impugned in deference to an overriding sense of fairness and sympathy.

No one disputes that utilization of benefits is a major driver of costs within the health care system. Disagreement does, however, exist when attempting to determine the cost of government imposed health benefit mandates. Most policymakers have adopted a utilitarian approach to health care benefits. In essence, policymakers want to understand the benefit before passing along the cost.

Premium costs also impact an individual and an employer's ability to afford health insurance. Ultimately, as premiums rise, the number of people without insurance also rises, which places enormous strain on the entire health care system.

While the cost of individual mandates may be small, the total cost imposed by mandates as a whole can be quite large. A small increase in premium can make a large difference in the required contribution of individuals to their health care. Though the Milliman and Robertson report found that mandates may increase premiums by 15-30%, for a small employer with 50 workers that could add \$40,000 to \$70,000 a year to the cost of coverage. Furthermore, it is impossible to determine how many employers do not offer health insurance coverage as a result of mandated benefits.

While mandates do drive up the cost of providing health insurance, much of the research suggests that individual mandates are not large cost drivers and that their impact on the number of covered individuals is small. Any cost/benefit analysis on mandates must also account for long-term savings as a result of detection and treatment. Development of a screening mechanism that will analyze the cost imposed by health mandates, the number of people projected to be served under the mandate, the benefit provided by the mandate, and the effect any new mandate would have upon the number of uninsured Texans should be incorporated into any proposal to impose new mandates.

LIFT Task Force Recommendations

- The Texas Legislature should require that before any health benefit mandate is passed a cost-benefit analysis of the mandate must be performed. The analysis should consider how the mandate would effect the cost of health insurance coverage in the state, the number of people anticipated to receive services covered by the mandate, the effect the mandate will have on the number of uninsured people in the state, and the effect the mandate will have on the overall health status of residents of the state.
- The Legislature should allow small employers to offer a “mandate free” policy to employees.
- The Legislature should require future health benefit mandates to be reviewed after a six-year period.

Long-Term Care Issues

Introduction

Texas' population is getting older. To be more precise, the number of Texans over the age of 65 is expected to increase from approximately 2 million right now to over 4 million by the year 2025. In addition to the fact that the elderly population is growing, public policy must evolve to accommodate longer life spans and increased mobility by many seniors. While Medicare will provide some basic coverage for the elderly population, it is not the catch all coverage that many people believe it is. Medicare, in fact, pays for very little of the long-term care in Texas. The majority of long-term nursing home care in Texas is paid for by Medicaid.

While the sheer growth of the aging population is an issue that requires preparation for the future, the current status of the nursing home industry in Texas is reaching crisis level right now. Nursing homes in Texas are filing for bankruptcy at an alarming rate. Unable to obtain affordable liability insurance, receiving among the lowest Medicaid reimbursement rates in the nation, and unable to hire quality staff, the industry is truly in crisis. Some corrective actions will have to be passed during the 77th Legislative Session if the nursing home industry is to survive in Texas. Texas must also look at the alternatives to traditional long-term care, such as assisted living facilities, home health care, and community models such as the Program for All-Inclusive Care for the Elderly (PACE) program in El Paso.

The Demographics of Aging

The statistics bear out this aging trend:

- The number of Texans age 65 and older is expected to increase from 1.9 million in 1996 to over 4.2 million by 2025.
- The number of Texans 65 or older made up 10% of the Texas population in 1990 and will represent a full 17% of the population in 2030.
- The number of Texans age 85 or older will double between 2000 and 2010.
- Nearly 43% of the elderly in Texas will enter a nursing home before they die.
- While the elderly account for only 12% of Medicaid recipients in Texas, they account for 30% of Medicaid expenditures.

The impact these changes will have on the quality of life for our seniors and the health care budget in Texas could be immense. While the elderly population is increasing and living longer, it should also be noted that many elderly are aging gracefully. Thanks to advances in medical technology, pharmaceuticals, public health, and lifestyle decisions (smoking cessation, increased physical activity, etc.), the elderly are enjoying better health status today as compared to just two

decades ago. Despite these improvements, it is estimated that nearly half of the elderly population will spend at least some time in a nursing home.

Medicare

Medicare is a government-funded federal health insurance program that covers nearly all Americans over the age of 65. Unlike Medicaid, the state has no financial or administrative duties; it is an entirely federal program. Medicare is a two-part program that provides basic hospital insurance (Part A) for those over the age of 65 at no cost (to them) based upon qualifications similar to those of Social Security (tax contributions and number of years in the workforce). While almost all seniors qualify for this basic coverage, those who do not are able to purchase it. The second part of Medicare (Part B) covers more basic health care costs, like physician visits, for a small monthly premium. Premiums finance about 30% of Medicare Part B, while the other 70% is financed by the federal government through tax revenue.²⁶ While Medicare provides some basic health insurance for seniors, it does not provide much in the way of long-term care. Medicare limits long term care, such as nursing home care, to 100 days for each incident that requires the service.²⁷ Medicare, as was highlighted during the presidential campaign, does not cover prescription drugs. Medicaid then becomes the major provider for long-term care, and many seniors purchase “Medigap” plans to help cover prescription drugs and other costs.

Medicaid

In Texas, Medicaid pays for about 70% of all nursing home care in Texas.²⁸ This represents over 65,000 seniors living in nursing homes throughout the state and over \$1.3 billion in expenditures on nursing home care.²⁹ Medicaid is a state- federal program, providing health insurance and funding for long-term care health services primarily to low income elderly and disabled individuals.

²⁶Texas Medicaid in Perspective. Third Edition. Texas Health and Human Services Commission. February 1999. P. 11.

²⁷Available at <http://www.hcfa.gov/medicare/medicare.htm>

²⁸Texas Medicaid in Perspective. Third Edition. Texas Health and Human Services Commission. February 1999. P. 63.

²⁹ *Ibid.* P. 82.

Eligibility for Medicaid coverage in nursing facilities is set at 223% of federal poverty (FPL). That means that elderly or disabled individuals with incomes up to \$18,620 are eligible for nursing home care, although most of their income must go towards payment of the nursing home.³⁰ Because the elderly population in Texas is so dependent upon Medicaid to pay for nursing home care, the implications of the growing and longer living elderly population are obvious. It is estimated that nursing home care paid for by Medicaid could reach upwards of \$8.7 billion by 2030.³¹

Nursing Homes in Texas

Nursing homes in Texas are currently in grave financial condition. Increased litigation, low reimbursement rates, dramatic cuts in federal Medicare reimbursement, and poor management have all contributed to the nearly 25% of nursing homes in Texas filing for bankruptcy at the time of this report.³² This situation has the potential for disaster, unless corrective measures are taken by the Texas Legislature. The following is a brief overview of the issues affecting nursing homes in Texas.³³

Reimbursement Rates

Although Texas has a lower cost of living and significantly lower tax burden than other states, the state still ranks 45th in reimbursement rates for nursing homes. Compounded with a tight labor market, the pressure on nursing homes is enormous. According to the Texas Health Care Association (THCA), Texas' Medicaid reimbursement rate for nursing homes is \$81 per resident per day, while the national average is over \$100 per day per resident.³⁴ While many lawmakers realize that the reimbursement rates are inadequate, many feel that it is vital that any increase in the reimbursement rate be tied directly to quality of care initiatives.

During the 76th Legislative Session, the Appropriations bill featured a rider which allocated

³⁰ Texas Medicaid in Perspective. Third Edition. Texas Health and Human Services Commission. February 1999. P. 16.

³¹ The Graying of Texas. Editorial from *The Dallas Morning News*. July 5, 1999.

³² House Committee on Human Services- Interim Report to the 77th Texas Legislature. October 2000. P. 23.

³³ For a more comprehensive look at the issues, please reference the above mentioned House Committee on Human Services Interim Report.

³⁴ House Committee on Human Services- Interim Report to the 77th Texas Legislature. October 2000. P. 27.

additional monies (about \$50 million) to nursing homes based upon their ability to provide additional direct care staffing.³⁵ While these additional monies are welcome, many within the nursing home industry say it is inadequate to address staffing problems. Furthermore, statistical evidence obtained by the Texas Health & Human Services Commission shows that the link between nursing home deficiencies and the staff to resident ratio is inconclusive.³⁶

Also affecting the financial viability of Texas nursing homes are the Medicare cuts that were passed as a result of the Balanced Budget Act of 1997. For a more complete discussion of this issue, please reference the House Committee on Human Services Interim Committee Report to the 77th Texas Legislature.

³⁵76th Legislature. House Bill 1 (Appropriations bill).

³⁶Meeting with HHSC Commissioner Don Gilbert. December 19, 2000.

Staffing

Although staffing is certainly tied to the reimbursement issue, there are a number of other issues affecting staffing. Texas' prosperous economy has had a negative effect on the nursing home industry. Nursing homes, especially in certain areas, are competing for direct care staff with any number of industries. Many nursing home staffers have the option to leave for higher paying jobs with less work, less stress, and more appreciation.

According to THCA, the turnover rate for direct care staff in nursing homes is over 150%.³⁷ While the Legislature attempted to deal with some of the staffing issues through some incentives for direct staffing, this may not solve the problems for some institutions where inadequate staffing is as much a supply issue as it is a result of low pay. Many nursing homes would be better served if they could use direct staffing funds to hire one high quality worker, as opposed to two less skilled workers.

Liability Insurance

Perhaps the most obvious indicator of the crisis facing nursing homes is the skyrocketing liability insurance rates and diminished access that nursing homes face. At a July, 2000, LIFT Task Force meeting, Texas Department of Insurance (TDI) staff revealed to the Task Force that they were aware of only three insurance companies in the state that were writing liability insurance policies for nursing homes. This was down from at least eight companies just four years before.³⁸ At the same meeting, nursing home representatives reported that liability insurance rates for its members had tripled in the past two years to almost \$2,000 a bed and that some companies were reporting increases of up to 1000%. While nursing homes may choose to operate without liability insurance, the risk of one lawsuit shutting a home down is a reality. Although TDI has recently taken steps to allow for-profit nursing homes to obtain insurance through the Joint Underwriting Association (JUA), this measure will do little to affect the cost concerns. Many believe that explosion in liability insurance rates is a direct result of an increase in litigation.

³⁷House Committee on Human Services- Interim Report to the 77th Texas Legislature. October 2000. P. 28.

³⁸ *Ibid.* P. 29.

Litigation

A simple analysis of advertising patterns and DHS survey reports yield some insight about the wave of litigation engulfing the nursing home industry- a targeted attempt by plaintiff attorneys to capitalize on the poor management and frail population served by the nursing industry. Senate Bill 190, passed during the 75th Legislative Session, enacted many nursing home regulations. Among the regulations was a change in the nature and availability of the survey reports used by the Texas Department of Human Services (DHS) to monitor and regulate nursing homes. The increased use of survey reports in civil lawsuits was cited by TDI as one of the major reasons for the liability insurance crisis facing nursing homes.

Furthermore, the Texas Legislature chose not to cap the amount of punitive damages that could be recovered for violations committed against the elderly. As a result, “the average amount of a claim paid in Texas is \$230,000 compared to a national average of \$47,900.”³⁹ Because there is no limit to the damages, the number of insurance companies willing to write policies in Texas is few.

Poor Management

The nursing home bankruptcy crisis is not confined to Texas; it is nationwide. Many of the nursing homes in Texas are owned by national chains experiencing many of the same problems in other states. A recent Dallas Morning News article wrote about the problems of one such company, Integrated Health Services (IHS), and its slightly overpaid CEO, Dr. Robert Elkins. “In 1999, *Forbes* magazine named him the nation’s most overpaid executive for earning \$44 million in five years while his Maryland-based company headed for bankruptcy.”⁴⁰ Also noted by many experts is the trend of many private pay nursing home residents, whom nursing homes count on to make up for Medicaid patients, are leaving for assisted living facilities which have grown immensely in the last 5 years.⁴¹

³⁹*Ibid.* P. 33.

⁴⁰“*Nursing Home Crisis Escalating*”. Kendall Anderson and Gayle Reaves. Dallas Morning News. December 3, 2000.

⁴¹Merrill Matthews, LIFT Task Force meeting. July, 2000.

Long-Term Care Insurance

As the number of elderly grow and life expectancy increases, the need for quality, affordable long-term care will increase. Although public programs such as Medicare and Medicaid contribute to the cost of long-term care, many people mistakenly believe that they offer benefits that, in reality, they do not. The average cost of nursing home care is approximately \$55,000 per year.⁴² As mentioned earlier, Medicaid pays about 70% of nursing homes costs. This does not account for the many “hidden costs” of long term care as nearly “60 percent of the disabled elderly living in the community rely exclusively on their families as caregivers.”⁴³ In studying long-term care, one of the most compelling ideas is that it is very much a women’s health issue. Nationwide statistics show that 75% of nursing home residents are women. The Texas Department of Aging statistics indicate that Texas’ sex ratio is 73.7, meaning that within the 60+ population in Texas there are 74 males over 60 for every 100 females over 60. The gap widens with age.⁴⁴ With longer life expectancies, women are more likely to end up in long-term care than men.

One possible solution to the long-term care needs associated with the “graying of America” is long-term care insurance. Long-term care insurance is a relatively new field and has yet to generate much popularity. According to a recent United States General Accounting Office (GAO) report, less than 10% of seniors have purchased long-term care insurance.⁴⁵ This is, in part, because it is a relatively new product and the public is unaware of the product. Other problems associated with long-term care insurance include vastly different premiums for the same product depending upon what region and which insurance company is selected. Also, like car insurance, long-term care insurance premiums are paid to obtain coverage, but can be dropped if consumers miss payments. That is, one does not build equity in a long-term care policy. Getting people into the market healthy and early in life is crucial to keeping premiums low. Changing the product to allow seniors to build some type of equity or allowing them to roll it over into a life insurance policy may provide incentives to some people. Another direction may be to encourage incentives for employers, especially small ones, to offer long-term care insurance to their employees and their parents.

⁴²Long-Term Care Insurance: Better Information Critical to Prospective Purchasers. United States General Accounting Office. September, 2000. P. 1.

⁴³*Ibid.* P. 2.

⁴⁴Demographic Profile of the Elderly in Texas. Texas Department of Aging- Policy and Planning Division. March 2000. P. 3.

⁴⁵Long-Term Care Insurance: Better Information Critical to Prospective Purchasers. United States General Accounting Office. September, 2000. P. 3.

Association for Programs for All-Inclusive Care for the Elderly (PACE)

During the course of the LIFT Task Force’s meetings, the membership had the chance to look at a variety of state and federal programs in place to provide health care services. One that received unanimous praise was Bienvivir Senior Health Services of El Paso, Texas. Bienvivir is a member of the Association for Programs for All-Inclusive Care for the Elderly, known as PACE.

Bienvivir, which operates under a waiver from the federal government, is a community based program designed to provide complete medical and social services to over 300 seniors who qualify for nursing home care. Bienvivir receives funding from both Medicare and Medicaid, pools those resources, and delivers any necessary service to its participants. The goal of the community based setting is to “keep participants functioning at as high a level as possible to reduce hospitalization and institutionalization costs.”⁴⁶

Eligibility for Bienvivir is based upon three factors:

- 1) A person must be fifty-five years of age or older;
- 2) have medical/health problems and impaired functional status that prevent or impede independent living; and
- 3) reside within a designated area of the community.

Services provided by Bienvivir are targeted to the elderly who meet Texas’ standards for nursing home care. Upon eligibility determination, participants are assessed by Bienvivir staff in order to determine what level of care will be needed. Once eligible, the medical and long-term care needs of the participants are met by Bienvivir until death. Bienvivir provides all services, including specialists, dentistry, prescription drugs, and rehabilitative services. Bienvivir has managed to provide exceptional care for the participants, while also saving Medicare and Medicaid a significant amount of money.

Bienvivir facts:

- Provides services to over 300 frail elderly;
- Provides a cost savings of 12 to 20 percent to federal and state programs;
- Typical participant is 80 years of age, ½ are incontinent, and 45% suffer from

⁴⁶History and Purpose of Bienvivir Senior Health Services.

- dementia;
- More than 70% of participants live alone or with family in the community, as opposed to institutional care;
- 92% of participants are dually eligible for Medicare and Medicaid;
- Most participants visit between 2 and 7 times per week;⁴⁷

One of the most attractive features of Bienvivir is its focus on the comprehensive delivery of health care services within a community model. The level of patient satisfaction, evidenced by the low disenrollment rate, is indicative of the staff commitment and the identity of Bienvivir as a member of the community. The “focal point” for delivery of services is the PACE center which combines an adult day health care center with a primary care clinic and rehabilitation center.⁴⁸

CONCLUSION

Long-term care will become increasingly important to Texas over the next few years. An essential part of Texas’ ability to deal with long-term care in the future is the steps that are taken now to create a healthy and safe nursing home industry. Without a healthy industry, there is no way to guarantee the health and well-being of Texas seniors. Although alternative forms of care, like assisted living facilities, are emerging, the nursing home industry will continue to play a vital role. Texas desires to provide high quality care for individuals in need of long term care. To ensure continued access to nursing home care, Texas must increase appropriations for nursing home rates as well as address the underlying issues impacting access and affordability of liability insurance. Moreover, Texas must ensure that its method of reimbursing nursing home care emphasize tangible quality measures.

⁴⁷ *Ibid.*

⁴⁸History and Purpose of Bienvivir Senior Health Services.

LIFT Task Force Recommendations

- The Legislature should appropriate funds that will allow Texas to approach the national average for nursing home reimbursement rates over the next six years.
- The Legislature should direct HHSC to develop a performance based funding system for nursing homes. The system should reward high performance by allowing nursing homes to collect as much as 120% of reimbursement rates for top performers, and as low as 80% for those performing at the bottom. The system should incorporate the use of three indices to measure which nursing homes are achieving superior results. The three indices would be a Quality of Care Index, a Resolved Complaints Index, and a Customer Satisfaction Index. The development of the indices would serve to promote competition between nursing homes and also remove some of the objectivity from the current practice of using survey reports to measure quality.
- The Legislature should direct HHSC to study possible locations for three future PACE sites. Locations should be chosen based upon demographics and the prospects for successful duplication of the Bienvivir model.
- The Legislature should amend the law to cap the amount of exemplary damages that can be recovered in cases involving injury to the elderly. Damages should be capped at four times the amount of economic damages plus punitive damages not to exceed \$1.5 million.
- The Legislature should extend a franchise tax credit to employers that offer long-term care insurance to their employees.
- The Legislature should expand eligibility for participation in the Joint Underwriting Association to for-profit nursing homes.

Pharmaceuticals

Introduction

One of the major issues during the recent presidential campaign was the issue of prescription drugs, especially for the elderly. Prescription drugs are now the fastest growing segment of health care expenditures in the United States. In the last thirty years, prescription drugs, as a percentage of total health care expenditures, has more than doubled from 7% to over 15%.⁴⁹ This has occurred despite the fact that prescription drug prices have remained relatively level during the same period. What, then, is driving the increase in expenditures?

Most experts attribute this change to increased utilization, rather than increased prices. The utilization increase itself is the center of much debate. The growing elderly population, a large number of new drugs that are replacing older medications, a changing notion of coordinated care, direct to consumer advertising, and a streamlined approval process for bringing drugs to market are all factors in increased utilization of prescription drugs. Many of the new drugs on the market could be considered “quality of life” drugs rather than drugs that are essential to a person’s well being. The rise of prescription drugs as a major public policy issue can be linked, in part, to the rapidly expanding elderly population. While they account for only 13% of the population, they represent a full 1/3 of all prescription drug expenditures.⁵⁰ Because Medicare does not cover prescription drug costs, many states have either developed or are developing programs to help offset the cost of prescription drugs to the elderly. Prescription drugs have also become a public policy issue because of the large quantities of drugs that are purchased by the state as part of Medicaid, the Children’s Health Insurance Program (CHIP), health benefit plans for state employees, and within the criminal justice system. All told, Texas spends in the neighborhood of \$3 billion a year on prescription drugs.⁵¹

While few would argue that the development of new medications is a bad thing, there is a legitimate debate over how the state should reconcile the growing budget pressures that are associated with these advances. In this section issues such as the value of medicines, research and development, disease management, pricing, advertising, and state initiatives to control costs will all be examined.

⁴⁹Prescribing A Cure: Texas Lawmakers Look to Reduce Prescription Drug Spending. Texas Medicine. December 2000. P. 55.

⁵⁰ *Ibid.* P. 55.

⁵¹ *Ibid.* P. 56.

The Value of Medicines

Over the course of the last century, human life expectancy has increased dramatically. This increase is due to many factors. Public health measures, like improved sanitation, advances in medical technology, immunizations, consumer education, and new medicines have all played a part in extending life expectancy. Advances made in the field of pharmaceuticals have been particularly scrutinized as of late due to recent debates in Congress and various state legislatures.

During the past thirty years numerous medicines treating such ailments as heart disease, stroke, HIV/AIDS, and tuberculosis have been developed. Additionally, drugs treating less serious ailments such as allergies, migraine headaches, impotence, stress, and anxiety have improved the quality of life for millions of individuals. According to the recent House Committee on Public Health Interim Report to the 77th Texas Legislature, more than 9 in 10 Americans take prescription drugs, most on a “regular basis.”⁵²

The obvious question is, “Is the increase in expenditures for prescription drug worth it?” Data from the Pharmaceutical Research and Manufacturers of America (PhRMA) suggests that the investment may be worthwhile. Among the many benefits of pharmaceuticals:

- Medicines have helped reduce deaths from heart disease and stroke by half during the last 30 years. Potential savings from reduced nursing home costs are up to \$100 million.
- During the same time period, drugs have helped cut emphysema deaths by 57% and ulcer deaths by 72%.
- Combined drug therapies have helped reduce AIDS deaths by more than 70% from 1994 to 1997.
- Increased use of blood thinning drugs has the potential to prevent 40,000 strokes per year, saving an estimated \$600 million.
- New drugs treating tuberculosis are the first to be developed in 25 years.

Prescription drugs can limit hospitalizations and nursing home care for the elderly and those with chronic illnesses, thereby saving the large costs associated with both types of care. Prescription drugs also offer a valuable opportunity to educate people about the nature of their illnesses and

⁵²Interim Report to the 77th Texas Legislature. House Committee on Public Health. October 2000. P.1.5.

the best way to manage disease through physician contacts, explanation of a drug's benefits and side effects, and literature associated with certain drugs. One of the unanimous opinions expressed by the members of the Task Force is the need for educated health care consumers.

While many new medicines are aimed at treating life-threatening illnesses, there are many aimed at simply improving the quality of life for individuals. Allergy medications, like Claritin, have allowed many people to live without the adverse effects of allergies. These quality of life medications also have a link to productivity in the workplace. Ailments like allergies and asthma are some of the most common reasons for missed workdays by employees. A recent study indicated that of patients with severe asthma, 71% had missed work during the previous three months as a result of their condition.⁵³ One estimate of the total annual cost of poor employee health to corporations was \$1 trillion.⁵⁴ Medicines, correctly used, enhance physical well-being while also promoting economic well-being.

Though no one disputes the positive impact prescription drugs have had on people's lives, there is a growing concern that direct to consumer (DTC) advertising and the myriad of new drugs available have led to the idea of "medicating" the human condition. That is, there is a pill for everything. Some critics also claim that many newer drugs produced by drug manufacturers are no more effective than over the counter drugs. One physician noted, "it's sometimes easy to forget that older, less expensive, but very efficacious, drugs are available."⁵⁵ Today, many patients come in not for a diagnosis, but to request a certain drug. While the free market is a wonderful thing, it is vital that doctors continue to take a leading role in the treatment of disease. Part of this role entails adjusting their prescribing habits to recognize the financial limitations encountered by some patients.

Research and Development (R&D)

Almost 3 billion prescriptions were written in 1999 in the United States alone. Prescription drug sales amounted to over \$100 billion in 1999. According to PhRMA's annual report, drug companies will spend over \$25 billion on R&D during 2001. Prescription drugs are big business in America. Much of the success in developing new drugs can be credited to the increased amount of money dedicated to R&D. Drug makers dedicate a significantly larger amount of money (as a percentage of sales) to R&D than almost any other industry, over 20%.⁵⁶ While

⁵³Health Care & Productivity. National Pharmaceutical Council.

⁵⁴Equating Health and Productivity. Ken Cohen & Eleanor Vogt. Business & Health Magazine. September 1997.

⁵⁵Who's Writing the Prescriptions. Laurie Stoneham. Texas Medicine. August 2000. p 47.

⁵⁶PhRMA Facts. December 1999. www.phrma.org.

R&D is essential to the development of new products, it is also a factor in increased utilization and higher drug prices, mostly for newer products. The advances made in treating a number of conditions, including HIV/AIDS, heart disease, and stroke, were made possible because of the research done by drug makers. Additionally, drugs in development aimed at treating diseases such as Alzheimer's, Parkinson's, osteoporosis, and diabetes, to name a few, are dependent upon the amount of money dedicated to research. Research, in turn, is driven by the level of profit which drug makers project. While many new drugs are expensive, there is a rationale for it. Very few drugs ever make it to market. Because patents expire after 20 years in most cases, the drugs that do make it to market are counted upon by drug makers to recoup the cost of failed ventures and to provide for new developments. The average cost of bringing a new drug to market is \$500 million. The average time to develop a new medicine is between 12 and 15 years.⁵⁷ Given that schedule, drug makers have between 5-8 years to recover their investment and pay for the drugs that never reach market. While the government has taken steps to reduce the amount of time needed to bring new drugs to market, increased competition between manufacturers and the presence of generic drug makers offer less time to recoup investments.

The United States is the world leader in developing new drugs. During the past two decades almost half of all medicines developed were developed in the United States. Only one other country, Great Britain, developed more than 10% of new drugs. This is in large part due to the freer market in the United States. Many other countries have instituted price controls on pharmaceuticals in order to contain costs. The United States is one of the few countries that offer drug makers an opportunity to make a profit on their products. In short, the United States subsidizes drug research and lower prices for the rest of the world. Though there is a great benefit in doing so, stories of lower drug prices across the borders in Canada and Mexico are a source of frustration to many.

While some have suggested that price controls will allow the United States to compete on a level playing field, the reality is that price controls, as they have elsewhere, will stifle the development of new drugs. The relationship between the ability to make a profit and the willingness of investors to invest is not a complicated one. A better solution may be to insist that other countries start paying their fair share for drugs developed in the United States.

As mentioned earlier, drug makers in the United States make a lot of money. They also invest a lot of money. However, some of the money spent on research and development is subsidized by taxpayers in the form of tax credits. By some estimates, almost 40% of the R&D is covered by tax credits.⁵⁸ Tax credits facilitate R&D and also are used as an economic development tool. Many states compete to bring drug makers, and the revenue and jobs they create, to their own state. Tax credits, especially for companies involved in the cash intensive R&D business, are a major selling point. R&D expenditures relating to life sciences, including drug makers, have increased by 182% since 1984.⁵⁹

⁵⁷Why do Prescription Drugs Cost so Much? PhRMA. Available on line at: www.phrma.org.

⁵⁸Testimony of Senator Chellie Pingree (D-ME). House Committee on Public Health.

⁵⁹Index of the 1998 Texas Healthcare Technology Industry. Texas Healthcare & Bioscience Institute.

R&D is a worthwhile investment because of the many jobs created, both directly and indirectly, and the influence it has upon institutions of higher education.

Disease Management

One of the emerging concepts in health care delivery is disease management. It has a different definition depending upon the source, but it can be described as a “patient-focused approach to providing all components of care.”⁶⁰ Disease management is aimed at doing exactly what its name suggests, managing disease. It is traditionally aimed at high-cost, chronic illnesses, such as diabetes, where there are a multitude of treatments that include physician care, institutional care, and pharmaceutical care to name a few. The goal of disease management is to provide a continuum of care over time, measure outcomes, and increase efficiency in managing disease outcomes. While the criteria are not set in stone, programs generally include the following:

- Identification of the best scientific evidence
- Defined goals and outcome measures
- Development of teams including doctors, pharmacists, nurses, and communication experts
- Identification of subpopulation of patients who would most benefit from disease management
- Patient education and behavior modification
- Remeasure and Redesign⁶¹

These criteria are general by design. Effective disease management relies on quality data and integrity in measuring outcomes. What kind of outcomes? Physical, service, and cost. **Physical outcomes** are measured by medical status, complications, and reaching therapeutic goals. Patient perception of treatment and outcomes should be included. **Service outcomes** should measure satisfaction of patients, their families, professionals, purchasers, employees, and communities. It should include measures like access issues. **Cost outcomes** should include the cost of treatment, but also measure the cost of the burden of disease. Disease management is focused on controlling costs through quality. Cost and quality are “two sides of the same coin, you cannot talk about one without talking about the other.”⁶²

⁶⁰Disease Management: Balancing Cost and Quality. National Pharmaceutical Council. February 2000. P. 1.

⁶¹ *Ibid.* P. 1.

⁶²Disease or Dis-ease Management: Performance Improvement Promises and Pitfalls.

Josie R. Williams MD, MMM. April 2000.

Disease management is also attractive as a treatment plan because it allows certain segments of the population (gender, ethnic, young/old, regional) to be treated, while providing a pool that is large enough to measure health outcomes reliably. For example, certain border areas in Texas have experienced large increases in the number of children diagnosed with diabetes. While the border area has traditionally been under served medically, these increases have occurred recently.⁶³ Similarly, it is known that certain ethnic minorities have considerably different reaction to certain drugs, while cultural attitudes also may influence the efficacy of a drug or treatment program.⁶⁴ Disease management, through a comprehensive approach, is better able to offer effective treatment.

Pharmaceuticals play a large part in effective disease management as they offer not only treatment, but occasions to educate people about their illnesses. Pharmaceuticals can help prevent inappropriate hospitalization and nursing home care for patients with chronic illnesses thereby controlling costs, but physician care is needed to measure side effects, compliance, and appropriateness of treatment. Though pharmaceuticals provide an easily measurable benefit, they are only a part of disease management.

Note: The House Committee on Public Health, as part of their interim report, has recommended that a disease management pilot program be developed. The program will focus on asthma disease management in both an urban and rural area.

Drug Utilization: Direct to Consumer (DTC) Advertising & Detailing

As noted in the introduction to this section, there are several major reasons why pharmaceuticals are growing as a percentage of total health care expenditures. The expanding elderly population, the development of new drugs in a streamlined process, disease management, and advertising are among the reasons most commonly cited by experts. All of the reasons have been touched upon

⁶³Testimony of Dr. William “Reyn” Archer to LIFT Task Force.

⁶⁴Ethnic & racial Differences in Response to Medicines. Richard A. Levy, Ph.D. National Pharmaceutical Council.

in some depth in this document, except for advertising. During the LIFT Task Force's meeting on pharmaceutical issues, DTC advertising and detailing were widely discussed.

The pharmaceutical industry utilizes a number of practices to market and sell their products. Most of the money used to advertise is directed at physicians and hospitals, but a growing portion is used to advertise directly to consumers. This may not seem like a very controversial practice, but until recently it was not done. In 1997, the federal Food & Drug Administration (FDA) changed its regulations governing direct to consumer advertising of pharmaceuticals. As a result, DTC advertising has increased at a remarkable rate. DTC advertising totaled \$1.5 billion in 1999, an increase of 16% from the year before and almost four times what was spent on DTC advertising in 1995.⁶⁵ Pharmaceutical companies also spent nearly \$6 billion on "detailing" in 1998.⁶⁶ Detailing is the practice of pharmaceutical company salespeople providing physicians and hospitals with free samples, promotional items, gifts, underwriting for seminars, and other practices designed to get face time with their customers (i.e.- doctors and hospitals).

DTC advertising is a source of frustration to some, while to others it represents a logical business practice consistent with the "Information Era." Whatever one's views are, DTC is certainly effective. A recent survey by *Prevention* magazine revealed that 53 million consumers talked to their doctor about a drug they saw advertised and 12.1 million consumers received a drug because of DTC advertising.⁶⁷ Many providers are frustrated that DTC advertising has led to consumers asking for a certain product rather than seeking a medical diagnosis. Furthermore, DTC advertising fuels increased utilization of drugs and, therefore, increased spending. While physicians are still free to not write prescriptions, one doctor stated that "I've had a lot of patients leave because I didn't write a prescription (they) needed."⁶⁸ Though DTC advertising may frustrate some doctors, it is also a natural result of how quickly information moves today. Prescription are available over the internet and so is information on particular drugs. Many see this as a move towards a patient focused health care system as opposed to a physician focused health care system. DTC advertising is also a direct result of competition between manufacturers and the competition by generic drug companies. On average, ten brand-name drugs lose their patent protection each year. Drug makers use DTC advertising as a means of distinguishing their product by quality and securing name recognition.⁶⁹

⁶⁵Report to the Council on Medical Service. Eugene Ogrod, MD.

⁶⁶Prescription Drug Trends. Janet Kundy and Larry Levitt. The Henry J. Kaiser Family Foundation. <http://www.kff.org/>

⁶⁷Report to the Council on Medical Service. Eugene Ogrod, MD.

⁶⁸Who's Writing the Prescriptions. Laurie Stoneham. Texas Medicine. August 2000. P.47.

⁶⁹Report to the Council on Medical Service. Eugene Ogrod, MD.

Pricing

The pricing of pharmaceuticals is a rather complex process as it involves a number of parties and a variety of private arrangements to adjust cost by certain variables, such as volume of sales. Drug makers, drug wholesalers, pharmacies, HMO's, and the federal government are all involved in the final determination of what consumers pay for a drug. A consumer who purchases via his/her HMO will almost certainly pay less for a drug than someone who is uninsured and pays cash. This is due to the rebate that an HMO may receive for purchasing large volumes of drugs or for promoting the use of a certain drug. It is difficult to completely analyze the nature of drug pricing because the private arrangements made between these parties are not a matter of public record.

Manufacturers begin the process by selling their drugs to a wholesaler for an established price. This price encompasses the production costs, R&D costs, taxes, and a certain level of profit. However, while the established price is listed as the sale price, it serves only as a guideline. Manufacturers often provide discounts to wholesalers, particularly if they are not the sole maker of a certain drug. Not surprisingly, in cases where a company is the sole maker of a product, the level of profit that a drug maker seeks to recover may be much higher than the profit level for other drugs.

After a wholesaler purchases a drug from the drug maker, the wholesaler will sell the drug to a retailer, usually a pharmacy, for the price that they paid to the drug maker plus a markup. This price is generally referred to as the "average wholesale price," or AWP. AWP represents a list price suggested by the manufacturer, though wholesalers are free to sell below this price to pharmacies or offer discounts to particular customers. "Industry sources suggest that the price charged by the manufacturer to the wholesaler typically runs about 20 percent below the list price or AWP."⁷⁰

Finally, the retailer, or pharmacy, sells to the consumer for a price that incorporates the price at which they purchase the drug plus their own value added markup, usually 20-25%.⁷¹ This price is affected by the discounts offered to Pharmacy Benefit Managers (PBMs) and private insurance companies.

⁷⁰Issues in Prescription Drug Coverage, Pricing, Utilization, and Spending: What We Know and Need to Know. Peter Lamy Center for Drug Therapy and Aging. February 2000. P. 101.

⁷¹*Ibid.* P. 102.

Pharmacy Benefit Managers (PBMs)

PBMs manage pharmaceutical benefits for a variety of health providers, including private plans, HMO's, and employers. PBMs never actually distribute drugs, but “construct a complex web of relationships with retail pharmacies, drug manufacturers, doctors, and patients to manage drug utilization and costs for their clients.” That is, they negotiate discounts from pharmacies and drug makers. Additionally, PBMs help in disease management, promote generic use and formulary compliance, and process claims. The PBM field is dominated by three companies, Merck-Medco, PCS Health Systems, and Express Scripts, which manage nearly half of prescriptions administered by PBMs.⁷²

Federal Pricing, Medicaid, and the Federal Supply Schedule (FSS)

Unlike other consumers, certain purchases made by federal agencies require that manufacturers offer certain prices. One of the programs guaranteed lower prices is the Medicaid program. When Congress passed the Omnibus Budget Reconciliation Act (OBRA) in 1990, one of the requirements was that Medicaid programs receive rebates from drug makers. If drug makers do not offer these rebates, then their products are not offered through Medicaid. Since drug purchases made through Medicaid represents better than 10% of pharmaceutical sales in the U.S., participation by drug makers is essentially mandatory.⁷³ The rebate offered under Medicaid must be equal to the difference between the average manufacturer price and the manufacturer's “best price.” The best price is the lowest price a drug maker offered to any purchaser during the year.

Federal agencies are given access to lower drug prices through the Federal Supply Schedule (FSS). The FSS, administered by the federal Department of Veterans Affairs (VA), is simply a list of drugs and the prices available to federal agencies. The list must include brand-name drugs in order for the drug makers to be reimbursed under Medicaid. FSS prices are based upon the prices that drug makers offer to their “most favored” private purchasers and must be equal to, or lower, than that price. Additionally, drug makers must sell brand-name products on the FSS to the VA, and a select few other agencies, at a price “at least 24 percent lower than the nonfederal average manufacturer price (NFAMP), a ceiling price that is lower than the FSS price for many drugs.”⁷⁴

In Texas, the Medicaid Vendor Drug Program spent nearly \$950 million in 1999, and received rebates amounting to 19%.⁷⁵

⁷²The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit. Anna Cook, MD, et al. Prepared for the Henry J. Kaiser Family Foundation. January 2000. Available online at: <http://www.kff.org/content/2000/1543/PBMPaper.pdf>.

⁷³Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes. United States general Accounting Office. August 2000.

⁷⁴ *Ibid.*

⁷⁵Texas Department of Health.

CONCLUSION

The issue of pharmaceuticals encompasses a broad spectrum of related issues. Though much has been made of the sharp rise in total expenditures on pharmaceuticals, the increase in utilization has been due, in large part, to reasons that are beyond control of government. Among the reasons:

- New drugs have taken the place of older, less expensive ones;
- People are living longer and using more prescription drugs to maintain their health and quality of life;
- Pharmaceutical companies are having more success in bringing products to market through reduced bureaucracy;
- Pharmaceuticals have become a larger part of treating illnesses;
- DTC advertising has spurred the use of new drugs;

All these reasons are intertwined, but the fact of the matter is that the U.S. is in a cycle of health care spending which has caused increased expenditures which will probably not produce savings for some time.

Despite this fact, there are steps that can be taken to reduce total expenditures on drugs. As seen in the section on pricing, pooled purchasing power often results in savings from manufacturers and pharmacies. Texas may be able to produce cost savings through pooled purchasing by consolidating certain programs. Additionally, pharmaceutical companies currently give away about \$500 million in pharmaceuticals to the uninsured and charities each year. While these programs should not serve as a replacement for insurance, they currently operate with little cohesion. Finally, a large supply of drugs go unused in nursing homes. This situation, with appropriate oversight, can be corrected.

LIFT Task Force Recommendations

- The Legislature should examine the potential cost savings to the state through pooled purchasing of drugs provided through state agencies. Savings from pooled purchasing should be returned to General Revenue.
- The Legislature should authorize at least three disease management pilot projects relating to treatment of asthma. At least one of the pilots should be centered in a non-attainment area. The Legislature should also expand its diabetes disease management pilot to encompass a border region. Finally, a disease management pilot project relating to the treatment of tuberculosis should be authorized as well.
- The Legislature should authorize a pilot project to include pharmaceuticals in the capitated rate under Medicaid managed care.
- Continue efforts made by the Attorney General to assure that providers that defraud the public programs are made to reimburse the state and be subject to fines and penalties.
- The state should develop guidelines under which prescription drugs may be recycled in appropriate settings.
- The Legislature should amend state law to allow companies with earned, unused tax benefits, such as R&D credits, to have the option to sell them to another company or back to the state for cash. Companies could then invest the funds back into R&D activities and not have to wait until the company is profitable.
- The Legislature should reject any proposal designed to institute prescription drug price controls.

Medical Privacy

Introduction

Privacy will be a major issue for the 77th Texas Legislature. Nine committees, including the House Committee on State Affairs and the Senate Committee on Health Services, studied the issue of privacy in depth during the interim. Of particular importance to this report is privacy with respect to health care information and records.

Most people are familiar with stories of identity theft, where a hacker or some other criminal is able to adopt an innocent person's identity by obtaining a social security number, credit card information, or some information that uniquely identifies a person. A growing percentage of the population is becoming aware of just how easy it is for outside parties to access their health information. The growing use of databases and electronic transfers spurred by the Internet, the use of tracking devices by companies to monitor customer's web activity, government efforts to monitor public health, and the selling of personal information by companies are among the many threats to our medical privacy today. While medical privacy has always been a concern, evidenced by the sanctity of the doctor-patient relationship, it is even more pronounced in a time where massive amounts of information can be transferred in seconds. This is especially true as scientists continue to map the human gene and it is becoming possible to identify those people who may be predisposed to certain forms of cancer, mental illness, and other diseases. This raises practical concerns about one's ability to obtain health insurance or get hired by an employer if their medical information shows they are almost guaranteed to get skin cancer. It is doubtful that many people would want the world to know that they carry a sexually transmitted disease or have sought mental health treatment. In addition to the practical concerns, there is the philosophical concern that one's health history belongs to them and that neither an employer, nor a business, nor the government has any right to know more than an individual wants them to know.

Medical privacy is an interesting topic because of its practical application and the philosophical tensions that arise from it. How do we weigh the need to protect society through public health measures, like collection of information on disease, yet still protect the individual right to privacy? What is the threshold for regulation of privacy by the government and the threat of losing one's individual rights to the government? How do we balance the needs of a digital economy to have free flowing information with the rights of its citizens to privacy? Can the free market protect medical privacy or does government need to promulgate regulations governing privacy as a legitimate protection of our rights? If laws are needed, then should the regulation be done in one fell swoop or in a piecemeal fashion? The questions are numerous and the options many. This section will examine the current laws regulating privacy, the recently released privacy regulations developed by the United States Department of Health and Human Services, the consumer and business concerns that any privacy law must weigh, the recommendations of the Texas Senate Health Committee with respect to privacy, and certain reforms within the current health care market that would enhance the protection of privacy.

Medical Privacy Law

Privacy laws governing the release of health care information and medical records are a combination of federal and state laws. In Texas, the Medical Practice Act governs the circumstances under which doctors, hospitals, and other health care providers are allowed to release patient information. The list is extensive and covers everything from the release to the federal government, to release in order to secure payment, to release to investigate a crime.⁷⁶ While there is no comprehensive medical privacy law at the federal level, rules recently promulgated by the United States Department of Health and Human Services (DHHS) are set to go into effect in two years, barring any action from Congress or the new Bush Administration. In the opening section on insurance issues there is a modest review of the Health Insurance Portability and Accountability Act (HIPAA). One of the provisions of HIPAA required that a unique health identifier be developed for each individual, health plan, health care provider, and employer in order to facilitate electronic transformation of medical information. Attempting to ensure that Congress would act with due diligence, HIPAA also was written to include a provision that allowed DHHS to develop and implement privacy regulations if Congress did not pass a medical privacy law. Surprising no one, Congress did not pass a privacy law, but did place a moratorium on the development of the unique health identifier.

U.S. Department of Health & Human Services Privacy Rules

On November 3, 1999, in accordance with the provisions of HIPAA, the United States Department of Health and Human Services issued its proposed regulations to secure medical privacy. The proposed rules would limit disclosure of medical records and health information without patient consent to certain organizations involved in activities that allow the “health care system to operate smoothly.”⁷⁷ The list of organizations includes groups involved in:

- oversight of the health care system
- public health
- research
- judicial proceedings
- law enforcement
- emergency services
- government health data
- patient directories

⁷⁶For a more complete list see the Texas Senate Health Committee’s Report to the 77th Legislature.

⁷⁷Federal Register

banks that process health care payments⁷⁸

The reality of the proposed regulations is that they do not protect medical privacy, but instead authorize the government to release private medical information when it sees fit. The constitutional problems of the federal government developing uniform privacy standards notwithstanding, the initial proposed rules to “protect” medical privacy also allows law enforcement to obtain records without a search warrant, develops the unique health identifier, and leaves to government the decision of when the release of private medical information is appropriate. After much public input over the proposed rules, many changes were made. The updated rules allows states to enact more stringent privacy regulations, allows consumers the right to request correction of their medical records, and provides that patients must authorize release of medical records in certain situations. Still, many of the aforementioned problems persist.

Business Concerns vs. Consumer Privacy

One of the drivers of the sustained economic growth experienced in Texas has been the development of numerous online and high tech companies. Some of these companies are directly involved in the health field. Online pharmacies, to use one example, now number more than 400 and are expected to make more than \$1.4 billion next year.⁷⁹ Buying prescription drugs online has made many drugs more accessible, cheaper, and less time-consuming for many people. The competition among these online outlets is fierce, and the ability to market is essential to their survival.

Many of the pharmacies track the web habits of online purchasers through computer tracking devices, or “cookies.” Using this information to develop user profiles and target their marketing efforts allows the online pharmacies to keep prices lower and compete with traditional retail pharmacies. While much of the polling data available shows that most people are willing to provide certain information, such as their name, gender, e-mail address, ethnicity, and address to websites they are using, they overwhelmingly oppose letting those same websites sell their information to other sites. However, with little accountability on the Internet and health care spending on the web expected to reach \$10 billion in the next five years, the motivation for

⁷⁸How Clinton’s Health Care Regulations Will Undermine Patent Privacy. Sue Blevins. Heritage Foundation. April, 2000.

⁷⁹Computers and Medicine. The Congressional Quarterly Researcher. Adriel Bettelheim. October 2000.

online pharmacies to protect privacy is unclear. Moreover, many of the current laws regulating privacy are aimed “at the individuals who keep the information, but do not necessarily deter the release of such information.” An online pharmacy, for example, may notice that a user is researching a particular drug that treats a mental health condition.

Whether the selling of this information constitutes a crime is subject to interpretation and the nature of any privacy policy the company may advertise. The practice is generally unregulated. If such information were sold to a health insurer, it could irrevocably harm a person by making insurance cost prohibitive or making the person a hiring risk for an employer. If such a scenario seems unlikely, consider that a 1996 survey of Fortune 500 companies found that 35% said they considered an applicant’s medical record before hiring and/or promoting them, while over 60% of them released employee information to creditors who requested.⁸⁰ Consider, also, the testimony of Carolyn Purcell, Executive Director of the Department of Information Resources, before the Senate Committee on Health Services:

“I recently engaged an Internet service company to find out anything they could about me through public records. I conveyed only my name, current home address, and a credit card number for payment. In fewer than 24 hours I had a 12 page report that provided my Social Security number, date of birth, possible aliases, driver’s license number, the fact that I had a pilot’s license, the latest date of my medical exam, the cars I had owned and their previous owners, the property I owned and the previous owners along with their Social Security numbers, my ex-husbands’s Social Security number and a string of his addresses, my voter registration information, and finally, a note apologizing that ‘some people...content with a simple lifestyle’ produce a sketchy report like mine”

While many of the concerns of business over medical privacy regulations have to do with the ease of conducting business, there are concerns over the health and well-being of individuals as well. Doctors and hospitals, both business and consumer, have a stake in both the ease of information flow and strong privacy measures. Businesses are also rightly concerned over the cost of implementing such privacy standards and what their liability will be. Blue Cross & Blue Shield Association recently estimated that business may have to spend as much as \$40 billion to implement the privacy standards promulgated by the DHHS rules. Furthermore, for the proposed regulations to be effective “every hospital, pharmacy, insurance company, and health-information clearinghouse that routinely sends information to other health-care organizations must switch over to the new formats at the same time.”⁸¹ The new technology that allows for storage and transfer of medical records in electronic format allows doctors and researchers to analyze health data more accurately and with better detail. Fields such as disease management, outcomes

⁸⁰Comments of Consumers Union on DHHS Proposed Rules for Standards for Privacy of Individually Identifiable Health Information. October 1999.

⁸¹Getting Tangled in Health Care’s Web. Business Week. December 2000.

research, and public health require accurate data. In Texas, this technology allows some rural health care providers, fighting to survive as the state demographics change, to compete. Electronic data transfer and free flow of information “are helping cash strapped health-care providers, such as rural medical centers, which....cannot afford to keep specialists on staff.”⁸² Privacy can also have an adverse effect on the health of individuals (as opposed to group public health measures) by limiting coordination between doctors. If a patient were to be taking a drug like Prozac, “that fact could be withheld from doctors who are not mental-health specialists, even though the medicine can interact with certain heart and sleeping medications.”⁸³

Privacy and the Health Care Market

One topic that is often overlooked in the privacy debate is how the evolution of health insurance and health care delivery has affected privacy. The vast majority of people who hold private health insurance obtain it as a benefit from their employer. Employer-sponsored health insurance plans became popular during World War II as employers sought to fill labor shortages caused by the war and the resulting wage and price controls. Employers used health insurance as a recruiting tool, yet did not count this benefit as part of the employee salary. Congress eventually passed legislation that exempted employer-sponsored health insurance from taxation. The advent of employer sponsored health insurance and third party pay has, in many ways, isolated people from the true cost of health care. Since individuals are not responsible for paying for their health care, there is little incentive to shop for health care or to determine what one’s health care needs are. Because employers are generally centered on running their businesses, rather than administering health care plans, the presence of health care administrators, or insurers, has become prominent. It is in this development that the conflict with privacy becomes evident. Individual health care information is often available to and distributed far beyond the patient and the doctor as insurers process claims. Additionally, efforts to control costs have led to approval measures, specifically managed care, which compromise medical privacy. Further efforts to control the cost of disease has led to the collection of data and the need to distribute the information to providers and researchers, further jeopardizing privacy.⁸⁴

⁸²Computers and Medicine. The Congressional Quarterly Researcher. Adriel Bettelheim. October 2000.

⁸³Getting Tangled in Health Care’s Web. Business Week. December 2000.

⁸⁴Mental Health: A Report to the Surgeon General. Department of Health and Human Services. U.S. Public Health Service

LIFT Comments on Texas Senate Health Committee
Recommendations on Medical Privacy

Note: For the entire list of recommendations on privacy, please see the full Senate Health Committee interim report.

The LIFT Task Force concurs with the Senate Health Committee's recommendation that Texas should establish and develop privacy standards separate and distinct from the federal regulations developed by DHHS. This is necessary because the federal regulations are wholly inadequate and the state has a vested interest in protecting the privacy of its citizens. While it is the belief of the Task Force that privacy should be governed by contract between individuals and providers to the extent possible, privacy standards are imperative in a system that is heavily dependent upon employer sponsored health insurance.

Individuals should have the right to "opt in" in order to consent to any and all disclosures of individual medical records that are not necessary for treatment or payment.

Patients should have access to their individual medical records and the right to correct inaccurate information.

Any business operating in Texas dealing in the transfer of medical records should have a clear and easily accessible privacy policy available to consumers and patients.

Employers, as sponsors of health care plans, are entitled to certain medical information. Employers should not have access to any individual medical record or aggregate medical record that allows individuals to be identified.

CONCLUSION

As quickly as the market for medical information is expanding and developing, the need to develop adequate privacy protections in a timely manner is essential. There are many factors to consider and a balance must be struck between regulations that accommodate the need for privacy with the need for health research, disease management, coordination between health care providers, and the needs of a digital economy. Texas, as a state with strong open records laws, should heed the example of Florida. Florida's open records law, regarded as one of the strongest in the nation, now has more than 750 exemptions to it as the state tries to address the need for individual privacy.⁸⁵

LIFT Task Force Recommendations

- The Legislature should petition the United States Congress to allow a greater number of Medical Savings Accounts (MSA's) and to allow large employers to utilize MSA's. MSA's serve to restore the patient-doctor bond and promote privacy of medical records by limiting the third parties.
- The Legislature should ensure access to appropriate and necessary information to parents of minors, guardians, fraud investigators, payers, and providers.
- The Legislature should enact reasonable disclosure and consent mechanisms and provide for civil penalties to protect individual privacy.

⁸⁵The Privacy Panic. Governing Magazine. December 2000.

Fraud and Abuse

Introduction

Because of the very nature of fraud, it is virtually impossible to accurately place a dollar amount on it. Some estimates place the amount at 10% of total health care expenditures, around \$100 billion. Others say that while fraud is a major problem in the health care field, it is probably closer to 5%, or \$50 billion. Whatever the figure is, it is clear that a significant portion of total health care expenditures is a result of fraud. In a system that heavily relies on third party payers and government funds, it is no surprise that fraud is a problem. While private insurance providers have an incentive to root out fraud to protect their profits, government must act in order to protect taxpayer funds. While it is essential that government act to prevent and punish fraud, it must also deal with other concerns. Privacy, for example, is often compromised when a health care provider or individual engages in fraud using actual patient records. Another concern is dealing with fraud while not creating administrative nightmares for health care providers, the vast majority of whom are honest. Distinguishing between fraud and honest mistakes is not always easy in a health care system like Medicare, a system governed by over 100,000 pages of regulations.

In Texas, where the Attorney General does not have the authority to independently prosecute those who engage in defrauding the health care system, it is vital that program management discourage fraud. The Attorney General's Medicaid Fraud team, HHSC's Office of Investigations and Enforcement (OIE), and the Medicaid Fraud and Abuse Detection System (MFADS) all operate to prevent and punish health care fraud. While it is certain that as long as government engages in paying for health care there will always be individuals engaging in fraud, it is an important function of government to ensure that taxpayer dollars are accounted for and spent wisely. Fraud detection and enforcement is necessary, but it must also account for privacy rights, errors of interpretation, and the administrative burden placed on providers.

Medicaid & Medicare

Two of the programs most often targeted for fraudulent claims are Medicare and Medicaid. According to the United States General Accounting Office, the two programs have strong incentives for providers to over provide services, have weak fraud and abuse controls, and impose few limits on those that bill.⁸⁶ In Texas, during fiscal year 1999, Attorney General John Cornyn's office found that \$7.6 million in Medicaid payments were illegitimate, some fraudulent claims and other legitimate mistakes. With over 30,000 Medicaid providers in Texas, fraudulent claims are obviously part of the cost of doing business. Limiting the amount of fraud in the system, especially in government funded programs, is important because of the need to use

⁸⁶United States General Accounting Office.

taxpayer funds wisely, but also because the public perception of widespread fraud undermines the legitimate ends of such programs. Stories such as a Medicaid provider who cheated the government out of \$2.5 million in false claims by falsely indicating that juvenile patients were receiving counseling services, raise concerns about government waste and create cynicism about government services.

Like Medicaid, Medicare has also become a target of those who engage in fraud. In 1999, DHHS reported that \$13.5 billion in Medicare fee-for-service claims were improperly paid due to error and fraud. As recently as 1997, federal investigators found that unjustified payments accounted for almost \$23 billion in overcharges to the Medicare program, representing 14% of all program expenditures.⁸⁷ While fraud is part of the problem, the federal Medicare program is comprised of a complex combination of central planning and price controls administered through the Health Care Financing Administration (HCFA) that serve to complicate matters. The scope of this agency's regulatory authority encompasses virtually every aspect of the financing and delivery of health care to America's seniors. According to the Mayo Foundation, of the 132,729 pages of federal health care regulations, laws, rules, guidelines, and related paperwork, over 110,000 are related to the Medicare program.⁸⁸

While the federal government has cracked down on fraud in recent years through increased detection efforts and reduced Medicare funding for certain services, the efforts have also hurt services such as nursing homes in Texas. According to the House Committee on Human Services interim report, "Texas nursing homes have historically used Medicare revenues to compensate for low Medicaid rates....Whether the over-billing in Texas was intentional or not, HCFA's cutting of nearly \$9.7 billion in revenue to Medicare providers nationwide over the last three years, has clearly affected the nursing home industry."⁸⁹

Texas Perspective

⁸⁷Health Care Fraud: Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers. United States General Accounting Office. July, 2000.

⁸⁸Congressman Pete Strak (D-CA), statement on the funding requests of HCFA.

⁸⁹Interim Report to the 77th Texas Legislature. House Committee on Human Services. October 2000. P. 27.

In 1997 the Texas Legislature passed Senate Bill 30, which provided a package of reforms intended to improve the state's ability to combat fraudulent acts committed against publicly funded programs. Among other things, SB 30 mandated the consolidation of staff from the Sanctions Department of the HHSC, the Utilization and Assessment Review Section at the Texas Department of Human Services (DHS), and the Policy Analysis and Claims Review Section at the Texas Department of Health (TDH) into the Office of Investigations and Enforcement(OIE). The OIE has three primary functions:

- Medicaid Program Integrity (MPI)- responsible for investigating allegations or complaints of Medicaid fraud, abuse, or misuse.
- Utilization Review (UR)- responsible for monitoring utilization review activities in Medicaid contract hospitals.
- Compliance Monitoring and Referral (CMR)- responsible for monitoring and reviewing Medicaid claims processing to ensure compliance with federal regulations an the Medicaid state plan requirements.

SB 30 also provided for the use of a new Medicaid Fraud and Abuse Detection System (MFADS) designed to use learning or neural network technology to identify discrepancies in Medicaid claims. Neural network technology relies on mathematical algorithms to analyze substantial amounts of Medicaid claims data to identify situations in need of further investigation by the OIE. In the first two months of operation, using only 3 out of 22 existing algorithms, MFADS produced 244 suspects and identified \$623,096 in overpayments in a 63 county database. OIE reports recovering between eight and ten dollars for every dollar spent on fraud, misuse, and abuse detection. Once suspected fraud is identified by the OIE the case is referred to the Office of the Attorney General for prosecution.

One of the difficulties in combating fraud in Texas is the statutory limitations placed upon the Attorney General. Unlike many states, the Attorney General in Texas is not allowed to prosecute independently. Instead, the Attorney General must convince district attorneys or United States attorneys to prosecute fraud cases. This problem is compounded by the lack of resources that some district attorneys have and the complex nature of prosecuting fraud cases. While some of those profiting from fraud are forced to repay funds, many are not and have little chance of being prosecuted. In fact, in many cases the matter is settled without conviction and the provider is allowed to remain as a Medicaid provider. In 1999, more than 260 fraud cases were opened by the OAG with only 38 convictions resulting.⁹⁰

Private Insurers

Insurance fraud is not limited to the public sector. Insurance fraud in the private sector is a problem as well, and it drives up the cost of premiums for everyone. As mentioned earlier,

⁹⁰Office of the Attorney General.

private insurers have an incentive to limit fraud to protect profits and keep prices similar to those of their competitors. Private insurers have reported that their losses to fraud are in the 3-5% range, a substantially lower rate than found in the government sector.

CONCLUSION

Fraud, whether in Medicare, Medicaid, or the private sector, should be rooted out and prosecuted.

At the same time, it should be acknowledged that program management plays a key role in discouraging fraud from happening in the first place. Efforts by the Texas Legislature and HHSC to develop and implement systems such as MFADS are a positive step. The best method of controlling fraud is to return a larger portion of the population to private insurance. As long as the government is engaged in paying money for claims, the presence of fraud can be assured.

In the private sector, a direct exchange between buyer and seller is least susceptible to fraud and more likely to catch any fraud that does occur. The bureaucracy associated with Medicaid and Medicare makes detection tough and prosecution even more difficult. Policy makers must also be aware that efforts to combat fraud can conflict with issues such as efficient delivery of health care services and the privacy of patient's medical records. Any policy or effort to combat fraud must be sensitive to these issues.

Finally, efforts to combat fraud must recognize that health care providers are not in the business of interpretation of law. As mentioned earlier, the over 100,000 pages of regulations dealing with Medicare present a significant challenge to providers, while Medicaid regulations are constantly changing.

LIFT Task Force Recommendations

- Allocating funds to the Office of the Attorney General to assist district attorney's with the prosecution of fraud cases involving public health programs such as Medicaid and Medicare.
- The Legislature should allow HHSC to partner with private insurers in using MFADS to better detect fraud and abuse.
- Enhanced civil penalties for those found to be engaged in fraud.
- Study the possibility of extending the Attorney General's authority to prosecute those who defraud state financed programs.

Indigent Care and the Uninsured

Introduction

The large number of people in Texas without health insurance has received a significant amount of attention from the press and the Legislature in the past two years. According to some figures, the number of people without health insurance is nearly 25%, or one out of every four Texans under the age of 65. In an effort to find solutions, which would allow more people to have health insurance, the Blue Ribbon Task Force on the Uninsured was formed during the 76th Legislative Session. A variety of options exist to address the number of uninsured, ranging from tax changes at the federal level to extending publicly provided health coverage to a wider range of people. The LIFT Task Force also heard from many different health care experts on the topic of the uninsured and indigent care. As part of the discussion on the uninsured, the LIFT Task Force also discussed the current system in place to care for the indigent, including Medicaid, CHIP, local hospital systems, and the county. Though the term indigent has specific meanings throughout the law, for purposes of this section the term is used loosely to describe government funded health care coverage.

In Texas, health and human services makes up the second largest budget item (behind education), totaling more than \$27 billion for the 2000-2001 biennium. The majority of those funds, around \$23 billion, will be spent on the Medicaid program and its 2.6 million recipients. The amount of funding dedicated to Medicaid as well as the number of people covered by it has exploded over the course of the last twenty years, nearly doubling enrollment and increasing spending by 500%. During the 76th Legislative Session, the Children's Health Insurance Program (CHIP) was also created to subsidize health insurance for children in families living at or beneath 200% of federal poverty level (FPL). Between these two programs, Texas provides health insurance to nearly two million people.

Another major provider of indigent care is the hospital system in Texas. Many of the uninsured use public, private, or university hospital emergency rooms as their primary source of care. While this method ultimately delivers health care, use of the emergency room as a source of care is both inefficient and costly. The state and federal government provide assistance to hospitals by reimbursing them, in part, for the free care they provide to the indigent. However, hospitals must provide a certain amount of charity care to be eligible for reimbursement.

Although the LIFT Task Force recognizes that health insurance provides greater access and continuity of care, it should also be noted that health insurance and health care are not

synonymous terms. Texas spent almost \$5 billion providing care to the uninsured in support of that fact. The LIFT Task Force also noted distortions within the insurance market. The most notable is the lack of a tax credit for health insurance for individuals while employer sponsored health insurance is fully deductible. Other issues affecting the number of uninsured are Texas' geographic location along the border of Mexico, the large number of new and small employers in Texas, and a relatively large population of people who choose not to purchase health insurance.

The Uninsured in Texas

As stated above, almost 25% of the Texas population under the age of 65 does not have health insurance, compared to a national average of about 16%. Why is this? There are many reasons, but the ones most often cited are:

- Texas has a low percentage of senior citizens compared to other states.
- Texas has a very large Hispanic population compared to other states.
- Texas has a large number of small employers and new employers who generally do not offer health insurance due to solvency issues.
- The rising cost of health insurance has caused many employers to either drop coverage or not extend coverage to employee's family.

Texas' low percentage of senior citizens affects the rate of the uninsured because the population over the age of 65, nationwide, has a very high rate of being insured. This is due, in large part, to the fact that Medicare is available to the elderly population. It is also known that young adults are significantly more likely to not have health insurance than the population as a whole.⁹¹

Texas' large Hispanic population also contributes to the state's high uninsured rate. In fact, almost half of the uninsured in Texas are Hispanic. Hispanics are more likely to be employed in low-wage service oriented jobs than blacks or Anglos. Many of these jobs do not offer health insurance to their employees or, if they do, require a large employee contribution to the cost of health coverage. There is also a cultural issue involved. Much of the growth in Texas population during the last decade is due to immigrants from Mexico. Health insurance is not an essential part of the health care delivery system in Mexico as it is in the United States. It is noteworthy that the five states with the highest percentage of Hispanic population (New Mexico, California, Texas, Arizona, and Nevada), are the five states with the highest percentage of people without health insurance. It is also known that the 13 Texas counties with uninsured rates higher than 30% are all in South Texas or rural West Texas.⁹² In order to address this problem, there must be an open and honest dialogue about this fact.

⁹¹Demographic Profile of the Texas Population Without Health Insurance Coverage. Texas Health and Human Services Commission. May 2000.

⁹²*Ibid.*

Despite the economic boom that Texas, and the rest of the country, has experienced, many of the new jobs have been in the service industry, or other low-wage, nonunion businesses that do not offer health insurance.⁹³

One of the federal regulations that has served to distort the health insurance market is the tax code. The federal tax code exclusively favors employer-sponsored health insurance over individually purchased health care. Employers receive unlimited tax relief for the purchase of health insurance, while individually purchased health insurance receives no such relief. The tax exemption for employer-provided health care has two effects:

“First, it leads employees to rely on their employer, rather than themselves, to make arrangements for medical care. Yet employees are likely to do a better job of monitoring medical-care providers, because it is in their own interest, than is the employer or the insurance company or companies designated by the employer. Second, it leads employees to take a larger fraction of their total remuneration in the form of medical care than they would if spending on medical care had the same tax status as other expenditures.”⁹⁴

By amending the law to allow tax relief for individually purchased health insurance, the United States Congress could improve the number of insured, the affordability of health insurance, the wages of employees, and portability.

Finally, the cost of health insurance has gone up considerably. Many small employers, prominent in Texas, are the first ones to drop insurance or not offer due to solvency reasons.

⁹³Texas Department of Insurance. Information Provided to the Blue Ribbon Task Force on the Uninsured. December 1999.

⁹⁴How to Cure Health Care. The Public Interest (Number 142, Winter 2001). Milton Friedman. P. 7.

This further affects the uninsured rate because many employers may choose to cover employees, but not their families.

Despite the high cost of health insurance and the high rate of people without health insurance in Texas, there is a “safety net” in place.

Medicaid

Medicaid is far and away the largest health care expenditure in Texas. During the 2000-2001 biennium Texas will spend approximately \$23 billion on the Medicaid program to cover 2.6 million recipients.⁹⁵ Medicaid is state-federal program which provides health insurance and funding for long-term health services to a number of Texans based upon their age, income level, and health status. Medicaid is an entitlement, meaning that Texas may not place a cap on the number of people who enroll or on the funds it must expend on required services. In Texas, the Health and Human Services Commission is the state agency charged with oversight of the Medicaid program. At the federal level, the Health Care Financing Administration (HCFA) is responsible for oversight of the Medicaid program.

The majority of Medicaid recipients (60%) are children, while single parents are the second most likely to receive Medicaid. While these two populations make up nearly 80% of Medicaid recipients, they account for less than 40% of expenditures. The majority of Medicaid expenditures are spent on the elderly and those with chronic illnesses. Medicaid eligibility varies depending upon certain factors. For children aged 1-5 the eligibility level is set at 133% of federal poverty level (FPL), while pregnant women and infants are covered up to 185% FPL. States are free to enhance eligibility levels as they see fit, with some limitations. Medicaid covers a vast array of services including:

⁹⁵Historical and Projected Texas Medicaid Caseload and Expenditures: FFY’s 1988-2005. Texas Health and Human Services Commission. October 2000.

- Medical and dental check ups for minors
- Family planning
- Federally Qualified Health Centers
- Home health care
- Hospital treatment
- Medical transportation
- Nursing home care
- Rural Health Clinics
- Physicians
- Prescription drugs
- Dentists⁹⁶

One of the important features associated with Medicaid is that any benefit deemed medically necessary must be provided to Medicaid eligible children. It is up to each state to define what constitutes medically necessary.

Another important feature in Medicaid is funding for Disproportionate Share Hospitals (DSH). Federal law dictates that states make payments to certain hospitals that serve large populations of Medicaid and low-income clients. These funds are different than other Medicaid funds because they are not allocated based upon provision of any specific services, but to the number of low-income patients a hospital serves. Hospitals may use DSH funds with some latitude in order to cover the cost of providing care to the uninsured and medically indigent.

Because Medicaid is a state-federal partnership, the required contribution made by the state is determined by HCFA when they establish Texas' Federal Medical Assistance Percentage, or FMAP as it is better known. Currently, Texas pays 38.6 cents and the federal government 61.4 cents for every dollar spent by Medicaid on services. The FMAP is based upon the state per capita income and is extremely important because even small changes in the FMAP can mean millions of dollars to the state.

Medicaid is a large part of the state's effort to provide health care to the poor and the uninsured (through DSH). Medicaid was originally intended to provide health insurance for those with low incomes, though it is safe to say the program has far surpassed its intended goal. While there is a need to provide a safety net to the medically indigent, many of the provisions in Medicaid do not allow states the flexibility to adjust their programs unless given permission by HCFA. The rigidity of the Medicaid program, combined with the fact that its benefits far surpass anything sold on the private market, make Medicaid a liability to the state in many ways. One of the recommendations of the LIFT Task Force is to petition Congress to make Medicaid funds available to the states as a block grant, which will allow for much needed flexibility.

⁹⁶Texas Medicaid in Perspective. Third Edition. HHSC. February 1999.

One of the anticipated issues of the 77th Legislative Session is expansion of Medicaid. The expansion effort consists of three primary changes:

1) Elimination of the face-to-face interview

2) Continuous eligibility for 12 months

3) Elimination of the assets test

One of the main argument for these changes is that enrollment in the Children's Health Insurance Program (CHIP) for higher income families, is easier than enrollment in Medicaid, which provides for the poorest families. While these efforts to expand Medicaid will cost the state over \$1.4 billion, there are a number of good reasons to maintain the requirements. The face-to-face interview is an essential part of Medicaid as it provides the best opportunity for caseworkers to explain to applicants the benefits of Medicaid and the need for preventive health care check-ups. The face-to-face is also important because of its function in determining eligibility for Medicaid. Because Medicaid is an entitlement program, it is important that the state assures that taxpayer funds are being used to assist those who are actually eligible for Medicaid. In interviews DHS caseworkers have repeatedly noted the importance of the face-to-face interview as a means of verifying eligibility and explaining the benefits of Medicaid. Some of the documentation requirements for Medicaid are essential as well. Applicants, for example, are required to establish paternity and attest to whether or not they are receiving child support funds. It is important that the state ensure that parents obligated to pay for their children's health care actually provide health insurance if they have access to it. Medicaid is not intended to supplant private health insurance for those who have access to it.

The state currently enrolls children in Medicaid for 6 months at a time to assure that the families enrolled in Medicaid are indeed eligible for the entitlement program. Improvements in the renewal process are already underway to assist families in renewing Medicaid. By sending families Medicaid renewal forms with their original information already filled out, the family must only confirm that they have had no significant changes in income or assets, hardly a stringent requirement. Continuous eligibility is also a serious budget issue for Medicaid in a time when Medicaid costs are skyrocketing. Medicaid is expected to consume a significant portion of the state's surplus, and continuous eligibility will cost the state almost \$600 million in an already strapped budget.

Finally, elimination of the assets test will allow Medicaid to expand to those who have assets above the current resource limit. Integrity in the Medicaid program is essential because it is an entitlement and therefore the state cannot limit enrollment or services to eligible applicants. As such, it is important that the state provide Medicaid to those who are actually in need. It is not unreasonable for the state to ask that those who would be eligible for Medicaid make efforts to spend down their assets before accessing Medicaid. Additionally, Medicaid already exempts the

entire value of one whole car used for work and a portion of another from the assets test and numerous other assets as well.

Perhaps the best reason not to expand Medicaid eligibility is that children who are Medicaid eligible will be denied access to CHIP. As Medicaid expands, the eligibility for CHIP narrows. Many parents who have asked to enroll their children in CHIP have been told that their children are Medicaid eligible and that they may receive Medicaid or nothing at all. This is unreasonable as CHIP offers families private insurance, with the opportunity to contribute to their health care costs and allows families to avoid the stigma of welfare attached to Medicaid.

Because of the size and scope of the Medicaid program, it is not feasible to include all of the services and provisions of it in this document. For an overview of the program and its principles, please see *Texas Medicaid in Perspective*, published by the Texas Health and Human Services Commission.

CHIP

Other than Medicaid, the Children's Health Insurance Program (CHIP) is the other major program in place that provides government subsidized health insurance. CHIP coverage is targeted at children in families that are at or below 200% of the poverty level. In Texas, it is estimated that there are 400,000 children eligible for CHIP. The latest enrollment figures show that Texas is ahead of other states in their outreach and enrollment efforts. Since the program was rolled out, over 200,00 children have been signed up.

CHIP was created by the federal government as an optional program for states to insure children. The inducement to the state is the enhanced federal matching rate of three dollars for every one dollar spent by the state. In Texas, the state portion was financed through funds gained in Texas' settlement with the tobacco companies. CHIP is much different than Medicaid in that it is not an entitlement program. The state can limit enrollment, provide the benefit package, with some limits as it sees fit, and require that participants, again with some limits, contribute financially. CHIP is also different from Medicaid in that it merely subsidizes private health insurance, rather than creating a health care system unto itself. CHIP, in part because it is not an entitlement program, is also much easier to enroll in than Medicaid. One of the recommendations of the LIFT Task Force is to apply to HCFA for a waiver that would allow the state to enroll Medicaid eligible children in CHIP, while not imposing greater financial contributions on the federal government by drawing down only the Medicaid match for Medicaid eligible children.

Though CHIP is preferable to Medicaid in every sense, it too can be improved. While participants are required to contribute financially to the coverage, the required amount is very low. For families at 200% of poverty, the required contribution is a maximum of only \$18 a month. Unfortunately, if the family moves to 201% of poverty, their insurance rates will be much higher. In this sense, the CHIP program does not provide much incentive to rise above the 200% threshold or offer a realistic view of the insurance market. The LIFT Task Force recommends that a realistic sliding scale be introduced to the CHIP program that will help parents prepare for the eventual transition to the private insurance market.

Indigent Care at the Local Level

In 1998, the state of Texas spent over \$4.7 billion on health care for the uninsured. Of this amount, over \$2 billion was spent by hospital districts and local hospitals on the uninsured and unreimbursed services for Medicaid and low-income individuals. Other sources of care include local governments, private providers, and charities.⁹⁷ Hospitals, however, are clearly the main source of health care for the uninsured and medically indigent.

⁹⁷Texas Estimated Health Care Spending on the Uninsured. Texas Comptroller of Public Accounts. December 1999.

Non-profit hospitals are required, by law, to provide charity care at certain levels in order to maintain their status as a tax exempt organization. As detailed in the House Committee on Public Health interim report, one of the following standards must be met:

- Provide charity care at a level reasonably relating to the community's needs
- Provide charity care at a level equal to 100% of the hospital's tax exempt benefits
- Provide charity care at a level equal to at least 5% of the hospital's net patient revenue.⁹⁸

Counties that are not served by a hospital district or public hospital must administer their own indigent health care program for residents of the county not served by a hospital. Counties must, at the very least, cover individuals with income levels at or below 21% of poverty. Counties must also provide the following basic health services to those who qualify for indigent care:

- Primary and preventive services
- Immunizations and medical screenings
- Inpatient and outpatient hospital services
- Rural Health Clinics
- Annual physical exams
- Lab and X-ray services
- Family planning services
- Physician services
- Prescription drugs (up to three per month)
- Skilled nursing facility services⁹⁹

In exchange for providing basic services, counties are eligible for state assistance funds if they spend at least 8% of the county's general revenue on basic and optional services which are medically necessary.¹⁰⁰

⁹⁸Interim Report to the 77th Texas Legislature. House Committee on Public Health. October 2000.

⁹⁹Texas Health and Safety Code. Chapter 61.028.

¹⁰⁰Texas Department of Health. Available at:
<http://www.tdh.state.tx.us/hcf/ihcp/default.htm>

University Health System- San Antonio, TX

One of the success stories heard by the LIFT Task Force is the experience of the University Health System in San Antonio, Texas. The Bexar County Hospital District, like other hospital districts, has special taxing power to provide local medical and hospital care to the needy and medically indigent. As such, it preempts the city and county authority to provide medical and hospital services. The district has an affiliation with the University of Texas System that allows the District to participate in teaching the next generation of health care professionals. This affiliation also allows the District to attract medical research funds and allows them to provide certain types of care that attract paying customers. Unlike some hospital districts, the Bexar County district has made the decision to market its services to paying customers as well as the medically indigent.

One of the unique aspects of Bexar County Hospital District is that, in the era of managed care, it has developed an HMO that is run by the hospital district itself. The HMO, titled *CareLink*, has a specific focus which has helped the program succeed. Specifically, *CareLink*:

- Serves as financial assistance, not as insurance
- Defines a schedule of benefits
- Serves to offer a medical home
- Demands patient responsibility. Contributions are expected when patients can afford to contribute. The obligation to pay is based upon federal poverty level.
- Has defined medically indigent as those at or below 75% of federal poverty (the federal government defines it as at or below 17%)

To qualify for *CareLink* patients must be Bexar County residents and either indigent (below 75% FPL) or needy (75-185% of FPL).

Bexar County has also been unique in the way it has developed partnerships. For instance, the Hospital was able to establish San Antonio AirLife, an emergency air ambulance service, by networking with the private sector to provide a two helicopter fleet covering 150 miles. Similarly, the Hospital has contracted with veterans groups to provide regional laundry service. Finally, the District has had strong support from the community to finance its operations. Ad valorem taxation makes up 25% of the system budget.

The LIFT task Force believes that the success of the University Health System in San Antonio should serve as a role model for other districts as well. Though it may not be feasible in the current financial climate for hospitals, the Task Force believes that an important change may be to have hospital DSH funds dedicated to establishing programs like *CareLink*.

CONCLUSION

Contrary to popular belief, Texas does provide health care to the medically indigent. Through Medicaid, CHIP, local hospitals and hospital districts, and charity care, the medically indigent and uninsured receive quality health care. While the presence of such a safety net is imperative, many aspects of the system, Medicaid in particular, could be changed to better serve Texans in need. First among the Task Force's recommendations is to petition the United States Congress to change Medicaid to a block grant system. Under such a system, Texas would have the flexibility it needs to provide care for the indigent in an efficient manner. A second recommendation of the Task Force is to direct HHSC to seek a waiver from the federal government allowing Texas to enroll Medicaid eligible children in CHIP. Many families have expressed such an interest and have been refused due to federal requirements. Rather than enrolling in a program that many associate with welfare, parents have chosen to not enroll in Medicaid, an option which can prove costly to the family and the state. Other recommendations of the Task Force include:

- The Legislature should expand utilization of private, group-based health insurance by recipients of public assistance using programs like the Health Insurance Premium Payment System (HIPPS).
- Retain the assets test, face-to-face interview, and 6 month renewal requirements for Medicaid. Extend office hours for DHS offices where necessary to allow working parents the ability to sign up for Medicaid without taking off from work. Any expansion of Medicaid should be linked to improvements in health outcomes. The state should continue efforts to reduce bureaucratic barriers where possible.
- Ensure that Medicaid applicants continue to establish paternity so that parents, required to provide health insurance for their children and those with access to health insurance, will do so.
- The Legislature should increase local flexibility to develop, implement, and administer public health insurance programs. One possibility is to explore the prospect of lowering the ad valorem tax rate in local hospital districts in favor of a regional local option sales tax to shift funding burdens more equitably to those who are accessing services.
- The Legislature should petition Congress to make the tax code more equitable by amending it to allow tax relief for individually purchased health insurance.

Hospital Issues

Introduction

Hospitals play a unique role in the delivery of health care services. As the providers of emergency care, trauma care, newborn care, and a major source of care for the medically indigent and uninsured, hospitals are often the central point of promoting healthy communities. This is especially true in many rural areas where health care providers are sometimes scarce and hospitals are the only source of specialist care.

There are many different types of hospitals. The majority of hospitals are either non-profit, public, for-profit, or university hospitals. Financing for all hospitals comes from a variety of sources, including Medicaid, Medicare, private insurance, private pay, state funding, and charity. In recent years, hospitals have experienced financial difficulties due to reduced payments and the high number of uninsured that seek care through the emergency room (ER).

Adding to the financial difficulties of hospitals is the fact that they have a duty to treat the ill. Hospitals cannot turn away patients because of an inability to pay for services. Though this issue affects hospitals disproportionately, it is also a crucial issue in the debate surrounding the best way to deliver health care.

The Task Force recognizes the enormous challenge facing Texas hospitals and deliberated about how to best improve the delivery of care to the Texas population. Without exception, members of the Task Force agree that the health care system must have a strong emphasis on primary and preventive care. Hospitals, however, indicate that they are experiencing increased use of the emergency room for conditions that are not emergency in nature or, if they are emergencies, could have been avoided with care provided earlier.

Public policy must demand a strong emphasis on community-based primary and preventive care, but policymakers cannot neglect the need for emergency, trauma, and other acute care services. Hospitals provide a large portion of these vital “safety net” services to the Texas population.

Business Structure

Hospital business structure, which impacts the services available, varies widely with Texas and even within some communities. For-profit, non-profit, university, and public are typical classifications for the types of hospitals within the state.

For-profit hospitals may be organized as either private or publicly-held companies. Unlike non-profit hospitals, these hospitals are generally subject to federal taxes on profits. They seek to enhance shareholder value by providing health care services in-patient and out-patient settings.

Non-profit hospitals, which are not generally subject to federal income tax, are usually affiliated with a sponsoring organization. Sponsoring organizations can include religious, community, and other private organizations. Additionally, non-profit hospitals have a strong focus on raising private dollars to offset the cost of expensive services such as trauma, medical education, and transplant services.

County hospital districts and state universities operate public and university hospitals, respectively. In addition to fees from services, these hospitals receive funding from local tax dollars and state appropriations. They play a very vital role in the delivery of hospital care by providing services not regularly offered by other hospital providers. Without diminishing the important role of other hospital providers, public and university hospitals can be described as the provider of last resort for many individuals within Texas communities.

Financing

Funding for hospitals varies by structure, services, and population served. Sources for funding include Medicaid, Medicare, private insurance, local tax revenue, private pay, charitable donations, and other appropriations. Each funding source is vitally important to the financial health of hospitals. The Task Force recognized increasing pressure within each source.

Medicare's growth and financial difficulties have been well documented but not addressed by federal policymakers. Reductions in Medicare expenditures, while prompted by Congressional efforts to become and remain fiscally responsible, have been acknowledged as too deep. Congress itself has revisited the issue of Medicare financing and mitigated some of the previous reductions.

Private insurance, particularly managed care, has also increased pressure on hospital revenues. Increased review of patient utilization combined with tough negotiations between hospital and managed care company finance officers have impacted the amount of revenue.

Medicaid is a government health care program that is financed by both the state and federal government but administered by the state. While the program began as a health benefit for recipients of cash assistance, it has evolved to serve a much larger population including many children, persons with disabilities, and elderly. An entitlement program, Medicaid consumes a large portion of state revenues in order to meet the obligations required under federal law. Even with the dramatic growth of Medicaid, many providers, including hospitals, cite low-reimbursement as impacting access to care.

Charity care definitions vary based on business structure and legal requirements. While all hospitals provide some level of charity or uncompensated care, non-profits are usually most associated with this funding source. While government has limited role, other than to encourage charitable contributions to health related entities, policy makers should be mindful of

requirements to influence the use of charity dollars without regard of the intent or wishes of donors.

Public hospitals rely heavily on local tax revenues to finance health care operations. The Task Force reviewed the evolving role of public hospitals and noted the heavy reliance on property tax as well as legal constraints on partnering with other entities to address health care concerns on a regional basis. Task Force discussions included expanding authority for local communities to determine the type of financing mechanisms used to pay for indigent health care and increasing flexibility, with appropriate individual safeguards, to allow a more regional approach to health care delivery.

Private pay, while a relatively low percentage of overall hospital revenue, does represent an important source of funds. The Task Force discussed mechanisms to ensure collection of debts owed to hospitals by private individuals and generally favored strong measures to assist all healthcare providers in collecting money owed.

Emergency Room Utilization

Emergency room care is one of the most expensive methods of delivering care. Many factors are responsible for making ER care so expensive. The need to be open at all times and the need to maintain specialists and surgeons on staff to perform any number of procedures are major cost drivers. It is known that 65-70% of all emergency room visits are for non-emergencies that should be provided in a doctor's office or clinic.¹⁰¹ The uninsured, and many Medicaid patients, use the ER as their primary source of care. In 1998, hospitals spent more than \$2.1 billion on care for the uninsured, almost half the total amount spent by the entire state on the uninsured. When the uninsured use ER's as their primary source of care, they are not only receiving charity care, they are receiving the most costly form of charity care possible.

Hospitals do receive some relief in exchange for treating the uninsured and medically indigent. State revenue as well as Disproportionate Share Hospital (DSH) allotments provide funds to hospitals that perform certain levels of charity care or serve a large portion of Medicaid clients. These funds, however, do not equal the cost of providing services.

Evolving Role

Empowering and encouraging people to lead healthier lives involved a combination of education and increased responsibility measures. Hospitals of all type have recognized this need and began cultivating a system of community-based clinics and outreach that provide education within neighborhoods. While the overriding impetus of this policy is to improve health status, the cost

¹⁰¹UTMB Hospital. LIFT Task Force meeting. March 2000.

avoidance of reducing inappropriate emergency room visits cannot be overlooked. Moreover, improved health status and better allocation of already scarce resources provide a framework by which policymakers can evaluate future health care proposals.

Texas itself has taken positive steps to enable competition within the Medicaid population by moving to a system of managed care intended to promote provider accountability and expand choice of providers for Medicaid recipients. While expanded choice has opened new doors to Medicaid recipients, the system has also caused stress with traditional providers of indigent care such as university and public hospitals. Providers remain skeptical of the benefits of this new delivery system, but the newfound choice of providers has made consumers cautiously supportive. Policymakers should continue to demand accountability throughout the entire Medicaid population and empower Medicaid consumers with a reasonable amount of provider choice.

Issues

The Task Force recognized the enormous challenges facing Texas hospitals and deliberated about how best to improve the delivery of care to Texas population. Without exception, Texans can agree that the health care system must have a strong emphasis on primary and preventative care. Hospitals, however, indicate that they are experiencing increased use of the emergency room for conditions that are not emergency in nature or, if emergency in nature, could have been avoided with care provided earlier.

The Task Force discussed measures to increase utilization of primary and preventative care and ultimately decrease the inappropriate use of hospital emergency rooms. Increased education, expanded use of co-payments for emergency care, rewards for use of primary and preventative care, use of Medical Savings Accounts were all explored as possible alternative. While encouraging responsible behavior is not always easy, the health of Texas' population demand nothing less than public policy that encourages appropriate use of primary and preventative care as well as responsible behavior related to health care.

Critical labor needs also confront many of Texas' hospitals. The prosperity enjoyed by Texas over the last few years has yielded low unemployment rates. But with this tightened labor market, many hospitals have faced nurse and nurse aide shortages. More ominously, Texas nursing schools are experiencing a corresponding demand for nurse educators. The Task Force reviewed many of the issues surrounding professional training and recognized the need to address the shortage of nurses and nurse educators. The Task Force examined Texas' present system of educating nurses, recruitment of nurses and nurse educators, and retaining and supporting existing registered nurses.

The Task Force took particular interest on a program implemented by the University of Texas Medical Branch in Galveston to "grow your own" nursing staff. In Galveston, UTMB has encouraged and provided incentives for its non-medical staff to pursue nursing degrees. Housekeeping, food service, and maintenance staff are allowed to pursue nursing degrees in conjunction with their existing jobs. Texas should foster programs such as UTMB's by

examining ways to encouraging recipients of Temporary Assistance for Needy Families (TANF) to obtain a nursing degree while fulfilling the requirements of the personal responsibility agreement.

While the nursing workforce pose an immediate challenge to many Texas communities, hospitals in rural Texas face an even tougher dilemma - inadequate supply of all providers categories. Greater emphasis needs to be placed on recruiting and supporting doctors and other health care providers in rural communities.

While Texas is currently pursuing numerous strategies to recruit medical personnel to rural areas, technology, properly implemented, may allow greater collaboration among and support for rural providers. The Task Force reviewed current barriers to expanding technology, particularly telemedicine, to rural Texas. Specific proposals reviewed include expanding eligibility for grant funding from the Texas Telecommunications Infrastructure Fund (TIF) to for-profit clinics and authorizing greater reimbursement for telemedicine services under Medicaid. Policymakers should be mindful, however, not use technology to supplant existing doctors in rural areas. Additionally, licensing boards should develop clear expectations about how their respective practice should use technology to provide care.

CONCLUSION

The Task Force examined the business structure, financing, evolving role, and issues related to hospital care, including both rural and technology aspects. The discussions acknowledged the vital role that hospitals play in the continuum of care for individuals as well as the need to develop greater focus on primary and preventative care. The Task Force identified increasing an individual's role in health care decision through greater education as well as increased financial responsibility as a key element of long-term fundamental reform. Moreover, strategies were identified to increase education and training for individuals employed in health care to help address labor shortages and promote the use of technology to support the efforts of rural health care physicians and other health providers.

LIFT Task Force Recommendations

- As the Legislature should award funds for better health outcomes, it should also fund hospitals, in part, on their ability to divert emergency room care through community outreach, education, and the use of primary and preventive care.
- The Legislature should ensure that quality nurses are available by ensuring that nursing is addressed on both the health and human services side and the higher education side. This may be better accomplished through the development of partnerships. Encouraging recipients of Temporary Assistance for Needy Families (TANF) to obtain nursing degrees is an option as well.
- The Legislature should continue promotion of telecommunications improvements in rural areas to allow telemedicine to become a viable means of providing health care.
- The Legislature should direct HHSC or TDH to review state policies affecting hospitals to reflect the change in demographics in Texas. Census data indicates that most of the growth in Texas has occurred in urban areas. Rural hospitals may need to operate under new rules that account for population shifts.
- The Legislature should authorize greater access to telemedicine reimbursements under Medicaid for rural providers.
- The Legislature should direct HHSC to assist hospitals in complying with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
- The Legislature should direct HHSC to explore competitive contracting with hospitals for Medicaid managed care.

