



Searching for the Cure:

Reforming
Health and
Human Services



*
**Texas
Conservative
Coalition
Research
Institute**



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**LIFT
Task Force
on Health
and Human
Services**





February 25, 2003

Dear Colleagues:

The Texas Conservative Coalition Research Institute LIFT Task Force on Health and Human Services was established to provide a conservative perspective to health and human services issues at the state level. The Task Force released its first report in 2001 and continued that work in the interim of the 77th Legislature. This report is the culmination of eighteen months of work done in the second phase of this Task Force. The report lays out a conservative vision for reforming health and human services in Texas and expresses our resolve that now, due to Texas' budget shortfall, reform is imperative.

The conservative vision for reform stands in stark contrast to the ideas that suggest that the government alone can save health care. In accordance with conservative principles, we believe that limited government and emphasis on individual responsibilities is the only way to successfully reform health and human services. It is the responsibility of the state to provide a safety net for the truly indigent, but it is essential that we remember that a safety net is in place to provide temporary assistance, not lifelong medical care. Similarly, long-term care, when required, should be designed to maximize the assistance of the family as efficiently as possible. It is our hope that the recommendations made by this report will lay the foundation for implementing needed policy changes to better serve the people of Texas.

The Task Force brought together stakeholders within the health care industry from across the entire state to better understand health and human services issues that are unique to Texas. We want to extend our thanks to the dedicated and committed supporters of the Task Force who worked to make this report possible. We look forward to continuing to work together to reform and improve health and human services in Texas.

Sincerely,

A handwritten signature in black ink, reading 'Arlene Wohlgemuth'. The signature is written in a cursive style with a large initial 'A'.

Arlene Wohlgemuth

Chairman

TCCRI LIFT Task Force on Health and Human Services

State Representative, District 58

Acknowledgements

We would like to extend our sincere thanks to the participants in the Texas Conservative Coalition Research Institute's LIFT Task Force on Health and Human Services. This document represents countless hours of work from the task force participants. This report would not be possible without their commitment and dedication to the work of the task force.

Texas Conservative Coalition Research Institute
LIFT Task Force on Health and Human Services

Searching for the Cure: Reforming Health and Human Services

February 2003

The contents of this document do not represent an endorsement from any individual member of the Texas Conservative Coalition or the Texas Conservative Coalition Research Institute LIFT Task Force on Health and Human Services. There may be some policy recommendations that individual members may be unable to support. We recognize and respect their position and greatly appreciate the work of everyone involved with the task force.

Executive Summary **of Recommendations**

Place a hard cap of \$250,000 on non-economic damages for physicians, EMTs, hospitals, nursing homes, and pharmaceutical companies.

Place a cap on punitive damages for nursing homes.

Implement collateral source reform.

Establish limits on when a minor can bring suit.

Implement periodic payments for future damages.

Amend the Good Samaritan Law.

Enforce statutory requirements for expert witness affidavits.

Encourage the use of arbitration and establish special courts to handle medical malpractice cases.

Establish a basis for a bad faith cause of action.

Use screening panels to determine validity of a claim.

Re-visit Senate Bill 1839 to determine whether it is possible to expect all nursing homes to carry liability coverage, particularly by September 2003.

Prohibit the admissibility of survey documents in nursing home litigation, unless the survey documents are germane to the specific issue in the trial.

Protect the pharmaceutical industry from exposure to litigation by refusing changes to the learned intermediary doctrine.

Allow pharmaceutical companies a government standards defense.

Pursue a waiver from the federal government allowing the state to move nursing home accreditations to private accreditation.

Remove DHS from nursing home supervision and transfer accreditation to private accreditation organizations.

Implement a defined contribution model for insuring state employees and teachers.

Give small employers the opportunity to provide health insurance to employees through the Texas Health Insurance Risk Pool.

Direct TDI to provide businesses with information purchasing Medical Savings Accounts.

Address the increasing number of health benefits mandates and their negative effect on the uninsured by establishing dates to sunset all existing health insurance mandates.

Require any proposed health benefit mandate to include a sunset date, as well as state the impact of the benefit on the uninsured.

Offer options for mandate-free and limited benefit health insurance policies.

Allow insurance companies to submit health benefit designs to the Commissioner of Insurance for approval. Allow the Commissioner to bypass current plan requirements.

Cap the maximum rate charge in the Texas Health Insurance Risk Pool at 150% of the standard rate.

Pursue Medicaid block-grant funding.

- Set subsidy amounts for a family based on the family income and local cost of living.
- Craft a benefit package that more closely corresponds to the unique needs of our low income populations. Texas has radically different needs than Minnesota. It does not make sense to hold both states to the same mandates.
- Outsource eligibility determination.
- Subsidy would be on a sliding scale: as families increase their income, their government subsidy is gradually decreased.
- Give families a subsidized debit care to shop around in the free market for group insurance, private insurance, or a state safety net insurance plan. A Health Reimbursement Arrangement would be incorporated where possible to pay for supplemental services. Any unspent HRA monies could be used to help bridge the gap as the family transitions off Medicaid.
- License participant assistant liaisons (PAL's) to be provided at the time of eligibility determination to low-income families to provide education on preventative care, healthy lifestyles, and the appropriate insurance for the family.

Increase Medicaid fraud control efforts by beefing up the Medicaid Fraud Control Unit in the Office of the Attorney General.

Establish a pay for performance system or a full-grant denial program for individuals that are not in compliance with work requirements.

Remove exemptions from work requirements and work orientation to allow case managers to screen for good cause.

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The Truth About Health Care

The traditional health care system stands in disrepair, hobbled by the myriad demands placed on the system and misguided perceptions about the purpose of health care and the role of health insurance. Everyone can agree that the current system of health care needs to be fixed, but it is equally clear that there is no consensus on how to go about those reforms. Proponents of universal health care, or a single payer system, have been beating that drum for years, though losing some momentum by the defeat of “Clinton-Care,” and it is clear that such a plan has its supporters. Even in the 2002 election cycle, Oregon had a universal health insurance bill on its ballot. Although it failed, its presence on the ballot is a testimony to the fact that there is a pressing desire for health care reform. Dissatisfaction with the current health care system raises the need for reform and conservatives must shape the debate.

Until recently, conservatives have rarely jumped out on the offensive on health care reform. Certainly, health and human services reforms were made here and there when conservative leaders like then-Governor Tommy Thompson of Wisconsin, were able to garner support for some reforms. Even still, liberals talking rather openly about “socialized medicine,” have driven and controlled the debate on reforming health care. However, conservative leaders at both the national and state levels have begun to step up and lay out a vision for reformed health care based on conservative principles. Conservatives must combat years of fascination with government programs and the left’s increasing willingness to reform health care by turning it over to the government. More government cannot and will not help health care, and it is hard to think of anything “socialized” that is either an improvement or satisfying. Simple, cosmetic changes to the system are not sufficient—fundamental changes to the structure of the system must be made. And, in addition, it is important to confront the myths and attitudes toward health care that conservatives must face to make the case for health care reform.

Health Care Spending

The United States spends a great deal on health care, 14.1% of its gross domestic product, in fact.¹ Recent figures released by the Centers for Medicare and Medicaid Services show that national health spending rose 8.7% in 2001 to total \$1.42 trillion dollars, the fastest one-year rise since 1991.² Breaking that down further spending on hospitals, nursing homes, doctors, dentists, and drugs alone totaled \$5,035 per person, and

that doesn't account for all the spending.³ Every time figures like these are released it seems that they are seized as evidence to prove that a problem exists in health care because spending is so high. The only reason that this is an issue is because the third party payer system creates artificial demand and federal and state funded systems can never keep pace with the demand. Why should it matter how much a person spends on health care and who should determine what is too much?

Health care is a highly personal area and valued differently by everyone. Thanks to advancements in science and technology, people have access to treatments and pharmaceuticals that improve and extend life. The reality is that medical advancements are welcomed by almost everyone and people want to have access to the best care possible. A recent article in the Wall Street Journal points out that any questions about increased spending on health care must be balanced against the value of these advancements. As an example, the article cites the odds of a childhood leukemia patient surviving at about 80%, whereas 30 years ago odds of survival were only about 10%.⁴ Undoubtedly the parents of a child with leukemia 30 years ago would have paid anything for the health and life of their child, which advancements in medicine have made a reality for parents today. It isn't even necessary to look at such a dramatic example either. Lasik eye surgery has become a popular procedure to correct vision in ways that people only dreamed of in the recent past, illustrating that many of these advancements are accessibility to the average American today. While it is difficult to attach a value to these advancements, most patients wouldn't hesitate to spend money on things that would prolong, and improve, their quality of life. Simply pointing out how much we spend in a year, neglects to address the value of health care, and although the value is hard to calculate, quality health care is certainly valuable.

Can we get too much of a good thing, though? Of course, over-utilization and inappropriate utilization are bad for health care, they drive up spending and clog the system, thereby slowing the care given for others. But drawing this line clearly can be difficult, particularly in a system that insulates the patient from the real cost of care. The third-party payer exacerbates the rise in spending on health care because the patient's financial stake is lessened by the third-party that pays for and manages health care decisions. Consider the person that visits the primary care physician for every slight ache, pain, and snuffle, setting in motion a system requiring additional paperwork, a battery of test, consultations from a nurse and the physician, and all for the diagnosis that the patient has, in fact, a case of the common cold. Undoubtedly every person has had an experience where they questioned the necessity of getting medical attention, but an out-of-pocket expense that is, quite frankly, cheap, does nothing to deter the person from seeking care unnecessarily. It is

quite reasonable to expect consideration of the cost of service as well. Certainly this statement is not meant to minimize the need for care in legitimate circumstances, but over utilization is a serious problem made worse by the fact that patients have very little responsibility in making these decisions and in financing their own health care. The reality is that a person with severe injuries or illness is not likely to forego medical care whether they must pay or not, and it is unfair for this patient to wait in line behind other patients who seek care inappropriately. Individuals who would seek care inappropriately should have at least some incentive to control costs on their own. This is not about punishing people who need care; it is about inducing sensitivity to cost to lessen the demands for unnecessary care.

It is also true that over-utilization is not simply because people have no incentive to control costs, but also because there are many who are just simply unclear about what constitutes medical necessity. Anecdotally, nurses report that they spend a great deal of time instructing patients, particularly mothers of small children, on the difference in medical emergencies and things that can be addressed through preventive care. In these cases, curbing inappropriate use of emergency rooms and doctors' offices is, in part, about education. However, the history of health care through the third-party payer, whether through the government or private insurance, shows that people are unlikely to make wise decisions in spending money that is not theirs, which makes inducing any cost sensitivity difficult. Inappropriate utilization cannot be reduced through education alone. The creation of a new system with a better "stick and carrot" should aim to encourage appropriate utilization and strengthen the current weaknesses in the existing system.

The fact that some spending may be unnecessary does not mean that all of the spending is bad. Too often the blame heaped upon the health care system fails to recognize that some health care spending is completely appropriate and should be encouraged. Without question, it is important to control inappropriate utilization and to that end, there must be a heightened sensitivity toward costs. Combining limitless demand for services and a seemingly never-ending pocket for payment is clearly not the way to improve the system.

Health Care: A Priority or an Entitlement?

Americans have been well trained by years of government expansion to expect the government to play an increasing role in their lives. Health care is no different. The outcry over the expense of health care

illustrates this point best—everyone wants it, but nobody wants to pay for it. It seems paradoxical that health care is enough of a priority for almost everyone to want it or need it, complain if they don't get it or if it's not satisfactory, yet willingly cede the responsibility to the government. If health care is a priority, why is there unwillingness to pay for it? Is health care a priority or isn't it?

Americans willingly pay for luxuries and conveniences like cable television, cellular phones, and entertainment like movies and music, but complain about paying for health care. Medical procedures and benefits that are not covered under traditional health insurance often prompt the calls for mandated additional coverage, suggesting that while the patient wants access to these items, they do not want to pay for them. We complain about the cost of monthly premiums and visits that require greater out-of-pocket expense, but purchase VCRs and DVD players without blinking an eye. By most standards, the luxuries come after the priorities, not the other way around.

Advocacy groups want to protect Medicaid clients from paying co-payments for certain services and benefits, claiming that any amount of money, much less anything over the \$3 cap on co-payments, is too much for the client. Certainly, the truly needy should have access to care they need but cannot afford; however, it is also reasonable to expect these individuals to take some measure of responsibility for their health care, if it is a priority.

Of course, growth of the government and its increasing role as a health insurer leads many to believe that health care and health insurance is an entitlement. It seems that people are ever more willing to expect government to subsidize, if not all-out provide, their individual health insurance and health care needs. Perhaps it is the result of Medicaid and Medicare system that provide such rich benefits, or perhaps it is simply because all health care is perceived as a need. This belief begs the question: if health care and health insurance are an entitlement, to what level is the government responsible?

To be clear, the conservative vision for health and human services is one without government involvement in the provision of individual health insurance. Limited government applies to the health care arena as well as any other. The state must provide for the safety of public health and work toward a health care system that offers access to quality care in all areas of the state, but the state should have no responsibility as a provider of individual health insurance. Despite this, the distinction between access to care and access to insurance is often unclear. Advocates for expanded government insurance portray efforts for expansion as providing access to care. In truth, access to care is about

ensuring a system of medical care in the state to meet the needs of Texas' patients, but it is not about everyone having government subsidized health insurance.

Through the Medicaid and Medicare programs, the government has become the insurer of last resort for many of the most needy, yet this should not be construed as a blueprint for the future. In fact, quite to the contrary, this system should be seen as a labyrinth of complex regulations and provisions that the state and nation should avoid using as a model for anything. The best solution is for health care to be a truly market-oriented and consumer driven product, which would be hindered by greater regulation or expansion of government care. Consumer empowerment means that people have a greater stake in their health care and drawing people away from the mentality that health care is an entitlement.

While suggesting that health care is a question of priorities makes some uncomfortable, the truth is that consumer empowerment and priorities go hand in hand. The consumer empowerment model recognizes that everyone can establish different principles for their own health care needs, due largely to the different values individuals place on health care. Americans at any income level should make choices about what is important to pay for and what is not, in health care decisions, just as they do in all other areas. The government cannot simply pay for things that Americans want, but do not want to pay for. Conservatives must be clear in establishing expectations—if health care is a personal issue and a priority for the individual, it should be treated as such, and not as the responsibility of the government.

The Health Care Industry

Conservatives must combat the notion that being profitable in the health care industry is somehow immoral. The idea that a pharmaceutical company, a doctor, a hospital, or a nursing home should forego profits in the name of health care is a remnant of misguided compassion uneducated by the long experience that profit is good for progress. The profitability and continued solvency of the health care industry is vital to continued medical advancements and providing access to care.

Although stereotypes of rich doctors remain, and many nursing homes are increasingly (and unfairly) portrayed as cutting corners to make a profit at the expense of elderly residents, there is perhaps no single health care industry that receives more negative attention than the

pharmaceutical industry. The pharmaceutical industry has become a punching bag for people who blame prescription drugs for the increase in health care costs and cite the pharmaceutical companies' direct-to-consumer advertising as the culprit. Even in the presidential election of 2000, Vice-President Al Gore incorrectly remarked during a presidential debate that drug companies spend more on advertising than research and development.⁵ Statements like this only fuel the popular belief that drug companies are somehow gouging the public and are most concerned with profit, despite the fact that improvements and breakthroughs in medical treatments and devices are largely a function of privatized dollars invested in research and development leading to marketable products.

That a company or a health care provider is profitable is hardly a problem, and for these companies to be profitable may actually result in better health care in the future. No other industry commits a higher percentage of sales revenues to new innovation and future advances.⁶ This is a practice that should be encouraged and provides immeasurable benefit to health care consumers. In fact, the issue of cost containment in health care may best be addressed by the continued development of pharmaceuticals as research shows that pharmaceuticals keep people healthy and avoid the need for more costly alternatives. Amazingly, one figure shows that for every \$18 increase spent on new prescriptions, the spending on non-drug health care decreased by \$71.⁷ The fact that pharmaceutical companies can continue to make advancements in medicine is inextricably linked to their profitability. According to one industry leader, it costs more than \$800 million and twelve to fifteen years to bring a new medicine to market, and research-based manufacturers invested \$30.3 billion in research and development in 2001 alone. It is easy to suggest that the profitability of companies is a problem in the current health care system, but in truth, profits are what makes many of the medical advancements possible. Presuming that the health care industry puts profits ahead of patient care or access is troubling. No other industry must battle as emotionally charged claims, while putting so much into continually improving the care available to their consumers.

Furthermore, the current system of health care has done such a remarkable job insulating patients from the cost of health care that reasonable expectations of the cost of health care have been severely distorted. In truth, only the cost of prescription drugs is recognizable to the patient and calls for price controls on drugs and new and improved drug benefits continue to grow louder. Those plans without a drug benefit subsidize the cost of most of the care, yet have no break on the purchase of drugs—making everything appear free except for a \$70 prescription the patient pays out of pocket. Or, consider, that a visit to

the doctor typically has one easy co-payment--\$25 will pay for the consultation, the lab work, the diagnosis, and any incidentals along the way; what each of those costs on their own is generally unknown by the consumer. The fact that the cost of pharmaceuticals is rarely masked by any other services, or is perhaps full-price because the health plan does not offer coverage, means that the cost of pharmaceuticals is the most obvious cost a patient incurs. Of course, depressing the prices of everything compared to prescriptions means that people believe they are paying too much for pharmaceuticals.

The fact is that most of the health care industry in general receives little acclaim for the ways it partners with the government, and even individual patients, to provide low-cost care or benefits. Patient assistance programs and prescription drug cards are the backbone of the pharmaceutical manufacturers efforts to provide low-cost and discounted drug benefits to certain eligible recipients. Physicians, hospitals, nursing homes provide care to Medicaid and other recipients of government assistance, with low reimbursement rates. Portraying the industry as self-serving and suggesting that costs are high because the industry charges too much, fails to recognize that the industry makes important contributions to direct care as well as medical research and advancements. The health care industry is vital to ensuring the availability of quality care in the state of Texas.

Why More Government Won't Fix Health Care

American taxpayers foot the bill for about 45% of health care spending, mostly through Medicaid and Medicare.⁸ In this case, slightly more than half of all health care expenditures are private pay, or more accurately, not paid for by the government. This means that many American workers finance the health care of Medicaid clients and then pick up the increasing tab for their own health care through increased premiums and higher cost sharing. A recent report from the National Center for Policy Analysis confirms this, finding that Medicaid costs every person in the country almost \$1,000 each, and states that, "indeed, it is likely that many taxpayers are paying more in taxes to fund health insurance for the poor than they pay for private health insurance for themselves and their own families."⁹ This is an untenable situation and further illustrates that health care is *never* free. Advocates for government-run health care should keep this in mind and know that there are really only two options: either individuals can ration health care or the government can do it, but the second option cares more about what the government can afford and less what the individual needs.

The exploding cost of Medicaid combined with the budget shortfalls in a majority of the states has resulted in a closer look at the places that states spend money in Medicaid. Undoubtedly, this will result in at least some minor changes in Medicaid benefits for certain people. Of course, the federal government prohibits the denial of benefits and enrollment for Medicaid eligible persons, creating a limitless source of health care for anyone willing to take advantage of it. That Medicaid budgets are busting is no coincidence. While Medicaid may now provide a rich package of benefits to enrollees, any government-run health care program naively attempting to provide coverage comparable to Medicaid would soon find itself in the same situation. The question will always be whether the government continues with cost increases for health care or limits access and services.

The history of socialized medicine shows a system strained and unsatisfactory for most enrollees. Canada and many European countries practice socialized medicine, none of which have an enviable program. For instance, according to one leading pharmaceutical company, “the Canadian health care system does not cover many of the top 200 medicines used by the elderly in America.”¹⁰ The tradeoff? Unlimited coverage results in limited access. According to another statistic, Canada has fewer MRI machines per capita than Mexico.¹¹ Unlimited coverage results in limited access to medical technology. These are examples of the limited access, limited care, and limited technology that are common in socialized medicine, but which would be disastrous to the state of health care in the U.S.

In addition, the U.S. experience in government run health care is hardly any better. One study reports on the substandard level of care Medicaid delivers to its clients, pointing to findings that women on Medicaid were three times more likely to die of breast cancer than were women not on Medicaid.¹² Furthermore, women on Medicaid were found to have received late-stage diagnoses and receive less radiation treatment.¹³ The article citing these facts uses these as arguments why Medicaid should not be expanded to cover the uninsured, but these arguments are perhaps even better reason why the government shouldn't run health care for anyone. The promise of substandard care, combined with reduced access, and continual cost increases are proof enough that government health care is more problem than solution. To glimpse the future of a government run system one need only observe nursing home facilities which derive most of their funds from government and the quality of care deteriorates.

Conclusion

Conservatives must challenge the policies that would drive the health care system further into the hands of the government, as well as public opinion that although people believe the health care system is near collapse, many are willing to resolve the impending doom by turning the whole system over to the government. It is imperative to prepare a conservative vision for health and human services reform that lays out an alternative to prove that there are other ideas and better ways to address the crisis in the current system. To be sure, the solutions to the problems in health and human services are bigger than one action; many will require dedication to principles and commitment to vision over the next several years. The truth is that there is perhaps no greater need for reform than in the health and human services system, and conservative leaders must be prepared to take the mantle of reform and offer a competing vision for health and human services that will be best for the state of Texas and serve as a model for the rest of the United States

¹ Health Care Costs: Spending reaches Record Level of Growth, Government Report Finds. Email.

² David Wessel, "Health Spending: How Much Is Too Much?" The Wall Street Journal, January 9, 2003, A2.

³ "Health Spending: How Much Is Too Much?"

⁴ Robert Pollock, "Americans Need a Market For Medical Progress," January 22, 2003.

⁵ "The big drug companies...are now spending more money on advertising and promotion—you see all the ads—than they are on research and development," Al Gore, third Presidential Debate, <<http://www.nationalreview.com/gorelies/gorelies.shtml>>.

⁶ Galen Institute, "Links Between Drug Company Profitability and Investments in Research: A Fact Sheet," Joe Moser, July 2, 2002, <<http://www.galen.org/news/070202.html>>.

⁷ "Links Between Drug Company Profitability and Investments in Research: A Fact Sheet."

⁸ Robert L. Pollock, "Americans Need a Market For Medical Progress," The Wall Street Journal, January 22, 2003.

⁹ National Center for Policy Analysis, Reforming Medicaid, Bond et al., February 2003, p. 2.

¹⁰ Lilly, Prescriptive Perspective, International Pricing,

¹¹ National Review.

¹² The Heritage Foundation, "Why Expanding Medicaid to Cover the Uninsured Is Not the Solution," Nina Owcharenko, April 18, 2002.

¹³ "Why Expanding Medicaid to Cover the Uninsured Is Not the Solution."

Access to Care

“Access to care” is very different from “access to health insurance,” though the distinction seems rarely understood. Access to care is truly about the availability of medical care when it is needed, ranging from the care of a family physician when a child has a cold, to the emergency needs of a patient in a trauma center or emergency room, to the availability of long-term care for Texas’ aging or disabled population. Access to care is about much more than health insurance; clearly, all the insurance in the world will do a patient no good if there is no quality medical care available.

Texas faces very real challenges in providing access to care in almost every aspect of health care. Whether its doctors, hospitals, nursing homes, or pharmaceutical companies, each are concerned that there are threats to the delivery of health care in the state of Texas. While each section of the health care industry has particular concerns and challenges, most face similar obstacles. Of primary concern is the increasing threat of litigation and the plague that medical malpractice has become on the health care industry. Hospitals, doctors, nursing homes, and pharmaceutical companies all have concerns specific to their industries, the consequences of inaction are very much the same and many of the same solutions would address their collective needs. Anything short of comprehensive medical malpractice reform will leave the state exposed to continuing access to care problems.

In addition to simple access to care, the provision of quality care is also an important issue. Staffing shortages and over-regulation are impediments to a system that should be focused on providing quality care. The state now faces a nursing shortage, yet the looming nurse shortage is far more severe and will likely require some action from the state in order to stave off the coming crisis. In addition, it is imperative that the state address areas of over-regulation in the health care industry that divert attention away from direct, quality care.

Liability, Litigation, and Losing Access to Care

The issue of medical liability is not new in Texas. Since 1977, when the 65th Texas Legislature passed the Medical Liability and Insurance Improvement Act (MLIIA), the state has continued to address the issue when the law provided inadequate safeguards against litigation abuse, or

when the system appeared out-of-control. Over the years the law has been amended as portions of MLIIA, commonly referred to as it is codified in statute as 4590i, have been held unconstitutional, or as it became necessary to strengthen existing statute. Once again, the state must address the issue of medical liability and it must do so with comprehensive reforms to strengthen the current statutes and address questions of constitutionality that have been a concern in the past. The evidence shows that the health care industry faces a constant threat of litigation putting their ability to provide care in jeopardy. Difficulties in accessing care will only continue to increase if the current situation is not addressed.

Physicians

Recent figures show that just over half of all Texas physicians had claims filed against them in 2000. The figures are even higher for doctors in the Valley, where seven in ten had claims filed against them.¹ These numbers are staggering, but they do not tell the whole story; such numbers could indicate serious problems in the medical industry suggesting that the vast majority of providers are simply unfit to practice, but this is simply not the case. Over 85% of closed claims had no settlement or awards paid, yet they still take both time and money to resolve.² That the vast majority of claims are closed without payment implies that majority of these claims are frivolous to begin with, but even the frivolous claims cost an average of \$10,000 to defend.³ Furthermore, of the few cases that go to trial, and the even fewer cases that result in decision for the plaintiff, the most dramatic costs are in the erratic and unpredictable jury awards for non-economic damages. The losses to the insurance carriers are tremendous and continue to increase. The Texas Department of Insurance estimates the difference between direct written premiums, and indemnity and legal expenses, as a loss of \$103.5 million in 1999 and \$229 million in 2000.⁴ Those losses contribute to Texas' ranking as one of the ten most expensive states in terms of medical malpractice costs.⁵

The insurance market used to be a competitive place, and drove the cost of premiums down to what have become unsustainable levels. Large losses resulting from claims and litigation have driven carriers from Texas. Testifying before the Senate Finance Subcommittee on the Rising Cost of Health Care, the Commissioner of Insurance stated that the state of Texas is last in terms of profitability for insurers. It is not simply that these providers have already lost money in Texas, but that they expect to continue to lose money in the future. In 1998, there were thirteen carriers writing insurance in Texas, but only four writing insurance in

2002.⁶ The need to make up for losses, combined with less competition, means that liability insurance rates have increased dramatically. Reportedly, doctors have seen premium hikes of 50% to 200%, and with little room to increase revenue, these premium increases begin to eat into the doctor's bottom line.⁷ For example, the Texas Medical Liability Trust estimates that an OB/GYN operating in South Texas will pay premiums of \$91,894 annually compared to an average of \$43,196 in California. IN May 2001, the American College of Obstetricians and Gynecologists (ACOG) named Texas one of nine "hot states" where a medical liability crisis threatened the ability of physicians to deliver babies. In parts of Texas, medical liability premiums have risen to \$160,746 a year and the Texas Medical Association expects premiums for 2002 to increase by 30 to 200 percent. Malpractice premiums can make up between 10% and 25% of a physician's revenue, depending on the particular physician's work.⁸ Understandably, the cost of liability premiums has become prohibitive to many doctors now wrestling with whether they can even afford to stay in practice.

Doctors that survive the premium hikes fear having claims and/or lawsuits being filed against them. In order to protect themselves from premium hikes and lawsuits, doctors have not only begun to limit the services they will offer, but also who they will see and where they will practice. This practice, known as "defensive medicine," has tremendous implications to accessing care.

According to "The Fear of Litigation Study- The Impact on Medicine" poll conducted by Harris Interactive Inc. for a new bi-partisan organization called Common Good, 87% of all physicians responded that since the beginning of their career, their concern or awareness about the risks of malpractice liability have increased. The same study also found that 54% of physicians report that they are hesitant or reluctant to help an injured person when off-duty because of fear of liability. Furthermore, 79% of physicians say that they order more test than they would based only on professional judgment of what is medically needed because of the fear of malpractice liability.

In particular, the costs associated with high risk practices like obstetrics, neurosurgery, and trauma care have forced these providers to stop delivering babies and stop covering emergency rooms in order to reduce their liability. According to the Physicians Insurance Association of America, OB/GYNS were first out of 28 specialty groups in the number of claims reported against them in 2000 and had to pay the most of any doctor to defend themselves against often unfounded claims.

An article in the Dallas Morning News stated that physicians are hesitant to respond to calls of a medical crisis, or a "code blue," in a hospital for

fear of the unknown liability they may encounter.⁹ Even more startling is a recent survey of doctors that found that 54% claimed to have personal knowledge of physicians who have hesitated to help an injured person when *off-duty* because of liability concerns, and one-third said they know of an instance where a physician did not volunteer to help.¹⁰ The threat of litigation is so pervasive that it inhibits a doctor from rendering aid both in the workplace, and in his private life, and inarguably at times when the doctor is most desperately needed—in an emergency. The costs of defensive medicine clearly threaten access to care. While defensive medicine also directly drives up the costs of health care when doctors order more tests, procedures, and prescribe more drugs to protect themselves from liability, the foremost concern is that medical malpractice threatens basic level of care. The Texas Medical Association has stated that more than half the doctors in the state are considering early retirement as a result of the state’s medical liability crisis, which, if realized would severely impact the ability for Texans to find quality care providers.¹¹

Additionally, **Emergency Medical Technicians** (EMTs) should receive the same protections from liability as other medical providers. Due to the high-risk setting EMTs work in, their liability is also in question. Considering that EMTs, like physicians, treat unknown emergency patients and are often trying to care for a patient when immediate hospital access is impossible, EMTs should be included in liability protections. Surely what the medical malpractice climate has shown in recent years is that almost no one is immune to liability concerns and that if the liability burden is not equally shared nor equally protected, the burden shifts. Although liability concerns for EMTs are not as high profile in comparison to many of the other medical professionals concerns, the will most certainly become a target if others have greater protection. In addition, the EMT’s work environment is one where liability protection is essential as these individuals are first responders to scenes where quick reaction is needed and their ability to carry out their duties must be unencumbered by concerns of protecting themselves against medical malpractice.

Hospitals

Hospitals are not immune to the liability issues either and also suffer some of the trickle-down effect of the professional liability problems with doctors. Although hospitals have faced fewer claims than doctors, in recent years, the average claim payment of major business classifications in Texas was by far the highest for hospitals compared to any other business.¹² In fact, the average claim payment against Texas hospitals

increased 300% between 1989 and 1999 and the average medical malpractice verdict increased by 500% over the same ten years.¹³ More importantly the average economic award increased 57% between 1989 and 1999, while the average non-economic award skyrocketed 433% over the same period.¹⁴ This tremendous leap in non-economic damages illustrates the uncertain and erratic nature of non-economic damages that cause such concern for liability insurance writers and doctors alike.

Hospitals also face a challenge to provide quality care while struggling with high patient demand and shortages in staff. Physicians recognize that as their liability risk increases, so do their liability insurance premiums. As such, many doctors forego working in the emergency settings of a hospital because the liability is too high. This is particularly problematic in specialty areas like neurosurgery and obstetrics, where rising premiums have caused these specialists to discontinue their work with a hospital, and discourages those that may consider going into the hospital setting to begin with. Weighing the option between having a private practice where the physician can spend time getting to know a patient and the patient's medical history, and working in an emergency environment where a physician may not have any control nor full knowledge of the relevant details of a patients' medical history—exposing them to greater risk—it is understandable why some providers would prefer to protect themselves and practice outside the hospital. A newspaper article discussing the impact of these issues around the country quotes a Las Vegas doctor who puts it best, "If somebody comes in at 9 months with no prenatal care, I'm supposed to pull out a grade-A baby and hand it over to that mommy who never bothered to get prenatal care."¹⁵ Of course, the reluctance to provide care in a hospital setting means that the hospital struggles to stay staffed, which has a direct impact on quality of care. The nursing shortage in Texas only compounds the hospitals' challenge to recruit and retain physicians with needed specialties.

Nursing Homes

The nursing home situation in Texas is among the most severe in the nation- only Florida is considered to be worse. The 77th Legislature talked about the impending nursing home crisis, but did little to make things look any better and may even have accelerated the coming crisis.

Texas' nursing homes have also experienced dramatic increases in liability insurance premiums, driven in part by the fact that compared to all other states, Texas nursing homes are sued twice as often and the average claim per bed is more than twice the national average.¹⁶

Nationwide, the average cost per bed has increased from \$250 per bed in 1998-99 to as much as \$5,000 per bed in 2002.¹⁷ The increase in liability insurance premiums, combined with the few insurance companies that offer nursing homes professional liability insurance, has forced some nursing homes to go without coverage. In fact, according to the Texas Health Care Association more than half of Texas nursing home providers “go bare,” meaning they no longer carry liability insurance. Liability insurance rates have continued to increase and the number of insurers continues to decrease. The availability of liability insurance in the state has become so dismal that both for-profit and non-profit nursing homes have, in recent years, been made eligible for coverage under the JUA, a last resort insurance provider for health care providers. Of course, as the insurer of last resort, the JUA makes insurance available to nursing homes, but it must be the more expensive than any other insurance writer in the state. As such, the JUA is only beneficial for the few nursing homes that can afford the increased premiums. However, the truth is that for most nursing homes, liability insurance is neither available nor affordable.

One major concern for nursing homes “going bare,” is that a single high claim could shut down a nursing home entirely. However, of additional concern, is the liability insurance spillover onto physicians and medical directors working in the nursing homes. Physicians or medical directors working in homes that go without insurance become the target, and they are often named in suits against nursing homes. The consequence is similar to physicians in hospitals- physicians considering working in the nursing home may opt not to do so because of added risk and increased premiums, physicians already working in the nursing home may leave because the risk and cost are too high, or the professional liability insurance writer could simply choose not to renew the policy. Without professional liability insurance, neither the physician nor the medical director can work in a nursing home. Clearly, the presence of medical directors and physicians are critical in the operation of a nursing home and in providing quality care.

Furthering the nursing home industry’s problems is a provision in Senate Bill 1839 from the 77th Legislature, which requires that by September 2003, all nursing homes in the state of Texas must carry liability insurance. This mandate on nursing homes comes at a time when many homes struggle to remain solvent in the face of increasing premiums, high losses, and reimbursement rates that do not keep pace with their needs. Simply mandating that all of these homes carry liability insurance is impractical and ignores the fact that availability and affordability remain unchanged despite such requirements. Even homes that turn to the JUA for coverage are not insured against exemplary damages, meaning that homes that obtain insurance through the JUA

are still subject to additional liability they may be unable to afford. Should this provision remain in place, the reality is that many nursing homes may be forced to shut their doors.

The nursing home industry is also unique in that while MLIIA applies to nursing facilities, nursing facilities are held to standards that are far different compared to other areas of medical care. For instance, punitive damage caps do not apply to cases where there has been injury or death to children, the elderly, or the disabled. Of course, almost all nursing home residents would fit into these categories, leaving nursing homes exposed to even greater levels of liability in comparison to other types of health care. In this case, punitive damages are not simply reserved for the most egregious instances of injury to the elderly, which punitive damages are intended to address. Exorbitant awards for punitive damages are a driving factor in the increases in liability insurance. In a review of nursing home lawsuits, the Texas Health Care Association found that punitive damages far outpaced non-economic damages: between 1996 and 2002, punitive damages in sixteen cases totaled \$976.9 million, while non-economic damages in twenty eight cases totaled \$106.9 million.¹⁸ Clearly, to bring the necessary liability protections to nursing home liability any reforms considered must address punitive damages in addition to non-economic damages, in order to effectively address the current situation.

Pharmaceuticals

Liability issues for pharmaceutical companies are somewhat different than the liability issues described in the aforementioned industries; however, as the 78th Legislature looks at reforms to the current system, it is important that pharmaceuticals not be left bearing the litigation load. Attempts to safeguard physicians, hospitals, and nursing homes from frivolous claims and lawsuits, should not shift the liability burden to pharmaceutical manufacturers.

This, of course, is not to suggest that the pharmaceutical industry does not face liability issues today. Class-action lawsuits are increasingly common for pharmaceuticals, and drug companies are often named as defendants in cases where product liability is in question. Texas would be shortsighted to limit a physician's liability at the expense of pharmaceutical companies. Reforms to medical malpractice litigation should not leave pharmaceutical companies as the deep pocket and a prime target of future litigation. Placing the litigation burden on pharmaceutical companies will reduce the pharmaceutical products on the market, making access to pharmaceutical drugs and innovations

more limited. Most of the frequently discussed reforms, neglect to address the drug companies' liability in addition to other health care providers.

The first concern is that in a trial where medical malpractice and product liability are in question, if the doctor's liability is capped, the damages will be shifted to the pharmaceutical company. For instance, in the case of joint and several liability, the jury may return a verdict that maximizes the damages under the cap for a doctor, and shift the balance of the damages to the drug company. Capping only medical malpractice damages will expose pharmaceutical companies to greater liability. The future litigation frenzy, which would no doubt ensue, would result in a liability crisis for drug companies just as the state is currently experiencing for doctors, hospitals, and nursing homes.

A second major concern is that pharmaceutical companies now rely on doctors to understand the product warnings required by the Food and Drug Administration (FDA) when prescribing medication for a patient. This responsibility is placed on doctors since the product cannot be obtained without prescription; as such, courts have held that drug manufacturers' liability extends to the physician not the patient. Any action that would absolve the doctor of this responsibility could create problems for pharmaceutical companies and patients alike. Pharmaceutical companies would be forced to protect themselves by making warnings understandable to the consumer, which would be difficult and would limit the products available. This prospect alone should emphasize the need for comprehensive reforms in order to stave off threat to access to care. The sheer necessity of a prescription should be enough to protect pharmaceutical companies from being directly liable to the patient. Any legislation to address liability issues should weigh the cost of anything short of comprehensive reform.

Recommendations

Place a hard cap of \$250,000 on non-economic damages for physicians, EMTs, hospitals, nursing homes, and pharmaceutical companies.

Non-economic damages are commonly thought of as compensation for "pain and suffering," two ideas that are hard to quantify and open for broad interpretation. For this reason, these numbers vary wildly with little or no standardization. Non-economic damages are unpredictable and cause insurance writers and the insured great concern because they are so erratic and often expensive. Non-economic damages should not be

an opportunity to drain defendants for as much as a jury will allow, but there should be reasonable compensation for the non-economic consequences of certain actions. Capping non-economic damages at \$250,000 level will still allow plaintiffs to recover actual costs in economic damages, and even some portion of what they feel is their due in non-economic damages.

In order to meet the requirements of the Open Courts Doctrine that previously held caps on non-economic damages unconstitutional, the Legislature could either propose a constitutional amendment authorizing limits on certain tort damages, require medical professionals to carry malpractice insurance, or provide some other way by which a plaintiff could reasonably recover damages.

It is important that each of the four specified groups be covered under the cap on non-economic damages to ensure that there is access to care across the state of Texas. If the Legislature chooses not to put all of these industries under the cap, it can be expected that the liability crisis will only continue to worsen in each industry until such caps are put into place.

Place a cap on punitive damages for nursing homes.

Nursing homes suffer in a litigious environment in which punitive damages are more often the rule, rather than the exception. Punitive damages, which are awarded in an effort to punish a defendant, extend beyond economic and even non-economic damages and are often established at astronomical figures. These damages may be useful in surveying the overall landscape of a situation where one has a standard by which to compare cases; however, as a jury deals with only one case, they are unable to have this perspective. Arguably, every jury feels that it has heard one of the worst cases and feels compelled to punish the defendant accordingly.

In addition, the statute that generally provides exceptions to punitive damage caps encompasses virtually anyone that would reside in a nursing facility. As a result, nursing facilities, unlike any other medical care, may be assigned punitive damages. The unpredictable nature of these punitive damages, which are often even higher than non-economic awards made, makes liability insurance for nursing homes even more expensive and hard to find. The combination of uncontrollable non-economic damages and high punitive damages threaten to drive homes from business.

Implement collateral source reform.

Texas juries should be fully aware of any and all sources of payment a plaintiff may receive. Without information about what it costs to make the plaintiff “whole,” which is ostensibly the goal, the jury can name an award that would be far higher than what is actually needed.

Establish limits on when a minor can bring suit.

While most malpractice claims must be brought within two years, claims involving a minor can be brought any time before the minor’s 20th birthday. The rationale for this policy is that there are occasions where issues or evidence of medical malpractice may not appear until some time after the breach or completion of treatment. One obvious example of such a situation may be that complications arising from the birth of a child may not be immediately obvious until a baby has more fully developed. For such cases, there ought to be reasonable opportunities for recourse; however, it is not reasonable to link a doctor to a patient some 20 years later. There should be reasonable limits on when a minor may bring suit against a doctor.

Implement periodic payments for future damages.

Economic damages awarded to a plaintiff should be paid over time. Economic damages are compensation for identifiable costs and are awarded according to what the plaintiff would need for their entire life. However, in the event that the plaintiff dies earlier than expected, the economic damages awarded would exceed what was necessary to support them through life. Establishing a system of periodic payments would ensure that care is provided and paid for when needed, but would curb excessive awards as circumstances and unforeseen changes impact the plaintiff.

Amend the Good Samaritan Law.

The biblical story of the Good Samaritan was about helping someone in need. The Good Samaritan law should be so simple. Interpretation of the current statute, however, suggests that doctors must demonstrate prior to treatment that they do not expect payment. This presumes that the recipient of such aid is unclear as to whether they are purchasing such services or just receiving services without charge, and in many respects, it centers the law around the perception of the patient. Instead the law should focus on the doctor’s duty to render emergency aid, to be a Good Samaritan, not whether the patient understands the aid to be free. The Good Samaritan law should be amended to provide liability protection to doctors under such circumstances, encouraging them to provide emergency aid as necessary.

Enforce statutory requirements for expert witness affidavits.

Legislation in 1995 attempted to control frivolous lawsuits by codifying language in MLIIA requiring plaintiffs attorneys to file expert witness reports within 180 days of filing suit. The law also establishes standards for expert witnesses, as well as penalties for not filing the required reports. However, doctors believe that judicial discretion compromises the effectiveness of the report requirements, and that the intent of the law was to control frivolous lawsuits, which cannot be done if requirements are waived. Statutory requirements for expert witness reports should be enforced, and judicial discretion in the area should be reviewed.

Encourage the use of arbitration and establish special courts to handle medical malpractice cases.

One of the biggest problems in medical malpractice suits is the lack of expertise and technical proficiency in the area. Arbitration and the establishments of special courts would address this concern, as both would involve experts that would have understanding and appreciation for all of the issues in question.

Current arbitration guidelines prevent doctors from requiring or requesting patients to agree to arbitration, unless the agreement is signed by a patient's attorney prior to the treatment. Arbitration is frequently used and has been successful in a number of other areas, and should be employed in the case of medical malpractice where experts can oversee the proceedings. Cases that can be settled through arbitration would surely help to reduce crowding in the courts, and it could also encourage a more timely resolution to such cases.

Establishing special courts would allow doctors a better opportunity for a jury of their peers, where those involved would have specific expertise in the area of medical malpractice. Unlike other areas of the law, medical malpractice cases require a real understanding of the medical issues of a case in order to preside over a case fairly. The creation of these courts would require the parties involved to have the necessary expertise and allow those individuals to focus on efforts related to medical malpractice.

Establish a basis for a bad faith cause of action.

One of the reasons that the medical malpractice situation is so grim is the lack of vigorous self-policing. While lawyers portray the situation as one drive by bad doctors who rightfully have attention drawn to them, the doctors see it much differently. Certainly, findings that the State Bar of Texas has not regulated frivolous lawsuits filed by its members, raises

this concern more. Furthermore, a recent appeals court ruling found that suits brought maliciously and in bad faith do not constitute an abuse of the system.

Doctors should have a means of recourse when frivolous lawsuits are filed against them. The solution is to establish a separate cause of action that would allow doctors to sue independently or bring a countersuit to show that a suit was filed with reckless disregard.

The same lack of self-policing that exists at the Bar is equally unacceptable with the State Board of Medical Examiners. Each of these entities must take action to protect their profession from allowing the bad doctors and bad lawyers to represent their respective professions. The issue of medical error reporting is important to quality of care, which the attorneys claim to protect through filing of lawsuits. The establishment of such a reporting system is described in greater detail in the discussion of quality care.

Use screening panels to determine the validity of a claim.

All medical malpractice claims could go before a screening panel to determine if the claim is valid. Regardless of the panel's decision, a plaintiff could choose to pursue court action, but the plaintiff would be responsible for attorney's fees and the costs of the doctor if the plaintiff did not prevail at the trial and the panel found the claim to be without merit. The risk in such a process is that the screening panels become a testing ground for attorneys shopping to find cases they can pursue.

Re-visit Senate Bill 1839 to determine whether it is possible to expect all nursing homes to carry liability coverage, particularly by September 2003.

Nursing homes believe that they will have difficulty in meeting the requirement established in Senate Bill 1839 that all nursing homes carry liability coverage by September 1, 2003. Of particular concern is that the nursing homes which are unable to meet this directive will be forced to shut down. Affordability and availability are of the utmost importance in determining whether such provisions should remain in place.

The truth is that insurance is widely unavailable, and that when it is available it is expensive, often prohibitively so. This is the case with the JUA. Although the JUA offers nursing homes liability insurance, many nursing homes are still unable to meet the cost. Although the insurance is available, it may not be affordable. Additionally, the JUA only offers homes malpractice liability coverage, but leaves the facilities open to general liability and punitive damages.

Prohibit the admissibility of survey documents in nursing home litigation, unless the survey documents are germane to the specific issue in the trial.

Information in nursing home surveys is collected during routine nursing home inspections to determine how well they meet standards of care. These surveys were not intended for use in nursing home litigation and often create an inaccurate impression of a nursing home's quality of care. These surveys often do not reflect directly on the quality of care in question or even of the same timeline; instead, attorneys can pick and choose the surveys that best make their case, using surveys from periods unrelated to the case at hand, and facility problems unrelated to the quality in question. These surveys are for measuring standards of care, not for documenting a facility's failures to implicate them some time in the future. This is not about hiding the findings of the surveys, it is about using those findings responsibly. Survey documents should not be admissible in any nursing home litigation, unless they relate directly to the case at trial; survey documents reflecting medication errors should not be permitted in a trial talking about general neglect.

Protect the pharmaceutical industry from exposure to litigation by refusing changes to the learned intermediary doctrine.

Pharmaceutical companies should be included in any non-economic damages caps enacted for other areas of health care. Additionally, pharmaceutical liability protection should be respected and no action should be taken to expose the industry to greater lawsuits. In particular, pharmaceutical companies should not be responsible for product liability questions that arise from FDA approved drugs obtained through prescription. As such, the doctor, as the learned intermediary, should not be absolved of responsibility at the expense of the drug companies.

Allow pharmaceutical companies a government standards defense.

The Federal Food, Drug and Cosmetic Act (FFDCA) requires that medical technologies cannot be legally marketed until the Food and Drug Administration (FDA) approves them. The FDA's pre-market standards are rigorous and a product cleared by the FDA is deemed to be safe for market. In the case of a product liability claim, the pharmaceutical companies, and other manufacturers, should not be liable for a product that was approved by the FDA.

Quality Care

While simple access to care is important, encouraging a system of quality care is in the best interests of the state. In fact, what this truly means is that the state must not create policies that burden the health care industry and divert attention from the provision of quality care. Government's zeal to regulate industry often results in a focus on process rather than outcomes. This seems particularly acute in the case of nursing homes, which face enormous regulation and a highly punitive system.

Another obvious challenge to quality care is in staffing levels. Staff shortages, particularly in nursing, and the turnover rate in some areas of health care are particularly concerning. The nursing shortage is a problem at almost every level of health care with hospitals and nursing homes reporting the most critical shortages. Compounding the shortages are turnover rates that often exceed 100%, particularly in some nursing homes.

However, common throughout the issue of quality care is the fact government involvement in the health care system is part of the reason that quality is often low. Because the government pays for a great deal of the total health care spending it feels compelled to regulate the industry. The government's role as a payer and a regulator is conflicted and can often lead to poor quality and low reimbursements. This cycle is perpetuated because of the government's continued (and growing) involvement in health care.

Regulation

Nursing home liability is only part of the nursing home industry's problems. Nursing homes claim that over-regulation of nursing homes, and the punitive system that scavenges for problems rather than fixes them, are an additional headache for these facilities. A review of state regulatory activities and requirements substantiate this claim.

In accordance with federal law, nursing homes must be inspected once a year, and must meet federal certification requirements and be licensed by the state in order to qualify for Medicaid and Medicare payments. The Department of Human Services inspects the facilities to ensure that they meet federal guidelines; if a facility is not in compliance, the inspectors make note and determine the severity of the situation. The state employs a large number of inspectors compared to other states, in order to assess compliance with these federal guidelines.

In 2000 there were 70,849 nursing home residents in 1,026 facilities across the state of Texas.¹⁹ These nursing homes operate under 132,000 pages of regulations handed down by the federal and state governments.²⁰ Enforcing these regulations, the state of Texas has almost 5 survey and certification personnel for every 1,000 nursing facility residents.²¹ This ratio places Texas fifth in the nation in the number of surveyors to residents.²² Ostensibly, these inspectors and the standards they measure by are to improve care by pointing out areas of noncompliance. However, one of the biggest criticisms is that the inspections do not help facilities to improve care, they are simply used to punish facilities.

The inspections themselves are usually punitive and options for amelioration are rarely exercised. Anecdotal evidence suggests that nursing homes are frequently cited for such minor issues as “sweat” on a glass and corners of floor-mats that have a corner flipped up, and while both of these could create problems if an elderly or disabled resident dropped the glass or tripped on the rug, these minor incidences are only a snapshot in time of such a facility. With so many other issues dealing with direct care, these minor incidents seem insignificant. However, incidents like these are not uncommon citations. The highly punitive system in Texas has resulted in more than \$27 million in fines against nursing homes since 1995.

There is no reason to believe that stacks of additional paperwork make direct care any better. In fact, these efforts to protect quality of care through prescriptive measurements and standards may actually make things worse. This punitive system distracts facilities from providing direct care and instead preoccupies them with issues unrelated to direct care, like paperwork. Understandably, the federal government wants to be sure that the facilities that receive funding meet certain criteria; however, these guidelines have turned into overwhelming regulations that may actually impede direct care. A system that encourages remediation is not new, and although there have been attempts to strengthen its use, there is little evidence that the punitive nature of the system has changed any. Options like private accreditation may offer the state the best opportunity to meet the goal of quality care.

Accreditation methods that are outcome based, rather than excessively punitive, show evidence that they have the most success improving the quality of patient care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits 2,200 organizations that offer long-term care and sub-acute care.²³ JCAHO’s purpose is to accredit long-term care facilities, with particular emphasis on helping the facilities and their staff to “integrate quality improvement principles into

their daily operations, and improves resident health outcomes.”²⁴ Evidence shows that the emphasis on outcomes is successful--facilities with JCAHO accreditation have more success providing quality care than facilities without JCAHO accreditation. A 2002 LTCQ, Inc. report compared 13,654 nursing homes only accredited by the Centers for Medicare and Medicaid Services, to the 1,538 of those with JCAHO accreditation. The results of the study showed that:²⁵

- Significantly fewer high-level health related deficiencies.
- Fewer life safety code deficiencies.
- Fewer complaints and fewer substantial allegations.
- Fewer medication errors.

Part of JCAHO’s success, according to both JCAHO and the report, is that it has the highest and most rigorous standards of performance--evidence based standards, and remains quality focused. JCAHO’s emphasis on performance and outcome-based measurements focuses on patient care, which is the most important thing that the facility could provide.

Staffing Issues

Staffing shortages are a reality in many areas of health care. The predominant issue, however, is the shortage of nurses around the state of Texas and across the nation. The American Hospital Association projects that nationwide, seventy-five percent of all hospital vacancies are for nurses.²⁶ Alarmingly, the Bureau of Labor Statistics sees this pattern not only continuing, but getting worse with more than 1 million new and replacement nurses needed by 2010.²⁷ It is clear that something must be done to slow, if not stop, this coming crisis.

There are several things at work in the current shortage, including shortages in nursing faculty, an aging workforce of Registered Nurses (RNs), and job dissatisfaction, which stems mostly from the bureaucracy of the job. In March 2000, the average age of a working RN was 43.3, and the average RN population under 30 dropped from 25.1% in 1980 to 9.1% in 2000.²⁸ As the older nurses begin to retire and there are too few younger nurses to assume those roles the crisis will worsen. Finally, the American Association of Colleges of Nursing points to limited ability to retain and recruit faculty, as the leading reason they must turn down so many applicants.²⁹

Common sense suggests that care may be compromised if there are too few nurses, but the facts bear that out as well. The nursing shortage is a

threat to access to care, but an additional barrier to the provision of quality care. A survey of hospitals across the nation found that the nurse shortage causes ambulance diversions away from hospitals without enough nurses, overcrowding in the emergency room, and increased waiting times for surgery, among others.³⁰ The New England Journal of Medicine measured the perception of how important nurses are to the process and it found that 53% of physicians and 65% of the public cited the shortage of nurses as a leading cause of medical errors.³¹ However, nurses themselves acknowledge that direct care is compromised as more than $\frac{3}{4}$ (81%) of nurses report that they spend more time completing paperwork than on clinical needs.³² Increased medical errors, time lost from working with patient in lieu of administrative burdens, and increased caseloads as nurses try to meet their expectations and cover the slack of those that have left the profession—the nursing crisis makes conditions bad for nurses and dangerous for patients, according to these reports.

However, the nursing shortage is not limited to hospitals. Texas nursing homes are four RNs shy of the national average and eight nurses aides short of the national average.³³ In addition to the concerns about the nurse shortage, nursing homes also face an annual turnover rate for nursing staff of about 150%.³⁴ In this case, the problem is beyond the recruitment of nurses, and is tempered with the realization that retention efforts are also apparently poor.

Comprehensive nursing legislation passed by the 77th Legislature laid the foundation for bringing Texas out of these staffing problems. Senate Bill 572 established a program with the Texas Higher Education Coordinating Board (THECB) to award nursing programs funding to enroll additional nursing students, retain faculty, and recruit and retain students. In addition to the provisions on THECB funding and incentives to encourage teaching, the bill also established a nurse workforce data center to provide information to legislators on nursing workforce issues. This sweeping legislation to address the nursing issues in the state must be given time to work. More legislation will not accelerate the benefits SB 572 will have on the nursing workforce. While the staffing shortages for nurses are concerning SB 572 will address many of those concerns while providing additional time for legislators to more fully understand where additional needs lie.

Medical Error and Patient Safety

The stories about gross medical errors are frequent. In just the recent past several cases in particular received extended media coverage, including the case of a Wisconsin woman who was improperly diagnosed with breast cancer, unaware of a lab mistake until after undergoing a double mastectomy.³⁵ Although cases like these serve as examples of gross medical error and raise suspicion and concern among patients, these cases are not the norm. However, there is ample evidence that medical errors of varying scales are something of a common occurrence and cannot be taken lightly.

In our view, medical liability issues are largely due to lawsuit abuse; accordingly the recommendations focus on curbing those abuses and tightening a system that appears uncontrolled. However, medical errors very clearly impact the medical liability system and leaving those issues unaddressed would not only be a disservice to patients, but would also fail to fully address the liability issues.

In 2000, a comprehensive study of medical errors released by the Institute of Medicine (IOM) revealed that medical errors are the cause of 98,000 deaths in hospitals each year.³⁶ If this number is true, the report states that medical errors would be the cause of more deaths than motor vehicle accidents, breast cancer, or AIDS.³⁷ The total number of deaths caused by medical mistakes, as reported by the IOM study, has come under some fire since then and some experts have reduced this number as the standard for an error has been reinterpreted, but it is clear that medical errors are a problem that need to be addressed. A later study by the Commonwealth Fund reported that one in five Americans have experienced a medical error of some kind, either personally or through a family member.³⁸ If true, the Commonwealth Fund's finding illustrates that medical errors impact the lives of untold Americans each year; however, the discrepancies in numbers highlight the problems with inconsistent requirements for reporting medical errors, and often times, even the definition of a medical error itself is unclear. With unclear measuring standards and uneven reporting requirements it is difficult to have an accurate understanding of the situation, much less take steps to ensure patient safety.

In Texas, one problem with medical errors (and medical liability) is the lack of self-policing on the part of the State Board of Medical Examiners (BME). Where the State Bar Association has failed to hold some of its own accountable, the BME has also failed to ensure accountability. According Texas Association of Business recommendations to reform the BME, a national study estimated that medical errors cost the state \$1.2

billion a year.³⁹ Furthermore, a Dallas Morning News article reported that the BME was too lenient on questions of sexual misconduct between a doctor and a patient, revoking a few licenses and punishing some others.⁴⁰ This is simply unacceptable. The patient community must be certain that the BME is taking action to ensure the strongest measures of patient safety. The BME has an obligation to protect the people of Texas from doctors that pose a danger to their medical care or their safety.

Recommendations

Pursue a waiver from the federal government allowing the state to move nursing home accreditation to private accreditation.

Remove DHS from nursing home supervision and transfer accreditation responsibilities to private accreditation organizations.

Currently, the Department of Human Services is the accreditation authority over nursing homes in the state of Texas due to the number of beds paid for with federal funds through Medicaid and Medicare. However, the state should pursue a waiver from the federal government allowing private accreditation through a JCAHO-like source to replace the accrediting system currently in place.

Private nursing home accreditation options like JCAHO offer nursing homes an alternative to the highly punitive system at the Department of Human Services. Some would suggest that a punitive system pushes for better outcomes, however, you cannot simply punish the way to quality care. Private accreditation is known for its outcome-based approach that works to educate and consult with health care organizations, in order to help the organizations provide better care for their residents. This approach sets high standards and helps nursing homes reach those standards, with the goal of providing quality care. Private accreditation organizations have proven to be effective in helping nursing homes reach quality care outcomes and this practice should be encouraged across the nursing home industry to improve care at all nursing facilities.

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- ¹ Patricia V. Rivera, "Malpractice rates take feverish leap," The Dallas Morning News, January 20, 2002.
 - ² TMA Medical Liability Study-cited TMLT presentation
 - ³ Texas Medical Association, Practice Management, "Medical Liability Reform in Texas Talking Points." Sept. 2002.
 - ⁴ TDI- TMLT presentation
 - ⁵ Texas Medical Liability Trust presentation to the TCCRI Health Care Task Force, April 18, 2002.
 - ⁶ TMLT presentation to the TCC April 18, 2002.
 - ⁷ Patricia V. Rivera
 - ⁸ Patricia V. Rivera, "Malpractice rates take feverish leap," The Dallas Morning News, January 20, 2002.
 - ⁹ "Malpractice rates take feverish leap."
 - ¹⁰ Common Good, "The Fear of Litigation Study- The Impact on Medicine," conducted by Harris Interactive, April 2002, p.18.
 - ¹¹ Texas Medical Association, Practice Management, "Medical Liability Reform in Texas Talking Points." Sept. 2002.
 - ¹² Texas Institute for Health Policy Research, "Liability Issues for Texas' Physicians and Hospitals," October 4, 2002.
 - ¹³ Texas Hospital Association presentation to the TCCRI Health Task Force, "The Current Hospital Liability Environment," Feb 2002.
 - ¹⁴ The comparison made is between a 1989 ALL cases figure and 1999 MED-MAL cases figure. Texas Hospital Association presentation to the TCCRI Health Task Force, "The Current Hospital Liability Environment," Feb 2002.
 - ¹⁵ "Medical Malpractice Crisis: OB/GYNs shedding ER duties," Las Vegas Review-Journal, April 24, 2002.
 - ¹⁶ Texas Health Care Association, "Liability Crisis Worse in Texas Study Shows Lawsuits the problem," HEALTHlinks, Summer 2002.
 - ¹⁷ Texas Health Care Association, "The Texas Nursing Home Debacle," March 2002.
 - ¹⁸ Texas Health Care Association, "Legislative Priorities, 78th Legislature, January 2003.
 - ¹⁹ Memorandum from Don Warren, Program Director, Texas Legislative Council, to Senator Robert Duncan, September 6, 2002.
 - ²⁰ "The Nursing Home Debacle."
 - ²¹ Memo to Senator Duncan.
 - ²² Memo to Senator Duncan.
 - ²³ JCAHO web site, "Long Term Care Accreditation," <<http://www.jcaho.org/accredited+organizations/long+term+care/index.htm>>.
 - ²⁴ JCAO site, "What's New for Long Term Care," <<http://www.jcaho.org/accredited+organizations/long+term+care/index.htm>>.
 - ²⁵ LTCQ, Inc. study, JCAHO, "JCAHO Accreditation Helps Nursing Facilities Achieve Better Outcomes," 2002, <<http://www.jcaho.org/htba/long+term+care/ltcnursingbrochure.pdf>>.
 - ²⁶ American Hospital Association, "Trendwatch," June 2001.
 - ²⁷ U.S. Bureau of Labor Statistics, Monthly Labor Review, November 2001.
 - ²⁸ American Association of Colleges of Nursing, "Nursing Shortage Fact Sheet."
 - ²⁹ "Nursing Shortage Fact Sheet."
 - ³⁰ "The Healthcare Workforce Shortage and Its Implications for America's Hospitals" First Consulting Group website, <<http://www.fcg.com/webfiles/pdfs/FCGWorkforceReport.pdf>>.
 - ³¹ "Nursing Shortage Fact Sheet."
 - ³² Common Good, Harris Interactive, "Fear of Litigation Study."
 - ³³ THCA, "The Nursing Home Debacle."
 - ³⁴ "The Nursing Home Debacle."
 - ³⁵ <www.healthsafetyinfo.com>.

³⁶ Institute of Medicine, *To Err Is Human*, 2000.

³⁷ *To Err Is Human*.

³⁸ Texas Medical Center News, "New Safety Campaign Initiated, Aimed at Reducing Medical Errors," Vol. 24, No. 11, June 15, 2002.

³⁹ Texas Association of Business, Press Release, "Texas Business Group Urges Reform to State Medical Board," January 24, 2002.

⁴⁰ "Texas Business Group Urges Reform to State Medical Board."

Health Insurance

Health insurance is expensive. This often repeated fact is frequently used as the basis for greater government involvement in health care in an attempt to control cost and make health insurance more widely available. Experience proves that this thinking is flawed. Greater government involvement through regulation and the addition of health insurance mandates has, in fact, contributed to the increasing cost of health insurance as well as the increases in the uninsured. Government involvement has made a significant impact in how both the health care system and health insurance system are currently shaped, and certainly, there is broad consensus that the health care system is troubled. The answer is not more government. However, in order to successfully reform health care, it is necessary to take a comprehensive look at how health care has evolved, to identify the major problems with the current system, and then explore the options for reform that best address the current problems.

How we got here: A Brief History

The history of health care can be divided two ways for the purposes of this discussion, the first being government provided health care, the other being private health care. Private health care does not mean that it is free from the government's involvement, but only that it is supplied by private entities, while programs like Medicaid and Medicare are clearly government-run systems. Although each of these systems has developed in somewhat different ways, it is important to remember that the notion of single-party payer health care was present even from the earliest days of health insurance.

An understanding of the history of health insurance is instructive for several reasons, the first being that although the idea is discussed from time to time, there is no clear consensus that the single-payer approach would be an improvement. In fact, we believe that it would be a miserable failure. Second, it is worthwhile to consider that proponents of single party payer insurance expect the worst from the private market, and, as such, they continue to impose greater government regulation and involvement in the system. Unsurprisingly, a faltering health care system only reaffirms their belief that private health insurance cannot work, despite the fact that the health care system is in a mess precisely because of this thinking. Third, the emphasis all along has been to increase the role of the outside payer, whether through third-party like a managed care organization, or by the government as the single payer; there has been little done to encourage individuals to be the principle

payer and decision maker in matters of their personal health care. This is not to suggest that proponents of single payer health insurance are actively encouraging the failure of the health system, but rather, it illustrates the problem that there is no clear and coherent vision for health care, particularly from the conservative, limited government perspective. The President has laid out his proposed reforms to the health care system nationally, which often mirror policies that would include more limited government; however, the state has lacked any comprehensive, long-term plan for improving health care in the state. For this reason it is imperative that there be a thorough understanding of the history of health insurance to this point, in order to accurately identify the problems and to create innovative reforms that will strengthen the health care system in the state of Texas.

In 1911, the British National Health Insurance plan was enacted and gave way to the discussion of government health insurance in the United States.¹ Many Americans, enamored by the power and influence of the British, were persuaded that systems should be used as a model in the United States and the British health insurance plan was such an example. Although there was much discussion of this option, it didn't receive much serious attention until the mid-30s, when the Committee on Economic Security (CES), appointed by President Roosevelt, began to discuss sweeping provisions of social insurance in response to the economic turmoil of the time and New Deal policies. In fact, the debate over government health insurance began in earnest during these years and the issue was considered for inclusion in the Social Security Act, but President Roosevelt decided that the argument for government health insurance was not yet convincing and such provisions would jeopardize the passage of the social security bill, so those provisions were excluded.² Undaunted, members of Congress introduced the first government health care bill in 1935 just a month before the Social Security Act was signed into law.³ These early discussions, though they did not result in the enactment of government health insurance at the time, laid the foundation for the debate that eventually created Medicare and Medicaid some thirty years later and the larger debate on socialized medicine that exists today.

Employer provided health insurance has been used as one of the foremost employee recruiting tools. Health insurance really came to be a perk of employment during and after World War II, as factories needed to create incentives to encourage people to work in factories to keep pace with demand during the war despite government wage controls.⁴ Offering a benefit like health insurance would entice workers and allow employers to stay within the law. At first, the Internal Revenue Service (IRS) ruled that these benefits were not counted toward an employee's taxable income making this a "free" benefit to the employees. Obviously,

employers learned that these benefits were an attractive way to recruit and retain employees and that relationship between employment and health insurance continues in much the same way today.

The government's first real foray into acting as a large-scale health insurance provider came in the mid-60s upon the creation of Medicaid and Medicare. Unsurprisingly, the government's promise of rich health benefits led to years of continued government growth and government spending in support of those efforts. Through continued expansion of these programs, more services were extended to more individuals, driving up the cost of health care, the expectation of government provided health insurance, and the dependence on the government to provide such benefits. Stymied by the increasing financial burden, the government began searching for ways to control health care costs and found managed care to be an attractive option

Managed care was the health care revolution of the late 80s, and motivated, in part, by necessity to control the cost of health care. Specifically, health maintenance organizations (HMOs) were touted as the way to control the cost by moving from a fee-for-service model to what is essentially a pre-paid plan. In effect, HMOs provide a list of medical benefits for which enrollees pre-pay a fixed amount, and then pay virtually nothing for the services they receive. Of course, in exchange for "free" service, enrollees agree to have their health care decisions managed by a third-party rather than managing those decisions themselves. The hallmarks of managed care include requirements for prior-authorization of services by way of a patient's primary care physician, capitated fee scales, and denial of unapproved services. The managed care model absolves the individual of responsibility in health care decisions, thereby also allowing enrollees to receive services with little consideration of how much the services cost. Unsurprisingly, managed care has done little to control cost, despite the belief that the business foundation of managed care would induce greater discipline. However, as a result of Congress initial certainty that managed care would better control cost, the federal government made HMOs a most attractive option and drove almost everyone into an HMOs.

Health insurance has evolved from a simple perk of employment and a way to entice employees, to a basic expectation of employment, and is often thought of as a right. Certainly, the government's involvement in the system and the participation of a third-party, inserted into the doctor-patient relationship, has made health care a more bureaucratic and less personal feature of our lives, and has encouraged dependence on others to provide and make these decisions instead. Of course, while the public has abdicated these powers to a third-party, complaints

continue, making it clear that the system of health insurance that has developed is fraught with problems.

Problems with the Current System

It is futile to try to identify any one overriding problem with the current model of health insurance, but there are several aspects that need to be addressed in any discussion of reform. Primarily the problems with the current model of health insurance exist because:

- Current tax policies favor employer provided health insurance, and make individual health insurance less attractive.
- Unlike other products and services, there is no clear consumer, preventing the health insurance market from being responsive to the needs of the individual policyholders.
- Health insurance and the services it covers have come to be an expectation. Insurability is misunderstood, as is the cost of mandating additional health insurance coverage.
- The consumer has no involvement or power over their health care, and thus no incentive to control cost.

Each of these four problems is fundamental to the health insurance system as it has been established. Identifying these problems has proven illusive for some, with the focus often being on concern for the uninsured, the expense of health insurance, or demands to cover additional services. These are simply symptoms of greater problems. Full discussion of these four main problems is essential to reforming health care—identifying and treating only the symptoms will not address the root of the problem, ensuring that problems will continue.

Employer Provided vs. Individual Health Insurance

Current federal tax policies favor employer provided health insurance allowing employees to spend a great deal on health care through third-party health insurance. Employees take no tax penalty for receiving their health care through their employer, but individuals take a sizeable tax penalty if they set-aside funds to self-insure, including penalties from income tax, FICA tax, and state and local taxes on top of that. As a result of the tax structure, and what has become an expectation of

employers, about 90% of people with private health insurance have obtained it through their employer.⁵ These tax-protected health benefits total almost \$111 billion a year.⁶ Clearly, a tax structure that favors employer paid health insurance diminishes the importance of the rightful health care consumer, the patient, and lessens the patient choice involved. Furthermore, the system does not make individual health insurance an attractive option, leaving many to go uninsured.

In addition, employer sponsored health insurance is actually nothing more than wages that receive a pass from taxation. Under these circumstances, employees are encouraged not only to take such a benefit, but to make the most of it—after all, it's part of their salary!

The problem is not employer provided health insurance, but the special treatment it receives in comparison to individual health insurance. It is imperative that small businesses and the self-employed be given equally attractive incentives for offering health insurance to their employees. The fact that much of the uninsured population is in working families only supports the fact that individual purchasing of health insurance should be encouraged. Most of these uninsured do not have access to employer provided health insurance and find that the plans available to individuals are not as attractive.

The Consumer

Who is the health insurance consumer? Is it the employer that must negotiate contracts with carriers, or the physicians that receive payment from the health insurance carrier? Among all of the relationships and interaction between insurance companies, physicians, and employers, it is little wonder that the individual has been lost. The individual patient has become the incredible shrinking consumer, holding less and less authority over matters of personal health care, as all of the details have been worked out by the other parties. Although references to the “consumer” are typically understood to be the enrollee, or the patient, it is important to remember that in the case of health insurance the consumer is really unlike any other consumer and has little responsibility or control over the decisions made.

Consider, that in any other transaction, the consumer is the person that holds the dollars and pays for services. In most business transactions, the person receiving the service pays for the service, and has control over the quality of the service as a result. In the case of health care, however, the patient receiving care is unlikely to be the payer, confusing the real consumer and begging the question of who the physician is serving: the

patient, or the insurance company? This “power of the purse,” so to speak, means that the only person that has to be truly happy with the services provided is the payer—in this case, the insurance company itself. The patient, despite being the consumer of services, is rendered virtually powerless in terms of their health care decisions.

Diminishing the consumer’s power has several deleterious effects on health insurance and health care. First, the doctor has little or no accountability to the patient as the terms of service have been established before the patient was necessary or present. Furthermore, participants in any health benefits plan will experience changes in the medial providers as contracts change often, rolling physicians on and off the list of covered providers. Second, the insurance company often has no accountability to the patient when the terms of coverage are determined between the employer and the insurance company. Third, with no physician accountability and a plan’s revolving door for providers, on top of no insurance company accountability, the patient has no incentive to control costs by acting prudently in health care decisions.

In fact, applying the basic principles of a free market and competition, if allowed to work, should begin to right the health care system. Giving the patient, the true consumer, the ability to use their health care dollars as they desire would add appropriate accountability and controls on utilization. Allowing the consumer to choose between inadequate care and exceptional care, would introduce an important element of competition. Absent a clear consumer, the health care system inefficiently attempts to reconcile the demands of each party involved in health care transactions, rather than meeting the demands of the patient.

The Expectations of Health Insurance

Health insurance is entirely different than any other form of insurance that exists. No other insurance elicits such opinions, emotions, or attention as health insurance; the media never highlights the plight of the uninsured motorist. And while part of the reason that the uninsured, as it applies to health insurance, are so often discussed, is because of the cost of health insurance and health care, one of the major differences is that health insurance has become an expectation. Perhaps even more accurately, health insurance has come to be thought of as a right.

Insurability is really at the heart of the health insurance matter. An August 2001 article in the Washington Post explains it best:

The general definition of an “insurable event” – from traffic accidents to tornadoes – is something that, first, is very unlikely to happen; second, will come without warning; and third, is not something the person who is insured ever wants to happen.⁷

The current approach to health insurance does not match this explanation of an insurable event. Without minimizing the value of preventive medicine and the ultimate savings that it can offer, health insurance should be something of a safety-net, preventing a family from the dramatic and devastating effects of major illness and injury. Instead, health insurance is viewed as the way of financing even the most routine care. A frequently used analogy draws this important distinction: health insurance should be like car insurance, providing some measure of protection from liability, accidents, and major damage, not providing for gasoline, oil changes, and car washes. This analogy is not to insult the value we place on health care, rather it illustrates that the health insurance market is an anomaly in the insurance industry. Insuring routine health care services drives up utilization, feeds expectations that health insurance cover anything and everything available to a patient, and further distorts public perception of health insurance.

The expectation of health insurance, and more specifically, what health insurance covers, is evident in health insurance mandates. These mandates illustrate how well the current system of health insurance has fooled much of the public into thinking health insurance provides services at no cost. However, a public demand for services to be covered by the umbrella of health insurance and an obliging government that yields to those pressures, often places additional burdens on the health insurance industry. Health care is not free and certainly every additional mandate has dramatic consequences, unintended as they may be.

Mandates require an insurer to offer specific benefits in insurance plans. These mandates stretch from everything from mandating coverage for mammograms and parity in mental health treatments to non-medical items such as hairpieces. In 1965, there were only eight health care mandates nationwide⁸, by contrast the American Association of Health Plans counts 1500 mandates on the books today.⁹ Some of these mandates require insurers to offer an ever-expanding list of benefits, and others prevent insurance companies from restricting coverage, both can have a major impact on health insurance and the health care system as a whole.

First, mandates increase utilization and inappropriate dependence on health insurance. Services that are seemingly “free” are used as if they actually *are* free, and few individuals will weigh the actual cost of the service with their need. These services are not, in fact, free, nor are they always necessary. The provision of services may actually create a demand that did not exist before coverage was mandated. In addition, the presence of a third-party payer insulates the patient from making wise health care decisions, driving up both utilization and the dependence on health insurance. Health insurance covers more services than ever before and there are still demands for greater coverage, which illustrates how willing people are to have health insurance pay the bills, and conversely, how unwilling people are to pay for these services themselves.

Second, mandates raise the cost of insurance. Depending on the mandate itself, the additional cost toward the premium can increase dramatically--services that are used frequently are costly because of the number of people taking advantage of the service, and other service will remain expensive regardless of utilization. Also, utilization and cost of services can vary across the state and the nation depending on differences in regions, demographics, and population. According to a report by PricewaterhouseCoopers, mandates and government regulation increased premiums 2% nationwide between 2001 and 2002 and accounted for 15% of the overall increase in premiums.¹⁰

Third, mandates increase the number of uninsured. As premiums increase many employers find that they can no longer afford to provide coverage for their employees, and individual policyholders may also determine that their coverage is too expensive to maintain. Healthy people may also decide to gamble on not needing medical attention and forego costly health insurance premiums, a decision which also impacts the risk pool and cost for other policyholders. Compounding the loss of healthy enrollees, some mandates require carriers to insure applicants regardless of insurability, potentially adding greater numbers of unhealthy people to the insurance roles. The Congressional Budget Office has estimated that for every one percent increase in the cost of health insurance, 200,000 Americans lose their health insurance.¹¹ This numbers shows that even small percentage increases in health insurance can add up the number of uninsured quickly.

Lawmakers and advocates decry the increasing number of uninsured Americans, but too often their answer is either that health insurance is simply expensive by nature, or that government can somehow provide more insurance by greater regulation. Too often their solution is to simply require additional coverage through mandates, and it is disingenuous for these same lawmakers to wonder in astonishment why

health care is expensive. Mandates and regulations increase the prices of virtually every other commodity and the consumer bears the increased cost. Although it is difficult to identify the true consumer of health insurance and health care, it is easy to see that cost of mandates is born both by employers and individuals.

The Promise of Free Health Care

Health care is not free. Even if the patient does not pay for services directly out-of-pocket, it is important that this is not mistakenly assumed to mean that health care is without cost. However, this is one of the three important problems associated with a third-party payment system. First, the third-party payer insulates the patient from the real cost of their health care. Second, third-party payment causes employees to rely heavily on their employer for medical coverage. Third, such a system relies on some measure of rationed care to control costs.

Third-party payment is extremely common and the evidence is staggering. According to the National Center for Policy Analysis, “third parties—government, employers or insurers—pay for 85% of all health care today.”¹² Of the fifteen percent that consumers directly pay for, the majority is for over-the-counter drugs, vision, dental, and cosmetic surgery.¹³ The consumer’s responsibility for payments has diminished over the last several decades, from 28% in 1980, and from 56% in 1960. Third-party payment drives up costs because there is no incentive to be a wise consumer of health care. In addition, because it is treated as wages, the enrollee feels as if they should get their money’s worth.

The tradeoff from letting a third-party pay for health care is that they also make the decisions. Most complaints about health insurance and health care, other than the fact that it is expensive, are because people do not have unlimited access to everything they want. In an effort to control costs, most health plans ration care by requiring a primary care physician to make almost all initial referrals. Often the third party directs patients to complete one treatment before pursuing another, or requires that the patient see only certain providers. If the patient were responsible for the money, and therefore also the decisions, the patient could opt to choose the provider they most wanted, perhaps the patient could have direct access to the specialists without the required referrals, and the patient could even have more authority over the treatment plans. Instead, the third-party payer requires that since the patient will not control costs, the payer will, by requiring the patient to meet certain standards before accessing certain care.

The truth is that the cost of health care will never be controlled as long as someone else is paying the bill. Milton Friedman explains this scenario best: "...nobody spends somebody else's money as wisely or as frugally as he spends his own."¹⁴ Any reforms of health care that seek not only to return power to the rightful consumer, but also hope to control cost, must find ways to reduce third-party payment.

Solving the Problem

Who's not for reforming health care? The bigger question is how. Certainly there are those that believe that universal health coverage as it exists in Europe and Canada is the way to go, and such proposals have even gotten attention in the U.S. through the failed Clinton plan, and more recently a voter referendum in Oregon to move to a single-party payer system. Conservatives, however, believe in the power of limited government and individual liberties in determining how best to reform health care. Such a plan focuses on empowering consumers to make wise health care decisions, encouraging equitable an equitable tax structure that makes individual health insurance and other forms of insurance a more attractive option, and getting the government out of dictating the requirements of health insurance. The encouraging and attractive by-product of all these options is that it works to reduce health care costs, but this is not the sole reason to do this. The obvious fact is that the current system is not working.

There are a number of opportunities to control cost in health care, but most efforts to make lasting changes would require a fundamental change in the system as a whole. Absent the opportunity for wholesale changes to the current health care system, many have worked within the reality of the situation to require greater cost sharing through things like co-payments; however, these are patches that invariably fall short of truly taming costs. This is not to suggest that there are not other options that could, and should, be pursued. Moving toward a defined contribution system, encouraging availability of mandate free insurance and allowing the insured to choose which plans best fit their needs, expanding the availability of medical savings accounts, and making flexible spending accounts more flexible, are all ways to control the cost of health care and allow consumers greater control over their health care. Many of the innovative reforms that would most benefit the health care system must first happen at the federal level, but to the extent that the state can support those efforts, and encourage the use of these better options, the state should do so.

Consumer Empowerment: **Defined Contribution and MSAs**

The current system of health insurance is a defined benefit, by which an employer determines what services they will offer and finds a plan that meets those needs. This method limits an employees' choice in an insurance plan, as the employer decides which benefits will be paid for and selects the insurance carriers that best meet the employer's needs. This is increasingly difficult as prices continue to go up and employers are unable to sustain levels of health insurance that they were able to support in the past.

By contrast, the defined contribution method allows the employer to allocate a fixed amount of money that each employee may use to pay for health care. In some situations, the employer's contribution is ample enough to cover the entire cost of an employees' health insurance plan and, in other cases, the defined contribution acts as a supplement when the patient wants far more coverage than the basic plan offers. In a defined contribution model, the employer offers an array of plan options and typically determines the contribution based on the least expensive of those plans.¹⁵

The model most often associated with the defined contribution is illustrated by the Federal Employee Health Benefits Program (FEHBP), which provides health insurance benefits to more than 8 million federal employees and their dependents.¹⁶ For the year 2000, the program screened more than 300 programs and offered most employees around 10 plans to choose from, depending upon where they lived.¹⁷ This broad selection is almost unheard of in defined benefit plans. According to the FEHBP, the government pays almost 72% of the average premium toward the total cost of an employee premium, but it can cover not more than 75% of the total premium for any plan.¹⁸ In essence, this defined contribution model is something of a voucher for health insurance, where the employer gives the employee the ability to purchase a basic plan, while offering an option to "upgrade" the plan according to the employee's ability to shoulder the additional cost. This model is particularly concerned with how the insurance is delivered to the employee and attempts to provide employees with the best features of group health insurance with individual health insurance.

The FEHBP provides a good model for employers looking to reduce their responsibility toward providing very specific benefits, opting instead to offer health insurance at a cost partially covered by the employer and open to choice by the employee. One of the benefits of this plan is that it lessens the employee's expectation of their employer in offering health

benefits. The primary benefit, however, is that it offers greater patient choice than many employees currently have, particularly state employees. Additionally, the employee must weigh their additional out-of-pocket cost from enrolling in something other than a basic plan, with what extras the plan provides. These are attractive options that the state could implement in the short-term to better contain the state's cost, while also working to change attitudes toward health insurance over the long-term.

Medical Savings Accounts (MSAs) are similar to the defined contribution plan described above, in that the employer makes a fixed contribution to an employee's health care. However, in the case of the MSA, the distinguishing feature is how medical services are handled and paid for, as well as the employee's ownership of any contributions to the account.

MSAs are a fixed contribution for use in medical care along with coverage through a catastrophic insurance plan. In this case, the employer places money into an account dedicated to health care, which will pay premiums for a high-deductible insurance plan, while using the additional money paid into the account to cover the cost of minor and routine medical care. This method reserves the insurance to pay only nominally for anything outside of catastrophic care for things like serious illness, injury, disease, or medical treatment. For the bulk of any routine treatment and consultation provided, the insured pays those expenses out of the account. If funds in the account are insufficient to cover the basic expenses, the individual may then need to pay the additional costs out-of-pocket; however, prudent use of insurance allows the account holder to save that money in the MSA for future use on qualified medical expenses without tax penalty.

MSAs are currently being studied through a limited pilot-program, but have a disappointing success rate, primarily due to restrictions on the accounts, which hinder their progress. Among these limitations are, caps on the number of participants and eligibility that is restricted to small employers and the self-insured. Additionally, the accounts may only receive contribution from either the employer or the employee, but not by both, and the contribution amounts are also limited. Furthermore, the MSA program is to be phased out over time and was only recently extended to continue through 2003. Obviously, with government regulation hindering the success of this option, there is little more than theoretical evidence to support the contention that these accounts can be successful in meeting its expectations. Nonetheless, what we know about these accounts clearly points toward a more sensible approach toward health insurance, and, to the extent that these accounts have been used, there is enough evidence to see that the attractive features of the accounts warrant wider implementation.

The MSA has several distinct advantages over traditional health insurance, and even over the FEHBP defined contribution model. Chiefly, MSAs induce greater cost sensitivity, thereby reducing inappropriate utilization. The true cost of health care is realized when the first-dollar responsibilities are shifted from the insurer to the insured, prompting the insured individual to make decisions with their pocketbook. The claim that this responsibility will drive people to forego necessary medical care is a red herring; the truth is that people will consider whether a medically unnecessary trip to the doctor is worth dipping into the savings account, or whether those funds should be reserved for later use. This is a rational and responsible decision, which patients should be expected to make. Furthermore, that the accruing savings in the account can roll from one year to the next allows an individual to build something of a cushion for future health care expenditures, including a possible way to finance medical care later in life. Also, the MSA allows individuals to seek the care of specialists and other medical professionals that may be personally preferable to the patients themselves. This consumer empowerment is a central feature of the MSA.

Second, MSAs properly define and address the issue of insurability. Catastrophic insurance is a return to the idea that not every event is, or should be, insurable. These policies should serve to lessen reliance on insurance to cover everything and to remind people that insurance is for the unlikely occurrences that are often expensive—not routine medical care. Furthermore, the combination of a catastrophic policy with the savings account allows patients to make their own health care decisions and control utilization, thereby controlling cost.

Also, this low-premium, high-deductible insurance provides an alternative form of insurance to those who find that traditional insurance is simply too expensive to afford. Catastrophic insurance is characterized by low premiums and high deductibles, which would not only be attractive to many of the uninsured, but also attractive to those who consciously forego insurance coverage because they feel young and healthy. Figures from many health plans, particularly those run by the state like ERS, show that a large majority of the individuals covered are over-insured. While this may be a reasonable expectation of insurance companies looking to balance their risk, the truth is that many individuals will decide that going without insurance is preferable to spending a great deal of money each month to have health insurance that they are unlikely to need. If presented with an option to pay less each month in premiums, but meet a higher deductible in the unexpected event that care is needed, many would welcome this opportunity to have coverage. Furthermore, one of the concerns for

advocates of the uninsured is the loss of insurance coverage when employees leave their job, but because MSAs belong to the employee, they are portable. An individual that might normally go without insurance in between jobs could use the MSA to sustain their medical care needs in the interim. MSAs present a better alternative for the uninsured that simply cannot afford health insurance, as well as the uninsured resulting from changes in employment. The evidence bears this out. In a report released by the Internal Revenue Service (IRS) in 2002, the IRS reported that in 2001, 73% of the MSAs purchased were by individuals or families without health coverage.¹⁹

What is the real evidence that MSAs work? Despite the fact that Congress has limited the eligibility for MSAs and the number of accounts available, the brief history of the accounts in existence suggest that MSAs meet their objectives to control cost and empower consumers. Golden Rule is the nation's largest provider of MSAs and has more than 70,000 active MSA accounts nationwide.²⁰ According to Golden Rule, the balances on their MSAs have grown from \$355,921 in 1995, to over \$70 million in 2002. This accumulated savings is astounding and illustrates how the "defined benefits" approach of traditional health insurance encourages consumption to realize the benefit provided, whereas an MSA provides a quantifiable benefit to its policyholders through these balances. Additionally, because the funds in the account belong to the individual account holder, balances roll from year to year and are entirely portable. Also, similar to the way IRAs have penalties for early withdrawals, the funds in the account can be withdrawn for non-medical purposes, but the account holder pays taxes and a 15% penalty on the withdrawal.²¹ The primary drawback to the MSA, according to current law, is that the employee or the employer may contribute, but not both, which limits not only how much money can go into the account, but could also limit the account holder's opportunity to build a significant cushion to offset the first dollar responsibility, depending on the employer's contribution.

Many erroneously point to the limited implementation of MSAs as evidence that they do not work, which is quite the contrary. MSAs are limited because they are created that way and opportunities for broader implementation would almost certainly reveal even greater success. The other frequent mischaracterization is that somehow individuals will forego medical care in an effort to accumulate savings or because they have responsibility for first dollar coverage. For true medical emergencies one can only assume that the account holder would pursue appropriate medical care--regardless of the cost, but beyond those emergencies those decisions should be left to the discretion of the individual themselves. This is as it should be. In addition, MSAs are commonly thought to benefit only the wealthy and healthy, but even the

nation's largest provider of these accounts has not realized problems in adverse selection. In fact, a chronically ill patient could expect to pay less out-of-pocket under an MSA than in traditional managed care. Furthermore, the wealthy are most able to afford the traditional forms of health insurance, while others are left struggling to afford a policy on their own or the premium increases; that the wealthy might choose an MSA as a prudent way to manage their own care does not make it unaffordable to others.

Recommendations

Implement a defined contribution model for insuring state employees and teachers.

Figures from the Employees Retirement System (ERS) indicate that about 75% of covered employees incurred medical costs of \$1,000 or less for FY2001, illustrating that the majority of state employees are over-insured. For employees like this, introducing a defined contribution plan would be an attractive option for the employee and the state alike. The defined contribution plan presents employees with greater flexibility as it allows them greater choice in their health care decisions. Similar to the FEHBP model, employees could choose from a variety of plans, selecting the one that best meets their individual needs.

The defined contribution plan could take several forms. For one, because employees currently have their health insurance paid for by the state, the state could determine a set figure that the employee could allocate to health insurance as they choose. The employee could use the funds entirely for health insurance, or the employee could split the funds between a lower cost health insurance plan and the balance to a flexible spending account. Employees that want a more generous plan could use the funds to fund a portion of the plan and could pay the additional costs out-of-pocket. The goal of such a plan is to allow the employee greater opportunity to structure a plan to meet their individual needs.

Outside of the fact that it is increasingly important for the state to control health care costs, the implementation of a defined contribution system may be the best and only way for the state to continue to provide health insurance to its employees. With costs that continue to spiral out of control, the state will have a more difficult time providing employees the rich insurance package it currently offers. The best cost control measures that state currently has are to increase cost sharing with employees, which can vary from year to year. The prospect of increasing

co-payments and altering the structure of health insurance benefits for active employees and retirees is understandably unpopular with employees that have come to expect certain levels of coverage. However, it seems unlikely that the state will be able to continue offering the same benefits at the same price. With that in mind, radical changes to the system are in order, and the state can provide for a basic level of health coverage and allow employees the opportunity to upgrade to more generous levels of coverage out-of-pocket. This may be the only solution to the situation that does not require the state to cut benefits and begin higher premium sharing. With the opportunity to involve employees in their health care decisions, this is clearly the best choice.

Give small employers the opportunity to provide health insurance to employees through the Texas Health Insurance Risk Pool.

Small businesses often have trouble obtaining health insurance for employees, typically because the risk pool is so small. A few employees may have pre-existing conditions that make health insurance more expensive, or insurance companies may anticipate costs based on the profile of the employees, like a company with many young women who are likely to incur expenses related to child birth. This presents employers with a challenge of finding affordable health insurance, and when insurance is too expensive or unavailable, the employees often join the ranks of the uninsured.

Governor Perry highlighted these concerns when he noted that 75% of uninsured Texans have full-time jobs, and that more than half of those employees work at companies with no more than 20 employees.²² Accordingly, Governor Perry called for the Texas Health Insurance Risk Pool to be open to companies with fewer than ten employees, for the purchase of health insurance. Allowing these small companies the opportunity to join a risk pool, in order to mitigate the insurers risk and make coverage more affordable, would help employers find and provide health insurance coverage for their employees.

Direct the Texas Department of Insurance to provide small businesses with information on purchasing Medical Savings Accounts.

Small businesses may be unaware of the MSA option that would allow them to provide health insurance coverage to employees at less cost and with greater flexibility. The Texas Department of Insurance should make information on MSAs widely available to small business owners. The Governor's plan limits the employers eligible for purchasing by the Texas Health Insurance Risk Pool to only those with fewer than ten employees, but notes that small businesses with no more than 20 employees make

up a number of the uninsured. These small businesses, in particular, must be able to access information on alternative ways to insure employees beyond the traditional health insurance models. The Department of Insurance must find ways to inform these small business owners of the option.

Address the increasing number of health benefits mandates and their negative effect on the uninsured by establishing dates to sunset all existing health insurance mandates.

Require any proposed health benefit mandate to include a sunset date, as well as state the impact of the benefit on the uninsured.

The legislature should establish staggered dates to sunset all existing mandates. Dividing all existing mandates into thirds, a third of the policies should be set to sunset in 2005, 2007, and 2009. Many health benefit mandates are passed to cover the popular medical treatment or “need” of the day, by establishing dates to sunset mandates, not only can the state begin to scale back the large number of mandates it currently requires, but it can also address these issue of whether these mandates have any appreciable benefit to the public. Current mandates must be reviewed and dividing them into thirds and setting them to a date-certain sunset will make this process easier.

In addition, any new proposal for a health benefit mandate should include provisions to sunset the mandate six years after enactment. The proposed benefit mandate should also be accompanied by a Legislative Budget Board report to project the impact to the uninsured if the proposed benefit were put into place. Evidence points to a growing number of uninsured as a result of benefit mandates and this must not only be dealt with, but members of the Legislature must have complete disclosure about the consequences of these actions. Similar to selecting sunset dates for all existing mandates, the Legislature should review the mandates to determine whether a need for them still exists.

Offer options for mandate-free and limited benefit health insurance policies.

Allow insurance companies to submit health benefit designs to the Commissioner of Insurance for approval. Allow the Commissioner to bypass current plan requirements.

The state must provide a low-cost, mandate-free plan that is more affordable than the typical health plan that offers extensive, mandated coverage to policyholders. In order to allow consumers to choose

purchase plans that best meet their needs, the state needs to provide opportunities to purchase plans without the extra mandated benefits. Small employers should be able to purchase mandate free policies and, similarly, large employers should be able to offer employees limited benefits policies as the small employers are able.

In addition, insurance companies could willingly submit to a file and use-style system and present proposed health plan designs for approval. The Commissioner of Insurance should consider these designs and have the opportunity to bypass any current requirements.

Cap the maximum rate charged in the Texas Health Insurance Risk Pool at 150% of the standard rate.

The Texas Health Insurance Risk Pool was created by the Texas Legislature in 1989, and funded in 1997, to provide health insurance to certain Texas residents who cannot get insurance. Currently, the pool's rates cannot exceed 200% of the standard premium rate, which is the rate charged by a commercial insurance carrier for similar coverage.²³ Reducing the multiplier from 200% to 150% would make coverage for the uninsured more affordable. The risk pool concept is used in many other insurance arrangements and because the state places such emphasis on people having insurance, capping the rate would make this more possible.

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- ¹ The History of Medicare, Peter Corning, on the Social Security Administration website, <<http://www.ssa.gov/history/reports/cesmedical.html>>, 1969, Appendix A.
- ² The History of Medicare, Peter Corning, on the Social Security Administration website, <<http://www.ssa.gov/histroy/reports/cesmedical.html>>, 1969, p 40.
- ³ The History of Medicare.
- ⁴ Galen Institute, "Tax Initiatives Gain Strength," February 26, 1999.
- ⁵ National Center for Policy Analysis, Talking Points, Devon M. Herrick, Research Manager.
- ⁶ Galen Institute, "Mandates, Regulation, and the Uninsured," testimony by Grace-Marie Arnett, President, Galen Institute, June 15, 1999.
- ⁷ Larence H. Mirel, "We Call It Insurance, but That's Not Healthy," Washington Post, August 26, 2001.
- ⁸ National Center for Policy Analysis, "Fewer Have Health Insurance Due to Mandates"
- ⁹ Cheryl Jackson, "States look at costs of insurance mandates," amednews.com, <http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisc1111.htm>
- ¹⁰ Cheryl Jackson, "States look at costs of insurance mandates," amednews.com.
- ¹¹ Galen Institute, "Mandates, Regulation, and the Uninsured," testimony by Grace-Marie Arnett, President, Galen Institute, June 15, 1999.
- ¹² National Center for Policy Analysis, "Talking Points on Health Care," Devon M. Herrick.
- ¹³ "Talking Points on Health Care."
- ¹⁴ Milton Friedman, "How to Cure Health Care," The Public Interest, Winter 2001.
- ¹⁵ Haavi Morreim, "Defined Contribution: From Managed Care to Patient-Managed Care," p. 111.
- ¹⁶ United States Office of Personnel Management, Federal Employee Health Benefits, <http://www.opm.gov/insure/health/>.
- ¹⁷ "Shailagh Murray, "Why Health Insurance That Works Still Fails to Catch on Broadly," The Burton Report, January 18, 2000.
- ¹⁸ US Office of Personnel Management, "Federal Employee Health Benefits," <<http://www.opm.gov/insure/health/about/fehb.asp>>.
- ¹⁹ United States Senate Republican Policy Committee. "IRS Reports 63% of MSAs Are Purchased by Previously Uninsured," October 8, 2002.
- ²⁰ Golden Rule presentation to the TCCRI HHS Task Force, June 21, 2002.
- ²¹ National Center for Policy Analysis, "Three Avenues to Patient Power," Michael F. Cannon, January 30, 2003.
- ²² Office of the Governor, Press Release, "Gov.Perry Unveils Plan to Expand Health Care Options," May 29, 2002.
- ²³ Texas Health Insurance Risk Pool, Frequently Asked Questions, <www.txhealthpool.com/faq.html>.

Medicaid and CHIP

Any discussion of reforming healthcare would be incomplete without undertaking a thorough review of government operated medical assistance programs. While Texas faces a challenging fiscal session in the 78th Legislature, the reality is that much of what has driven this issue to the fore is the unchecked expansion of government programs. The health and human services area of the state budget is a maze of programs and funding sources that have continued to grow in size and scope over the last decade. The expansion of Medicaid programs and the advent of the State Children's Health Insurance (CHIP) program are the most obvious places this growth can be seen. In relation to the budget, the pressing need for controlling cost in the health and human services area requires consideration of the issues at a program level, which the Texas Conservative Coalition Research Institute tackled from the budget perspective in its finance report. The recommendations made at the program level are perhaps best characterized as patches to a system needed to address the most important issues. However, with program issues aside, it is imperative that much broader reforms be explored within these programs to address several fundamental problems with these programs.

The Uninsured

Underlying much of the discussion of the government's medical assistance programs, are references to the uninsured. Each time the number of uninsured Americans is released, politicians, advocacy groups, and the media rise up to denounce the problem of the uninsured. However, the uninsured are hard to identify and too often the uninsured are presumed to be the poor or the sick. In order for the state to appropriately address the needs of the uninsured, it must first have a clear understanding of who the uninsured are.

Certainly, the risk of being uninsured comes at high cost not only to the individual, but also to the state and to local governments. Uninsured individuals do not have a "medical home" and therefore turn to care at emergency rooms, often when the severity of the problem has advanced due to lack of preventive care. In addition, patients that cannot pay become a burden to local hospitals and counties. These risks are very real, but are often mischaracterized as a problem for the poor, when the truth is that many of the uninsured are in working families. Many workers may find themselves uninsured because their employer simply cannot afford to buy insurance for the employees, and the employees are

unable to afford insurance on their own. The first mistake is to assume that these individuals cannot make it without complete coverage provided by the government—in actuality, they may truly only need *assistance*. Furthermore, it is imperative that appropriate utilization patterns be stressed, guiding those who typically end up in the emergency rooms for minor problems to learn how to identify, differentiate, and treat minor health problems in the appropriate setting, rather than in an emergency setting.

In addition, the state must acknowledge that some of the uninsured may be uninsured by choice. Although it is often assumed that the uninsured cannot afford coverage, recent figures suggest otherwise. In fact, during the 1990s, the number of uninsured increased in relatively affluent households and decreased in low-income households.¹ Between 1993 and 2000 households with annual incomes above \$75,000 saw a 63% increase in the number of uninsured, and the uninsured jumped approximately 48% in households with annual incomes between \$50,000 and \$75,000.² As a result, almost one-third of the uninsured have an annual household income above \$50,000.³ Many of these uninsured may not decide that health insurance is too expensive, but rather that insurance is too expensive in comparison to what they believe their benefit will be. Census Bureau numbers report that forty percent of the uninsured are between 18 and 34 years of age.⁴ Certainly, some of these individuals may believe that they are healthy and health insurance is unnecessary, even though they could afford to buy it. Any attempts to expand government health coverage to reduce the number of uninsured would likely miss this segment altogether, as it is made up of individuals who may simply forego health coverage by choice.

Finally, it must be recognized that the mere existence of government health coverage through Medicaid does not mean that all who qualify for coverage will choose to participate. There are most certainly biases against anything that resembles welfare, including Medicaid and CHIP. Interestingly, the National Center for Policy Analysis reports that a study of low-income families, most of which would qualify for Medicaid or CHIP, did not enroll their children in CHIP, despite the fact that the vast majority of these families were aware of the program.⁵ The study, which was originally done by the Urban Institute, revealed that forty percent of people who had not inquired about the CHIP program, and sixteen percent who inquired but did not apply, said that they “did not need or want” the programs.⁶ As this study shows, attempts to reduce the uninsured by expanding programs will also fail to reach many people who feel that the program or service is unnecessary, as well as those who simply do not want to participate.

The state must not believe that it can reduce the number of uninsured by simply expanding coverage in any way. It is important to understand that there may be segments of the uninsured population who are uninsured by choice. If the goal is to eliminate the uninsured population and ensure that everyone has health insurance, we can reasonably expect to fall short of that mark every time. The uninsured by choice will remain an enigma to Legislators who believe that the state can provide insurance to everyone.

The Eligibility Standard

The income standard used to determine eligibility is not an accurate gauge of poverty or need. Medicaid and CHIP eligibility are both based on a person's income relative to the poverty line- a rather archaic formula for determining a family's ability to meet basic dietary needs, formally known as the Federal Poverty Level (FPL). Of course, this standard is problematic because income is highly variable. This idea was highlighted during the 77th Legislative Session as proponents of a measure to lengthen the eligibility period in Medicaid pointed out that some people, like seasonal workers, have significant fluctuations in income that may change their eligibility status from one month to the next, or even more frequently. This idea should not suggest that this means people need to be on Medicaid for longer periods of time, but should illustrate just how fluid income is and what a snapshot in time a person's relation to poverty truly is. Income is not an indication of overall economic health. For this reason, consumption is truly a better way to measure standard of living than income.

The Bureau of Labor Statistics Consumer Expenditure Survey shows that the poorest fifth of American households report spending \$2.30 for every \$1 of reported pre tax income.⁷ This figure shows why income is simply not the best way to measure a person's ability to pay for something, and this can happen in many ways. For one, a person who loses their job may feel certain that they will get another job, and regardless of the fact that they have no present income, they choose to purchase things against the expectation that they will be able to pay for them later. In addition, the poorest fifth of American households may receive many other government benefits determined by their income relative to poverty, but the monetary equivalent of those benefits is not calculated as "income" for each additional benefit. In this case, it is possible that a family would actually accumulate benefits that would push them over the threshold. For instance, a single parent with two children making \$7 an hour would be considered slightly below the poverty line at an annual income of \$14,544, but would be eligible for

certain benefits that could bring total annual income and benefits to \$28,360.⁸ At some point the accumulated benefits push this family across the poverty line and could possibly impact what service the family is eligible for. Furthermore, if all of the “necessities” are taken care of through government programs, the family’s income is no longer required to meet basic needs and becomes rather discretionary. Clearly, using income to measure poverty is flawed, as fluctuations in income and the income equivalent of benefits are not calculated in determining a person’s standard of living.

Also, while the poverty level can change every year, one figure applies to the entire continental United States. This does not take into account the widely different costs of living that a person may incur across the United States, or even within one state. Certainly, the cost of living in Texas varies, yet the poverty line stays the same across the entire state and these differences could make dramatic differences in a person’s standard of living and ability to meet their needs. This fixed poverty line does not accurately reflect the different needs and costs for different areas of the state. Furthermore, this fixed threshold does not recognize that the differences in eligibility under programs like Medicaid can be \$1 differences. A person making \$1 under the established cutoff receives full and complete coverage, while the person making \$1 over the standard receives nothing. The poverty line is an inaccurate and inequitable way to determine who needs government assistance.

The Safety-Net

Ostensibly these kinds of programs were created to provide short-term aid and not a long-term support group, but many now believe that people should have an unlimited claim to participate in these programs. These problems are readily identifiable throughout Medicaid and CHIP and hinder the ability for the government to not only control cost, but to continue providing a safety-net of quality care to the most needy. However, an expanding definition of “poverty” contributes to increased caseloads that stretch Medicaid beyond what it was initially intended to do. In addition, the state should not be encouraging people to stay enrolled in Medicaid or CHIP for the long-term, which is what the state has done by providing for a longer time frame for eligibility without recertification and by providing a benefit so rich that no private plan could possibly afford to offer the same benefits. Medicaid was originally a safety-net for the poorest and the truly needy, yet it has been stretched to cover people beyond that narrow group and it has given way to the creation of additional programs to extend coverage even farther.

Congress created the Medicaid program as part of the Social Security Act of 1965. Medicaid was intended to pay medical bills for low-income persons who would otherwise be unable to pay for care. In the beginning, this safety-net was reserved for welfare recipients or cash assistance recipients under the Supplemental Security Income (SSI) program only. In the 1980s and 1990s, however, Congress extended eligibility to more children, pregnant women, elderly, and disabled, bringing more people onto the Medicaid rolls. Efforts to increase Medicaid enrollees, combined with the increasing costs of care, drive the Medicaid budget skyward, and because the program is an entitlement, the state is prohibited from denying enrollment or services to anyone who meets the eligibility requirements. As a result, Texas, as well as the rest of the country, faces burgeoning Medicaid rolls that drain the resources of the state to provide care to a growing Medicaid population. Texas Medicaid began in 1967 and served less than \$1 million people for less than \$1 billion; by contrast, the Medicaid program currently serves about 2.7 million Texans and costs more than \$13 billion.⁹

The increasing caseload is not simply because population is growing, nor is it an indication that people are becoming more poor. The truth is that policy initiatives both at the federal and state levels have poured additional people onto the rolls by expanding and loosening eligibility standards. At its inception, Medicaid was designed to serve the poorest citizens, but it has grown to be an insurance provider to people whose income levels exceed that standard. With a broadening definition of poverty that now encompasses some individuals with an income of more than twice the Federal Poverty Level (FPL), many more people are relying on Medicaid for the provision of their health care than intended. The mistaken notion that because health care is expensive, the state must necessarily extend eligibility to more people is flawed. In response to the recommendations in the TCCRI's State Finance Report, one Texas advocacy group suggested that Medicaid coverage is about affordability; that when coverage is not affordable, the state must provide it.¹⁰ By this standard, the state would quickly become responsible for even more people's medical care, as well as a host of other things that are also "unaffordable." The truth is, that if the state wants to offer quality coverage to Medicaid enrollees, it must limit eligibility to the truly needy and end the practice of extending feel-good coverage to the next income group on the fence of affordability. Continued expansion compromises the state's ability to provide quality care to the population that Medicaid was meant for—the truly needy.

The 77th Legislature enacted legislation dubbed "Medicaid Simplification," which made several changes to the eligibility determination and enrollment process for Medicaid recipients. One of the features of this simplification plan was to provide for twelve months

of continuous eligibility allowing individuals to be eligible for Medicaid for a year without requiring them to recertify their eligibility any time during the year. Over the course of the debate, many proponents of the legislation argued that it was necessary to provide care for people whose incomes fluctuated causing changes in their eligibility status. The thinking was that these individuals, seasonal workers in particular, are eligible one month but ineligible the next, and as such, they should not have to bounce on and off the rolls.

These simplification and continuous eligibility proposals assume that the state is the only way that these individuals and families can receive coverage. The attitude that government is the only way gives proponents of such legislation the incentive to extend coverage to more people for longer periods, eroding the idea of Medicaid as a safety-net and replacing it with the notion that Medicaid is long-term health insurance. One major flaw is the assumption that a person's income on the day that they enroll in Medicaid will be the same a year later and every day in between. Presumably, the proponents assumed that these individuals would be back on the Medicaid rolls eventually, so there was no reason to allow them to go off in the first place. These policies discourage enrollees from finding other ways to cover their health insurance needs and assume that they cannot and will not have other alternative means at another time. Unless the Medicaid enrollee is in long-term care or other situation that will prevent the individual from ever working or providing for their care in any other way, the enrollees should be expected to work or find other avenues for coverage without relying on the state for an extended period. The provision of twelve months continuous eligibility simply misrepresents the intent of Medicaid as a long-term, government run, health insurance program, rather than a short-term safety net.

The federal government realized that the endless supply of government assistance allows people to linger on the rolls longer than they would if the assistance provided were limited. The Temporary Assistance for Needy Families (TANF) program was once considered an entitlement prior to the Personal Responsibility and Work Reconciliation Act (PRWORA) in 1996. PRWORA, also known generally as welfare reform, transitioned TANF from being an entitlement to being time-limited assistance. PRWORA has been very successful in reducing the welfare rolls and moving people toward jobs. The success of this program should stand in contrast to efforts to lengthen eligibility periods for Medicaid. The goal should not be to allow people to linger unchecked on Medicaid rolls—Medicaid should be a temporary last resort, not a lifelong insurance plan.

It is clear that the Medicaid program has grown beyond the bounds of providing a simple safety-net to low-income Texans, and it has done so through policy decisions that have driven Medicaid away from being a

short-term safety-net for the truly needy. Even with the increasing Medicaid population, and the recognition that the program strains the state's budget, the state has willingly expanded coverage to additional populations through the creation of new programs. The CHIP program was essentially Medicaid expansion, though it goes by another name and requires marginally greater cost sharing. However, the attitude of many that health insurance is an entitlement, led the state to create a plan that, in practice, adds unlimited numbers of additional people to the state's rolls.

The State Children's Health Insurance Plan (CHIP or SCHIP) was created to provide medical coverage to children under 19 years of age in families at less than 200% of poverty. This program extends medical coverage to greater numbers of children than ever before; in fact, prior to CHIP, Medicaid covered children ages 1-5 up to 133% of poverty and children ages 6-18 up to 100% of poverty. As expected, extending coverage to children up to 200% of poverty dramatically increased the number of people on the state's rolls. Although the state may cap the number of CHIP enrollees, it has continued to operate the program as if it were an entitlement like Medicaid. The state could choose to enroll people in CHIP according to need, or it could limit the number of enrollees altogether, but the current situation illustrates how far the original intent of medical assistance has come.

Medicaid was intended to be a safety-net, but has come to be viewed as long-term health insurance. Medicaid was intended to provide coverage to the most needy, but has come to cover greater numbers of people and provide a springboard for covering even more through the creation of new programs. Medicaid must return to its intended form, unless the state is willing to provide unlimited resources to the program to meet the demands of free health care.

The Need for a Seamless System

The Medicaid program has been built piece-by-piece over more than thirty years. Then upon addition of the CHIP program, even more people were brought into the fold of government run health care, essentially expanding Medicaid to cover more children. This piecemeal approach has resulted in a system cobbled together without any consistent or overriding vision or direction for the program as a whole.

Income is the standard test of eligibility for Medicaid and CHIP, but even when income is the same across applicants, the applicants may be enrolled in different programs. As an example, consider a family at 125%

of the poverty level with two children, ages 4 and 8. Because of the varying age and income eligibility, the four year old would be covered under Medicaid and the 8 year old would be covered under CHIP. Most of the talk about Medicaid simplification focused on the administrative hassles for enrollees like complicated forms and frequent recertification, yet it is hard to imagine a system that could be more of a hassle than a system in which the children are funneled into different health programs depending on their age.

In addition, Texas Medicaid has historically provided services without assessing co-payments for certain services or benefits, though federal law does allow the state to implement a limited co-payment model which it is currently pursuing. This policy stems from the belief that Medicaid eligible people cannot afford or be burdened with co-payments, and that these individuals would be tempted to forego taking medication or accessing care because of a co-payment. However, the CHIP program provides for a much more aggressive system of co-payments even where these incomes are equal. For this same family, the Medicaid child would pay nothing for services or medication the child receives, while the CHIP child would be subject to a \$15 per year/per family enrollment fee, \$2 co-payments on office visits, \$5 co-payments on emergency room services, \$5 co-payments on brand drugs, and an inpatient facility co-payment of \$25 per admission. Again, the hassle to this family is immeasurable as it has not only different program rules to keep up with, but also differing benefit levels and options. The inconsistent policies are highlighted by the fact that this overlap exists and the CHIP enrollees are expected to share in their health care costs, while the Medicaid eligible enrollee at the same income level has no comparable responsibility. The standards should not differ among enrollees, but should be consistently applied across programs without regard to the specific program in which an individual is enrolled.

The inconsistent and disjointed interaction between Medicaid and CHIP is rarely, if ever, among the reasons cited for the system being difficult to navigate. However, that the system lacks focus that could streamline the system to make it more seamless and easier to navigate. CHIP's sliding scale for enrollees increases cost sharing relative to increases in income and Medicaid should mirror this model. Medicaid should increase cost sharing at income tiers that would allow a person to progress through Medicaid, into CHIP, and on to self-sufficiency with gradually increasing responsibility. Recreating a plan that would provide for a smooth and seamless transition between the programs, and with the goal of preparing the enrollees to be better prepared to plan for their own health care needs, is necessary to repair a system that has been patched for too long.

Efforts to continue expanding Medicaid coverage have renovated the system without regard to the interaction between the two programs. Furthermore, defenders of the Medicaid population suggest that the enrollees are so challenged that they cannot share in their health care costs, yet even where all things are equal, enrollees in different plans have different responsibilities and expectations. The Medicaid and CHIP programs can be more effective if CHIP is used as a model for restructuring the Medicaid system, by implementing more aggressive co-payments and even enrollment fees. There must be uniform income tiers with the same benefit levels and cost sharing requirements.

Of course, federal limitations on the Medicaid program make such wholesale changes difficult. One of the contingencies of the CHIP program is that the state cannot make changes to the Medicaid population in an effort to shift enrollment to the CHIP program, which comes with a better federal/state match. Recognizing these, and other, limitations, the state should construct a comprehensive plan that would demonstrate how a new plan would be more workable for the state and the enrollees as well. The Centers for Medicare and Medicaid Services have encouraged states to submit waiver applications that propose innovative changes to the current system. As such, the state should seek such a waiver and make the strong case for a seamless plan. In fact, in developing this new plan, the goal is only to provide for a continuous system through standards that build on one another; this would not require shifting any population to another plan.

Recommendations

In crafting our own long-term vision for Texas health care, we are now more than ever resolved to the fact that federal Medicaid and CHIP programs must be reformed. And by reform, we are not advocating changing the structure of a program here and there, but rather about reforming the system in its entirety.

The current system of health care delivery to low-income persons is too bureaucratically complex and is unsustainably expensive. The inefficiencies lead to abuse of the system and inappropriate care or coverage. By federal design, Medicaid includes 56 separate programs and is significantly larger than Medicare. The specific eligibility criteria for the various Medicaid and CHIP programs have forced states to adopt several other funding sources to provide care for those not covered—indigent care, charity care, community health services, SKIP, and an endless list of other programs. Families are fragmented with family

members obtaining care from different provider from different programs, some being over-insured and others under-insured.

Texas needs added flexibility to make fundamental reforms to the current system of health care delivery to low-income Texans. Creating a seamless system with greater control at the state level will not only work better for the state of Texas, but it will also better serve Texas' low-income populations.

Pursue Medicaid block-grant funding.

The idea of block-granting funds has gained attention at the federal level from time to time and seems again to be getting included in the discussion over Medicaid. However, the specifics of what a block-grant entails can vary significantly from person to person.

Our vision for providing health coverage is to obtain a per-person block grant from the federal government, pooling Medicaid, CHIP, indigent care and possibly some TANF monies that can be distributed on a per family basis. Texas must have flexibility in structuring plans to meet the families' specific needs is the ultimate goal.

Current federal rules dictate that states cannot vary from mandated populations or coverage requirements. However, if the federal government will allow states to define populations and coverage levels and allow federal money to subsidize employer-based insurance, Texas can more effectively provide health coverage to low income families in the following ways:

- Set subsidy amounts for a family based on the family income and local cost of living.
- Craft a benefit package that more closely corresponds to the unique needs of our low income populations. Texas has radically different needs than Minnesota. It does not make sense to hold both states to the same mandates.
- Outsource eligibility determination.
- Subsidy would be on a sliding scale: as families increase their income, their government subsidy is gradually decreased.
- Give families a subsidized debit care to shop around in the free market for group insurance, private insurance, or a state safety net insurance plan. A Health Reimbursement Arrangement would be incorporated where possible to pay for supplemental services. Any unspent HRA monies could be used to help bridge the gap as the family transitions off Medicaid.

- License participant assistant liaisons (PAL's) to be provided at the time of eligibility determination to low-income families to provide education on preventative care, healthy lifestyles, and the appropriate insurance for the family.

This vision enables family choice and provides incentives to encourage responsible health choices. Families will be able to choose health care most appropriate for them. It greatly reduces administrative costs, directs insurance to the private market, and teaches self-responsibility for health care costs.

Increase Medicaid fraud control efforts.

The United States General Accounting Office estimates health care fraud to be about 10% of spending on health care. However, many dispute this figure with some experts believing that fraud is actually much lower than the 10% estimated, and still others estimating it to be as high as 30%. Regardless of the exact number, it is presumed that similar estimates would apply to the Medicaid program taking up a sizeable amount of the Medicaid budget. In fact, if the 10% figure is correct, the state could realize \$2.5 billion in fraud from the \$25 billion the state will spend on Medicaid in 2002-03. Even if the figures are lower at 5%, or higher at 20%, Medicaid fraud would still be around \$1.3 billion or \$5 billion, respectively. These figures are astonishing and highlight the need for aggressive fraud control efforts in the Medicaid program.

Of course, Medicaid fraud takes many shapes—it can be a provider that files false claims for Medicaid reimbursement, or it can be a person accessing Medicaid services fraudulently. In either case, fraud must be investigated, prosecuted, and ultimately, fraud must be prevented. The state must increase the funding for the Medicaid Fraud Control Unit and explore opportunities to use technology to prevent Medicaid fraud.

At the least, the state must recognize that fraud control is an effort to protect the state's money. Medicaid fraud is stealing money, and when the state faces a significant budget shortfall, a possible \$2.5 billion in fraud is clearly unacceptable. The potential for Medicaid fraud undermines trust in the system and creates unnecessary hassles for providers to prove that they rendered medically necessary services to a Medicaid eligible patient. Even still, investigations have revealed providers billing for services that were not performed as well as services that are not medically necessary. In addition, patients may access the system fraudulently as the identification required by Medicaid enrollees is often not easily verifiable. The state must explore ways in which

technology can assist the state in catching fraud on the “front end.” The Medicaid Fraud Control Unit in the Attorney General’s Office is necessary in catching fraud once it has occurred, but the state must invest in efforts to prevent fraud from happening in the beginning. Increase fraud control efforts could be handled by beefing up the Medicaid Fraud Control Unit in the Office of the Attorney General.

¹ National Center for Policy Analysis, “Uninsured by Choice,” Devon Herrick, Nov 15, 2001.

² “Uninsured by Choice.”

³ “Uninsured by Choice.”

⁴ “Uninsured by Choice.”

⁵ “Uninsured by Choice.”

⁶ “Uninsured by Choice.”

⁷ Nicholas Eberstadt, “A Misleading Measure of Poverty,: Washington Post, February 17,2002:B7.

⁸ Texas Council on Workforce and Economic Competitiveness, Family Income and Assistance Model, “Annual wage and Benefit Scenario for Single Parent with Two Children.”

⁹ Texas Health and Human Services Commission, Texas Medicaid in Perspective, April 2002.

¹⁰ Michelle Kay and Gary Susswein, “GOP leaders suggest \$4 billion in cuts,” Austin American-Statesman, January 16, 2003.

Temporary Assistance for Needy Families

In 1996 Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), commonly known as “welfare reform.” The Act established sweeping changes to the welfare system, ending government assistance as an entitlement and replacing it with a system that required work and offered only time-limited assistance. States were given additional flexibility in determining their Temporary Assistance to Needy Families (TANF) programs through block grants and with far less micro-management from the federal government. Welfare reform set strict requirements for work and work activities and provided that, with few exceptions, families are not eligible for assistance after an adult in the family has received federally funded assistance for five years. These provisions were intended to reach 3 goals: reduce welfare dependence and increase employment, reduce child poverty, and to reduce and prevent out-of-wedlock pregnancies and strengthen marriage. Welfare reform has been successful in meeting each of these goals. Currently, TANF reauthorization is pending in Congress, and President Bush has been very committed to continuing the success of these programs. In addition, increasing efforts to strengthen the marriage initiatives are gaining great attention as the next way to see continued improvement in reforming welfare.

Requiring Work

The success of welfare reform is mostly due to requirements for work and time limits on benefits. In the past, welfare recipients were under less stringent requirements for work and could receive benefits for an unlimited period of time, both of which were large disincentives to self-sufficiency. However, even with the success of the program, there are many advocates who believe that the work requirements are burdensome and look for opportunities to lessen those requirements. These requirements should not be diluted any and, in fact, should be strengthened. In keeping with the spirit of welfare reform, the idea is for individuals to find, get, and keep a job that will lead them to self-sufficiency. The state should unequivocally champion the importance of work and safeguard against policies that would weaken the state’s administration of the program.

Upon applying for TANF a family is required to sign a Personal Responsibility Agreement, which establishes certain requirements for

participation and sanctions for non-compliance. There is some concern that these sanctions are not a sufficient deterrent for behavior and that more stringent policies should be in place to encourage compliance with the responsibility agreement.

Because the work requirements are central to welfare reform, the state must encourage and enforce appropriate participation, including more stringent sanctions for non-compliance. Exempting clients or providing benefits without requiring compliance with work activities only puts the client at a disadvantage for the time when they become ineligible to continue TANF participation. Without work experience, and without skills training, these individuals are not well prepared to pursue work opportunities on their own, making their chances at being truly self-sufficiency far less.

In addition, to the end that work requirements can be strengthened, steps should be taken to do so. Termed the “full engagement” model, TANF recipients would have a case manager equipped to help them navigate the job market and match the TANF client’s skills with an employer’s needs. Under the current situation, however, many clients have automatic work exemptions that last for several months, exempting the individual from work requirements before it can be determined whether a suitable job exists. These automatic exemptions are not in keeping with the spirit of the work requirements.

Rather than automatic exemptions, the case manager assigned to a TANF client should have the ability to make good cause exemptions to address the specific needs of the client. The added flexibility of good cause exemptions determined by the caseworker and not by a prescribed standard, results in exemptions that are more appropriate for each individual situation and could return the TANF participant back to work faster than the prescribed standards would.

Supporting Marriage

At the time of the initial debate on welfare reform, vocal opponents of PRWORA predicted disaster and claimed, among other things, that welfare reform legislation was the “most brutal act of social policy since reconstruction” and that it would “hurt and impoverish millions of American children.”¹ Of course, the success of the program since then has proven those opponents wrong. Similarly vocal opponents of marriage initiatives claim that there is no evidence that marriage makes a difference and say that such initiatives are a waste of money. However, the facts bear truth the importance of marriage. The poverty rate among

single-parent families is about five times higher than the poverty rate among married-couple families.² Even further, more than 80% of long-term child poverty occurs among children reared in never-married or broken families.³ Compounding the long-term poverty effects for children, is the fact that around one in three children is born out of wedlock.⁴ The high rate of out of wedlock births coupled with the reality of long-term poverty for these children is disheartening and unacceptable. Though the benefits of marriage don't end with children, adults benefit from marriage also. Reports show that in comparing married adults and single adults, the married adults are far more likely to report that they are happy, and married mothers are half as likely to suffer from domestic violence.⁵ Clearly, marriage has an impact on the well being of adults, children, and families, improving satisfaction with life and economic stability.

These figures are evidence that the correlation between marriage and economic and social stability exists. This correlation also gives strong support to the idea that the tradition of marriage is important in preserving America's families and addressing the social costs that eventually become our fiscal problems. Opponents of marriage initiatives very often purport to be friends of the poor and the welfare dependent, yet fail to recognize that marriage is one of the best ways to combat a host of social problems that prevent people from living successful and independent lives without reliance on the government. Since the passage of PRWORA these advocates for the poor have been concerned about finding ways to exempt TANF clients from working. While many believe that good-cause work exemptions should be extended to cover other TANF clients that have "barriers" to work through things like domestic violence and other family emergencies; these exemptions do nothing to assist TANF clients in becoming self-sufficient. The reality is that the TANF population is challenged for a variety of reasons and some of these may place strain on marriage, making it all the more important that programs in support of marriage help participants create a strong foundation to address those problems. Supporting marriage initiatives is simply about giving these clients the tools to be more successful.

Finally, one of the problems with welfare is that it created a disincentive to marriage by allowing single parents to receive assistance with no expectation of work, and offers no incentive to have an employed spouse. To combat this, welfare reform established a nationwide goal of increasing two-parent families. State governments, however, did not make marriage initiatives a priority. Of the almost \$100 billion sent to the states for TANF funding between the enactment of welfare reform and 2002, only about \$20 million was spent on marriage programs.⁶ In response, President Bush has proposed increasing funds for marriage programs, and the U.S. House of Representatives has passed TANF

reauthorization, including between \$200-\$300 million for funding marriage initiatives. The commitment of funds illustrates the federal government's commitment to supporting and encouraging marriage. The emphasis on marriage is a message not only to TANF clients, but the entire country, that marriage is important.

Recommendations

Tie a client's TANF funds to participation and completion of marriage programs.

With the availability of additional funding for marriage initiatives, it is important for the state to respond with aggressive and innovative ways to provide this resource to Texas' TANF population. In particular, Texas should look for ways to encourage participation in marriage programs by tying a client's assistance funds to participation in marriage programs. Texas should establish three marriage enrichment courses tackling a variety of issues, including communication, anger management/dispute resolution, budgeting, parenting, and maintaining health lifestyles. TANF clients could choose to participate and receive an additional \$20 a month for each class completed. A client completing all three classes could receive an extra \$60 a month to their TANF allotment.

TANF clients often have challenges that other populations do not have, and it is possible that many of these clients have not had these appropriate behaviors modeled for them. The figures correlating poverty and marital status illustrate how the cycle of poverty may continue if a person has not had experience in a family with an example of a strong marriage. While not all persons coming from single-parent homes face these problems, the reality is that for many TANF clients the marriage enrichment courses may not only help them understand the importance of marriage, but may also be their first look at how a strong marriage works. In addition, the courses on parenting, budgeting, and even healthy living may be a TANF clients' introduction to establishing stability in a family. Since TANF benefits are time limited, it is about assisting people with skills that they will need to be self-sufficient and providing a foundation for building a strong family. Work is the paramount concern in TANF, as it should be, but the institution of marriage provides a foundation for continued success.

Establish either a pay for performance system or a full-grant denial program for individuals that are not in compliance with work requirements.

The cornerstone of welfare reform is the requirement to work. In keeping with this idea, TANF clients should be paid for meeting their work requirements; not meeting work requirements would result in a loss of benefits. Paying for performance could take several shapes, either in the way of small sanctions for each instance of noncompliance, or through a full grant denial. Texas has sanctions in place for noncompliance, but caps the sanction at \$78—once the cap is met, additional instances of noncompliance are not subject to sanction. Either a pay for performance model or a full grant denial model would stress the work requirement by allowing stricter sanctions for noncompliance.

Remove exemptions from work requirements and work orientation to allow case managers to screen for good cause.

Despite the clear expectation for TANF recipients to work, states continue to propose exemptions from these work requirements. While some TANF clients may have good cause not to work, such determinations should be made by a caseworker depending on the specific situation. Establishing exemptions before assessing the needs of the situation may allow to great or too little an exemption for reasonable needs. Furthermore, work exemptions may be subject to abuse as there is little follow up required. Using a case manager to determine good cause exemptions allows case managers to follow up with clients to determine when the good cause exemption is no longer valid and the client must return to work. Simply put, removing exemptions from work requirements and allowing case managers to make these determinations provides greater flexibility and accountability in the system and stresses the importance of meeting work obligations.

¹ The Heritage Foundation, “The Continuing Good News About Welfare Reform,” Backgrounder #1620, Robert Rector and Patrick Fagan, Feb 6, 2003.

² “The Continuing Good News About Welfare Reform.”

³ “The Continuing Good News About Welfare Reform.”

⁴ The Heritage Foundation, “Marriage and Welfare Reform: The Overwhelming Evidence that Marriage Education Works,” Backgrounder #1606, Patrick Fagan, Robert Patterson, and Robert Rector, Oct. 25, 2002.

⁵ “Marriage and Welfare Reform.”

⁶ “Marriage and Welfare Reform.”



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