



## *LIFT Perspective*

*Role of Government Series*

October 12, 2006

# **Improving Access to Health Care: A Critique of Massachusetts' Universal Health Care Plan**

### **Executive Summary**

Massachusetts' much-heralded "Health Care Access and Affordability Plan" pledges to tackle the problem of the state's uninsured by expanding government health care program enrollment, introducing subsidies to help people purchase insurance, and requiring that everyone purchase some form of health insurance if they are not covered by a government program or a private employer sponsored plan. These reforms fail to address the problem of the high cost of health care, which arises as a result of state-enforced mandates and the large number of people who rely on government programs such as Medicaid. Health care reforms should focus on reforming government programs, reducing mandates so that insurers can offer policies with differing levels of coverage, allowing private health care providers to operate disease management programs [and encouraging state programs to adopt the same], and permitting small businesses to adopt a "list billing" approach to providing health coverage to their employees.

### **Background: The High Cost of Health Care**

The high cost of health care treatment and insurance has become prohibitive for many individuals and businesses. In November 2004, a report by the Kaiser Foundation found that nearly half of all uninsured adults postpone seeking medical care because of the cost<sup>1</sup>, and a subsequent report in September 2005 found that businesses that do not offer

---

<sup>1</sup> *Kaiser Commission on Medicaid and the Uninsured*, November 2004;  
<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49531>

health benefits to their employees cite the high cost as their main reason for deciding not to offer health coverage<sup>2</sup>.

In 2004, the Census Bureau reported that 59.8% of people are covered by employer-based programs, while government programs cover 27.2% of the population<sup>3</sup>. This leaves barely 1 in 10 Americans wholly purchasing their own insurance without employer or government subsidy. For conservatives, free enterprise and limited government are important guiding principles – yet America’s health care system largely rejects both, in favor of expanding enrollment on government programs and shielding consumers from the true cost of health care.

In Texas, where 70% of all businesses have fewer than 50 employees, 6 million residents (27% of the population) lacked health insurance coverage for some or all of 2005. In a report that also revealed that Texas’ uninsured rate is the highest in the nation, the State Comptroller asserted that:

“The sheer number of uninsured Texans makes healthcare less affordable for Texas employers and individuals. Much of the cost of providing health care for the uninsured ultimately is transferred to those who have health insurance through higher health insurance premium costs—and to Texas taxpayers who pay for uncompensated care in public hospitals and other programs.”<sup>4</sup>

In addition to these problems highlighted by the Comptroller, health care costs also rise because few recipients of health care have an accurate knowledge of the true cost of any treatments or medical care they receive. President Bush recently signed an executive order<sup>5</sup>, requiring that four federal health care providers, including the Health and Human Services Department, make the price they pay for health care available to their customers. This highlights the extent to which health care consumers have been shielded from the true cost of the health care they receive. The majority of the cost of most treatment is picked up by either an insurer, or a program such as Medicaid. The patient has no concept of the true cost of care, and resultant behavior, as Paul Howard, managing editor of the Manhattan Institute’s *Medical Progress Today*, points out, is characterized by over-use of medical resources, such as requesting increasing numbers of prescriptions, and more visits to doctors, physiotherapists, and other health care providers<sup>6</sup>. Consumers would

---

<sup>2</sup> *Employer Health Benefits 2005 Annual Survey*, Kaiser Family Foundation, 2005; <http://www.kff.org/insurance/7315/index.cfm>

<sup>3</sup> *Income, Poverty, and Health Insurance Coverage in the United States: 2004*; US Census Bureau, August 2005, pg.17; <http://www.census.gov/prod/2005pubs/p60-229.pdf>

<sup>4</sup> *The Uninsured: A Hidden Burden on Texas Employers and Communities*, Texas Comptroller Special Report, April 2005. According to Families USA (2005), as a result of the amount of uncompensated care, health insurance premiums for a family of four in Texas are typically \$1,551 higher annually than they would be otherwise.

<sup>5</sup> *Bush to Sign Executive Order for More Information on Health Care Costs*, Fox News, August 22, 2006; <http://www.foxnews.com/story/0,2933,209744,00.html>

<sup>6</sup> *The State of the Union Health Care Proposals*, Paul Howard, *Medical Progress Today*, February 10, 2006; [http://www.medicalprogresstoday.com/spotlight/spotlight\\_indarchive.php?id=1150](http://www.medicalprogresstoday.com/spotlight/spotlight_indarchive.php?id=1150)

likely behave differently if the majority of health care expenditure had to be made out-of-pocket.

The lack of price transparency is an important factor in explaining high (and rising) health care costs. Within the health care market, cosmetic surgery stands out as an example of a form of health care for which prices are falling. Cosmetic surgery expenses are paid out-of-pocket by the patient. According to analysis by Devon Herrick of the National Center for Policy Analysis, while the growth of medical expenditures has generally outpaced the growth of inflation; cosmetic surgery spending has risen *less* than spending on other goods<sup>7</sup>. The key difference between cosmetic surgery and the rest of medical care is that cosmetic surgery is subject to market forces in which the prices are transparent and services are paid for by the patient at the time and point of service, truly empowering consumers. People seeking cosmetic surgery have the ability to compare prices and quality of service between doctors and choose the surgeon they think can best meet their needs. Although patients requiring emergency medical care are rarely likely to be able to choose their provider on the basis of cost, even patients receiving non-emergency medical services are ignorant of the true costs of care and cannot make market decisions in the same way as people seeking cosmetic surgery.

Regardless of cause, the rising cost of health insurance – now estimated by Kaiser Foundation to be \$11,480 for a family of four<sup>8</sup> – has prompted to the state of Massachusetts to take an aggressive approach to ending the problem of the uninsured.

### **The Massachusetts Health Care Reform Bill**

On April 12, 2006, the Governor of Massachusetts, Mitt Romney (R), signed into law a healthcare reform bill that is intended to address the number of uninsured individuals in the state. Massachusetts has roughly 550,000 uninsured individuals<sup>9</sup>, which represents 9% of its population. The “Health Care Access and Affordability Plan” pledges to tackle the problem of the uninsured in Massachusetts in the following ways:

- Medicaid enrollment will be expanded to provide coverage to approximately 92,500 already eligible but not enrolled individuals, most of whom will have incomes below 200% of the Federal Poverty Level (FPL).
- Subsidies, including insurance policies with \$0 deductibles, will be offered to low-income families in order to assist them with the cost of health insurance; this measure is expected to extend coverage to 207,500 currently uninsured residents earning between 200% and 300% FPL.
- Individuals or families earning at least 300% FPL (roughly \$30,000 per year for a single person) will be required to purchase health insurance or else face tax

---

<sup>7</sup> *Why Are Health Care Costs Rising?* National Center for Policy Analysis, May 2003; <http://www.ncpa.org/pub/ba/ba437/>

<sup>8</sup> *Health Insurance Jumps Twice Inflation Rate*, MSNBC.Com, September 26, 2006; <http://www.msnbc.msn.com/id/15014332/from/ET/>

<sup>9</sup> <http://www.mass.gov/legis/summary.pdf>

penalties and ultimately, a fine. This final measure is expected to affect 215,000 residents.<sup>10</sup>

To help meet the plan's goal of near-universal health care coverage, the bill also includes a \$295 fine for each employee to whom a business with ten or more employees fails to offer a health insurance plan, and a state run health insurance "connector", which certifies health insurance products, and helps individuals and small businesses to find suitable insurance policies.<sup>11</sup>

### **What are the Deficiencies of the Massachusetts Plan?**

#### ➤ *The Plan Perpetuates the Flawed Insurance Approach to Health Care*

The *Washington Post* (April 5, 2006) reported that Governor Romney likened the plan to mandatory auto insurance, saying "we insist that everybody who drives a car has insurance...and cars are a lot less expensive than people." Romney's comparison with auto insurance is significant because it highlights an important difference between the markets for health insurance and auto insurance.

The *Insurance.com 2005 Pricing Report* recorded a 1.8% drop in auto insurance premiums across the nation in the first half of 2005<sup>12</sup>, with some states recording drops as high as 15%. Conversely, a Kaiser Family Foundation report issued in 2005 found that health insurance premiums had increased 73% since 2000<sup>13</sup>, while insurance premiums for small businesses have been rising by 15% per year over the same period. Stated simply, auto insurance premiums are falling, while health insurance premiums continue to rise sharply. This disparity emphasizes the fundamental flaw in the Massachusetts Health Care Access and Affordability Plan: it does nothing to address the problem of rapidly increasing health care costs. This flaw was stressed by Kevin Drum, writing in *The Washington Monthly*, who argued that the plan "doesn't do anything to address cost containment and doesn't do anything to make the system more efficient."<sup>14</sup>

Additionally, although auto insurance is mandatory for vehicle owners, many people still choose to drive without insurance. The Texas Department of Insurance, for example, notes that "the current uninsured motorist rate in Texas is 20%."<sup>15</sup> This strongly suggests

---

<sup>10</sup> *Massachusetts Health Care Reform Plan*, Kaiser Commission on Medicaid and the Uninsured, April 2006; <http://www.kff.org/uninsured/upload/7494.pdf>.

<sup>11</sup> Massachusetts Legislature Conference Committee Report, "Health Care Access and Affordability", April 3, 2006; <http://www.mass.gov/legis/summary.pdf>

<sup>12</sup> *Auto Insurance Rates Fall 1.8% in First Half 2005*, Insurance.com, 2005; <http://www.insurance.com/Article.aspx/artid/318>

<sup>13</sup> *Employer Health Benefits 2005 Annual Survey*, Kaiser Family Foundation, 2005; <http://www.kff.org/insurance/7315/index.cfm>

<sup>14</sup> *Universal Healthcare in the Bay State*, The Washington Monthly, April 6, 2006; [http://www.washingtonmonthly.com/archives/monthly/2006\\_04.php](http://www.washingtonmonthly.com/archives/monthly/2006_04.php)

<sup>15</sup> *HB3588 Feasibility Study of an Interface Motor Vehicle Financial Responsibility Verification System*, Texas Department of Insurance; <http://www.tdi.state.tx.us/reports/pdf/hb3588rpt.pdf>

that a significant proportion of the population will decide not to do something that has been made mandatory by government, even if failing to comply can result in a financial or criminal penalty. The penalty for driving without insurance in Texas, for example, can be a fine of between \$175 and \$1,000, while second or third offenses can be additionally punished by suspension of an individual's driving license, and vehicle impoundment<sup>16</sup>.

Insurance generally is intended to cover a catastrophic event that creates a cost that an individual would not be able to afford. This is the principle upon which other forms of insurance, such as home insurance, life insurance, and auto insurance are based. Health insurance operates on an entirely different basis however, with anything from a \$50 visit to a doctor's office, to cancer treatment costing tens of thousands of dollars, being covered. Texas, for example, has over 50 state mandated health benefits<sup>17</sup>, which greatly increase the cost of coverage since health insurance policies must cover treatments by health care providers such as psychologists, acupuncturists, and marriage therapists, on top of the coverage policies must provide for emergency care and for serious illnesses such as cancer and diabetes.

For the current system of employer-sponsored health insurance to work more effectively, it would make more sense for state law to permit insurance policies to cover only catastrophic events or diseases for which costly treatments and procedures are required. Incidental medical expenditures for items such as prescriptions, outpatient visits, and dental check-ups, could then be paid for out-of-pocket by consumers. Senate Bill 541 (Williams, 78R) attempted to adopt precisely this approach by permitting insurers in Texas to offer policies that did not cover the range of health benefits normally mandated by the state. Although SB 541 successfully reduced the number of mandates for which insurers must offer coverage, a number of mandates remain, such as childhood immunizations, and permitting women to designate an OB/GYN as their primary care provider. A mandate-free policy still cannot be purchased in Texas, despite mandates being so strongly linked to the high cost of health insurance. Dr. Merrill Matthews, Director of the Coalition for Affordable Health Insurance argues that "state legislators [should be] aware of exactly what they have done to the cost and availability of health insurance," and expresses hope that legislators will "remove some of the mandates or give consumers the ability to opt for mandate-free policies."<sup>18</sup>

Again, the comparison with auto insurance is compelling. Motor vehicles are typically insured against catastrophic events such as traffic accidents or theft, but auto insurance does not cover regular maintenance, or the replacement of parts as they become defective; these expenditures are paid by the vehicle owner as they arise. The near-certainty of having to replace vehicle parts over time makes these expenditures uninsurable, because the risk of the expenditure occurring is so high. The same is true of

---

<sup>16</sup> *Automobile Insurance Made Easy*, Texas Department of Insurance, August 2005; <http://www.tdi.state.tx.us/consumer/consum86.html>

<sup>17</sup> *Health Insurance Mandates in the States 2005*, Council for Affordable Health Insurance, January 2005; [http://www.nahu.org/legislative/tools/State\\_Mandates\\_2005.pdf#search=%22health%20insurance%20mandates%20by%20state%22](http://www.nahu.org/legislative/tools/State_Mandates_2005.pdf#search=%22health%20insurance%20mandates%20by%20state%22)

<sup>18</sup> *Coalition for Affordable Health Insurance Releases State Mandate Publication*, TheFreeLiberal.com, August 9, 2006; <http://www.freeliberal.com/archives/000113.html>

incidental medical expenses – occasional visits to a doctor or dentist, or prescriptions to treat minor illnesses or injuries are required so much more frequently than lengthy or expensive life-saving medical procedures, that they are virtually uninsurable. Yet, most people are insured against almost the entire spectrum of possible medical expenditures. This is a costly and inefficient approach to providing health care coverage, which drives up prices, and creates an incentive for consumers to over-use health care services – especially once their annual maximum out-of-pocket expenditure has been reached.

The cost of health insurance would likely be far cheaper if it operated like other types of insurance. Taking the comparison with auto insurance further, it becomes evident that health insurers should be able to offer a full range of insurance policies, from catastrophic coverage only, to fully comprehensive coverage of virtually any type of treatment for a broad range of medical conditions. Auto insurers offer coverage ranging from third party only, through to fully comprehensive; health insurers should be able to do the same. By offering policies that provide different levels of coverage, insurers would be able to make their product more affordable. Consumers who choose to buy less than fully comprehensive coverage would pick up incidental medical expenditures out-of-pocket, and they would be able to choose their health care providers at least partly on the basis of cost – something which the current subsidized co-pay system makes almost impossible, and from the patient’s point of view, unnecessary.

➤ *The Plan Expands the Role of the State*

The Massachusetts plan simply expands Medicaid enrollment up to income levels as high as 200% FPL. While this approach certainly decreases the number of uninsured, cramming more people into government programs will simply drive health care costs higher for those who remain in the private market while also creating a more strenuous burden on the taxpayer. A study published in 2005 by the Milliman Group, found that private insurance companies typically pay more for the health care they cover than government programs pay for the same coverage. This is a causal relationship; private insurers pay more precisely because the government pays less. Health care providers negotiate with insurers knowing they need to raise their prices in order to account for government underpayments and other uncompensated care. As a result, although the average cost of a visit to a doctor’s office is \$41.47, private insurers pay an average of \$65.08, while Medicaid pays only \$29.66<sup>19</sup>. Similarly, state mandates in health insurance typically drive up the cost and make it harder for people to insure themselves.

In 2002, a Washington Policy Center study found that “among firms that offered health insurance, premiums were found to be 4% to 13% higher as a direct result of state mandated benefits<sup>20</sup>. The study also established that up to 25% of the uninsured cannot afford insurance because of the additional cost associated with mandates. This study is supported by a range of reports issued by the National Center for Policy Analysis

---

<sup>19</sup> *Study: Medicare, Medicaid Payments Drive Up Employee Insurance Costs*, Puget Sound Business Journal, May 31, 2006; <http://seattle.bizjournals.com/seattle/stories/2006/05/29/daily10.html?page=1>

<sup>20</sup> *How Mandates Increase Costs and Reduce Access to Health Care Coverage*, Washington Policy Center, June 2002; <http://www.washingtonpolicy.org/HealthCare/PBGuppyHealthCareMandates.html>

(NCPA), which have found a correlation between rising health care costs, state enforced health mandates, and the high percentage of Americans who do not have health care coverage. The NCPA reports highlight the fact that mandates increase health care costs not only because more types of treatment must be offered by insurers, but also because “most mandates increase utilization of the health care system, increase the total amount of money spent and force insurance rates even higher.”<sup>21</sup>

Any government program that offers health care coverage will lead to some measure of crowd-out of private insurance. Whether it is a program such as Medicaid, which offers coverage at practically no cost to the recipient, or subsidized insurance policies such as those being put forward for low income individuals and families in Massachusetts, the result is the same. Private health insurance is crowded-out and it becomes more expensive as a result.

➤ *The Plan Imposes Misguided Penalties on the Uninsured*

In addition to the expansion of Medicaid and government health care subsidies, there are other equally deleterious features of the Massachusetts plan. The provisions that individuals must purchase health insurance, or else face tax penalties and ultimately a fine, and the \$295 fine per employee for businesses who do not offer health benefits are, at best, misguided efforts to increase health care coverage. At worst, these measures reveal a woeful lack of understanding of economic incentives and the workings of the health insurance market.

The \$295 fine for each employee to whom an employer does not offer health insurance represents a straightforward opportunity for employers to buy-out of having to provide health benefits. Given that the average cost of employee-only insurance in Massachusetts was \$2,993 in 2002<sup>22</sup>, the incentive for employers to reject offering insurance in favor of paying a fine that is just a fraction of what insurance would cost will be hard for some businesses to ignore.

Forcing individuals or employers to pay a financial penalty to the state if they choose not to purchase health insurance does nothing to improve the individual’s ability to afford insurance, nothing to make insurance more affordable in general, and moves Massachusetts no closer to solving the problem of its uninsured.

## **Recommendations**

Legislative initiatives aimed at improving health care coverage must be rooted in the acknowledgement that the ever-increasing cost of health care is the biggest barrier to

---

<sup>21</sup> *An Easy Way to Make Health Insurance More Expensive*, NCPA, February 21, 1997; <http://www.ncpa.org/ba/ba224.html>

<sup>22</sup> *Generosity and Adjusted Premiums in Job-Based Insurance*, *Health Affairs Journal*, 25:3, 2006; <http://content.healthaffairs.org/cgi/content/full/25/3/832?ijkey=fynN4VYQoKFmI&keytype=ref&siteid=healthaff>

decreasing the number of uninsured. The Massachusetts plan is representative of the misplaced notion that government mandates are the best way to address America's health care problems.

Ultimately, a fundamental shift towards reducing mandates, and allowing insurers to offer policies ranging from fully comprehensive, to catastrophic care only, is required. Any role that the state plays in health care provision should be limited to subsidizing catastrophic care-only policies for those earning at or below 100% FPL. However, this objective may be unrealistic over the short or medium term, given how entrenched attitudes linking all health care to health insurance have become. Acknowledging this fact, the following recommendations are intended as gradual and achievable health care reforms:

➤ *Reform Government Programs*

An improvement to government health care programs such as Medicaid and CHIP, would be for the state to consider giving families a subsidized health care version of the Lone Star Card to shop around in the free market for group or private health care insurance. The Lone Star Card is currently used by the Texas Department of Health and Human Services to deliver the benefits of the Food Stamp program and the Temporary Assistance for Needy Families program (TANF). The Lone Star Card is presented as payment by Food Stamp and TANF recipients when they purchased approved products, such as food items<sup>23</sup>. Adopting a similar approach in the health care market, by allowing Medicaid or CHIP recipients to purchase their own health care insurance with a subsidized health care Lone Star Card would be advantageous because it will increase the size of the pool of individuals and families who purchase private insurance. This approach also provides a private-sector solution to the problem of health care coverage, while still allowing the government to play an appropriate role in the funding of health care for those who are genuinely needy.

➤ *Use the Health Insurance Risk Pool as a model for Medicaid and CHIP*

The Texas Health Insurance Risk Pool was created by the Texas Legislature and has been operational since 1997. The role of the Pool is to:

“[P]rovide health insurance to eligible Texas residents who, due to medical conditions, are unable to obtain coverage from commercial insurers. The Pool also serves as the Texas alternative mechanism for individual health insurance coverage, guaranteeing portability of coverage to qualified individuals who lose coverage under an employer group plan, church plan or state plan.”<sup>24</sup>

---

<sup>23</sup> In the Food Stamp Program, the Lone Star Card can be used to purchase only approved food items or garden seeds; in the TANF program, the Lone Star Card can be used to purchase a wider range of products, including food items, but also extending to clothing, housing, furniture, utilities, laundry, telephone, medical supplies not covered by Medicaid, and transportation. (Lone Star Technology Department of the Texas Health and Human Services Commission; <http://www.hhsc.state.tx.us/providers/LoneStar/EBT/EBTgeneral.html>)

<sup>24</sup> Extract from the 2005 Annual Report of the Texas Health Insurance Risk Pool.

The Health Insurance Risk Pool is one of the few areas of government intervention in the health care market which is a wholly appropriate role for the state to play. The Risk Pool essentially acts as a safety net for those who are rejected by a health insurance carrier as a result of a pre-existing medical condition, as well as those who lose coverage previously provided to them by an employer, church or government plan. The existence of the Risk Pool is therefore the truest form of a safety net.

The Risk Pool is funded primarily through premiums paid by enrollees (which are capped at 200% of the standard rate for commercial individual health insurance<sup>25</sup>) and assessments made against health insurers and Health Maintenance Organizations (HMOs) that participate in the Pool. The average premium paid by a member of the Risk Pool in 2005 was \$490 dollars, and almost half of all members opted for the \$2,500 deductible plan, with a further third opting for the \$5,000 deductible plan<sup>26</sup>.

The balance of funding of the Risk Pool currently places approximately 40% of the burden on carriers, and the remaining 60% on the premiums paid by beneficiaries of the Pool. Given the essential role that the Risk Pool plays in providing health insurance to more than 28,000 individuals who cannot obtain coverage in the private market, it is notable that the Pool is funded exclusively by those who participate in it, either as enrolled members or as health insurance carriers. This is in a stark contrast to the approach adopted in programs such as Medicaid and CHIP that require their enrollees to make little or no contribution to the cost of their health care. The Health Insurance Risk Pool model that requires participants to contribute to their health care costs should be used as the model for Medicaid and CHIP in Texas.

➤ *Introduce Meaningful Cost-Sharing into State Health Care Programs*

Given the success of cost-sharing in the Texas Health Insurance Risk Pool, a study into whether a similar cost-sharing model could be used in the Medicaid program should be undertaken. The CareLink program in San Antonio and Federally Qualified Health Centers (FQHCs) are strong models on which Medicaid cost-sharing could be based.

Cost-sharing is an essential element for bringing value to health care services. The lack of cost-sharing in the existing Medicaid program shields Medicaid recipients from the real cost of the care they receive and needlessly increases the strain on state resources. With 2006-07 Medicaid costs in Texas rising to \$15 billion from state general revenue alone, exploring how cost-sharing can alleviate budget pressure is both necessary and timely.

The 2004 Consumer Expenditure Survey, produced by the Bureau of Labor Statistics, found that the lowest income group (less than \$5,000 earned income per year) spends more on entertainment (including cable television) and tobacco products combined, than it spends on health care. According to the National Cable and Telecommunications

---

<sup>25</sup> "Texas Health Insurance Risk Pool Expansion Options," Texas Department of Insurance, January 2005.

<sup>26</sup> 2005 Annual Report of the Texas Health Insurance Risk Pool.

Association, the average monthly cost of a basic cable television programming package is \$41.17<sup>27</sup>. The comparison here is stark. Cable television costs a little over \$40 per month, and attracted over 65 million subscriber households in 2006<sup>28</sup>. There are only 110 million television households nationwide, yet almost 60% of these households find the money to subscribe to cable television. Research by the Texas Lottery Commission also reveals that 20.4% of people who play the Texas Lottery have incomes below \$20,000 per year<sup>29</sup>, and, in general, studies show that “the heaviest lottery players – the 20% of players who contribute 82% of lottery revenue – disproportionately are low income.”<sup>30</sup> With low income groups subscribing to cable television and showing a greater propensity toward purchasing lottery tickets, neither of which are essential expenditures, it would not be unreasonable to expect Medicaid recipients to contribute to the cost of their health care.

With certain limitations, federal regulations give states the authority to devise a system of co-payments that encourages the use of generic drugs. Currently, co-payments cannot be more than \$3, although states may request a waiver to increase the amount of the co-payment and to extend the co-payment requirements to the federally excluded categories of people (which currently include children, pregnant women, and people receiving either emergency services or family planning services.)

Texas should require Medicaid recipients to contribute a \$3 co-payment for a non-emergency visit to ER services. This co-payment should be increased to \$5 for Medicaid recipients earning between 101% and 150% FPL, while those earning more than 150% FPL should be required to contribute a \$20 co-pay. Generic medications should attract a \$0.50 co-pay for all Medicaid recipients (regardless of income) while brand-name medications should attract a co-pay of between \$2 and \$5, depending on the recipient’s income level.

In addition to co-payments, those enrolled in state health care programs should be required to contribute a monthly fee towards to the cost of their health care coverage. In general, requiring everyone to contribute to their own health care costs increases personal responsibility and creates an incentive for people to pursue healthier lifestyles. In addition, higher monthly enrollment premiums could also be charged to people who, through their lifestyle choices, increase their health care costs. Those who smoke regularly, for example, could be charged a higher premium to account for the greater risk they carry of having to be treated for various cancers, respiratory problems, and other smoking-related diseases.

Furthermore, instead of expanding existing programs and imposing cost-driving mandates, legislators should endeavor to create a fee-based system that is augmented

---

<sup>27</sup> National Cable and Telecommunications Association;  
<http://www.ncta.com/ContentView.aspx?contentId=65>

<sup>28</sup> Ibid.

<sup>29</sup> Demographic Study of Texas Lottery Players, Texas Lottery Commission, December 2005;  
<http://www.txlottery.org/info/demographicreport2005dec.pdf>

<sup>30</sup> *Why Poor People Win the Lottery*, Christopher Solomon, MSN Money;  
<http://articles.moneycentral.msn.com/RetirementandWills/RetireEarly/WhyPoorPeopleWinTheLottery.aspx>

through some form of consumption tax dedicated to addressing the uninsured funding crisis. Revenue generated by the tax would be dedicated exclusively to increasing the affordability of health care for low-income Texans (defined here as less than 100% FPL). Fees and consumption taxes, rather than mandates, are a superior method of financing health care because there is a measure of choice and personal responsibility embedded in the program.

➤ *Personal Preventive Care*

Those who are poor and very poor are still likely to end up relying on government assistance, even if health care costs fall significantly. For these groups especially, preventive care can be a particularly effective way to limit the likelihood of catastrophic episodes occurring. A report published in the American Journal of Preventive Medicine in 2001 found that:

“Some recommended preventive services are provided at lower rates to people who are of low-income status, less educated, or members of racial and ethnic minorities. These populations are at higher risk from some preventable illnesses, including cancer, heart disease, stroke, most infectious diseases, and both intentional and unintentional injuries. Improving delivery of preventive services to these populations may produce larger health gains.”<sup>31</sup>

The effectiveness of preventive care relies on patients actually receiving the screening and regular tests that are required. A study published by the Centers for Disease Controls and Prevention in April 2006 found that although “[p]reventive screening is widely recognized as a key component of cost-effective, high quality health care...response to reminders [to receive recommended screening] differs according to patient characteristics.”<sup>32</sup> The study established that age is an important factor in determining the likelihood that an individual will decide to receive recommended preventive screening. Younger patients are less likely to seek preventive screening, despite the fact that “the potential to improve their life expectancy and their quality-adjusted life years would be the greatest.”<sup>33</sup>

This underscores the point that health is a personal responsibility. Those enrolled on government programs cannot be forced to accept preventive care, even if it is more cost-efficient in the long run than failing to seek treatment until an illness has become serious or even life-threatening.

There is scope however, for personal preventive management programs to save taxpayers’ money in Texas. Studies have shown that Medicaid patients are more than

---

<sup>31</sup> *Priorities Among Recommended Clinical Preventive Services*, American Journal of Preventive Medicine, 2001, 21(1); [http://www.prevent.org/images/stories/Files/publications/Priorities\\_Clinical\\_Preventive\\_.pdf](http://www.prevent.org/images/stories/Files/publications/Priorities_Clinical_Preventive_.pdf)

<sup>32</sup> *Screening Rates and Characteristics of Health Plan Members Who Respond to Screening Reminders*, Centers for Disease Controls and Prevention, April 2006; [http://www.cdc.gov/pcd/issues/2006/apr/05\\_0063.htm](http://www.cdc.gov/pcd/issues/2006/apr/05_0063.htm)

<sup>33</sup> *Ibid.*

twice as likely as non-Medicaid patients with the same type of illnesses to be admitted to hospital via the emergency room because of an acute event. The majority of these hospitalizations are avoidable through the use of preventive care<sup>34</sup>. A cursory look at the Texas Medicaid program shows that 280,000 recipients, 9% of the total Medicaid population, have asthma, diabetes, heart failure, or a combination of the three<sup>35</sup>. These illnesses are among the most prevalent chronic illnesses, yet are also the most manageable.

Pharmaceutical companies like Pfizer are so confident that disease management can save public money that they are guaranteeing it with their own money. Washington State, for example, negotiated a contract with three pharmaceutical companies that will guarantee 5% savings, while Florida made headlines with its agreement with Pfizer that guaranteed savings of \$33 million over two years<sup>36</sup>. A report presented to the Florida House of Representatives Health Care Committee by the Agency for Health Care Administration in January 2005 revealed that with \$12 million of savings delivered in its first year, and \$29.9 million delivered in its second year<sup>37</sup>, Pfizer's disease management program had exceeded expectations by saving more than \$41 million over two years.

If private pharmaceutical firms are convinced that disease management programs can save money, the state should investigate areas in which such programs would be effective. Texas should instigate a disease management program in the Texas Medicaid program and target those populations with the most prevalent and manageable chronic illnesses such as diabetes, heart problems, hypertension, and asthma. The state should attempt to leverage its huge Medicaid population to secure an agreement similar to the agreement in Florida, by allowing a pharmaceutical company the opportunity to run a disease management program, guarantee the savings, and assume the risk for proper management.

➤ *Expansion of the STAR+Plus program*

In 1998, the state implemented the STAR+Plus (State of Texas Access Reform Plus Long-Term Care) pilot program in Harris County. The program was designed to help reduce health care costs while ensuring patients receive the highest quality care possible. STAR+Plus provides disease management programs and emphasizes preventive care to help enrollees maintain their health, quality of life and independence in their community.

From a budgetary standpoint, the strength of the STAR+Plus managed care model is that the contract between the carrier and the state fixes the amount of money paid for each patient. This allows budget certainty for the state, while the insurer takes on the risk.

---

<sup>34</sup> *A Roadmap to Responsible Reform*, Texas Conservative Coalition Research Institute State Finance Task Force Report to the 78<sup>th</sup> Legislature, January 2003; <http://www.txccri.org/publications/taskforce.pdf>

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

<sup>37</sup> *The Florida Medicaid Disease Management Experience*, Presented by the Florida Agency for Health Care Administration, January 26, 2005; [http://ahca.myflorida.com/Medicaid/deputy\\_secretary/recent\\_presentations/medicaid\\_disease\\_management\\_house\\_012605.pdf](http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medicaid_disease_management_house_012605.pdf)

Expansion of STAR+Plus is currently under way into Austin, San Antonio and Nueces counties, which will nearly double enrollment. In both urban and rural areas, the managed home and community based services model presently implemented in the STAR+Plus model should be available for the aged, blind and disabled population. This benefit should incorporate self-directed “cash and counseling” benefits where appropriate. Ideally, delivery of this benefit should be integrated on the same management platform as the acute care benefit (STAR+Plus or STAR Network)

For the aged, blind and disabled population, mandatory enrollment under existing STAR+Plus rules should be extended to all markets. Blind and disabled beneficiaries aged 0-21 should be mandated to enroll in STAR+Plus.

➤ *List Billing*

With the non-profit sector currently filling the gap between those enrolled on government programs and those who have private or employer-sponsored health insurance, legislators should focus their efforts on policies that make health insurance more affordable. One example of this is list billing. Half of all employed, but uninsured Texans work for businesses with fewer than 25 employees<sup>38</sup>. List billing is an approach that creates a more affordable way for small businesses to offer health insurance to their employees. Essentially, instead of having to purchase a costly small group insurance plan, employers can let their employees “obtain coverage in the less-expensive individual market...Once accepted by the insurer, the employees agree to have the premiums deducted from their paychecks.”<sup>39</sup> With such a large proportion of Texas’ uninsured population being employed by small businesses, adopting a list billing approach could significantly improve health care coverage in the state.

## **Conclusion**

Massachusetts’ Health Care Access and Affordability Plan fails to address the problem of the high cost of health care, which arises as a result of state-enforced mandates and the large number of people who rely on government programs such as Medicaid. In fact, by expanding Medicaid enrollment and increasing state intervention in the health care market, the Massachusetts reforms will only make costs rise further. In Texas, policymakers should focus on reforming government programs, using the Risk Pool as a model, so that a measure of personal responsibility and cost-sharing is introduced to Medicaid and CHIP. Expanding disease management and preventive care programs (specifically STAR+Plus), and assisting the small group insurance market by permitting a list billing approach to be adopted are also important areas that legislators should pursue.

---

<sup>38</sup> "Demographic Profile of the Texas Population without Health Insurance in 2001"; TxHHSC - <http://www.hhsc.state.tx.us/research/dssi/HIS/TXUNIN2001.html>

<sup>39</sup> *One Solution for the Small Group Market*, Council for Affordable Health Insurance, April 2006; [http://www.cahi.org/cahi\\_contents/resources/pdf/n133ListBilling.pdf](http://www.cahi.org/cahi_contents/resources/pdf/n133ListBilling.pdf)

Health care reform in Texas should be rooted in the acknowledgement that rather than relying on the state, it is, ultimately, an individual's responsibility to ensure that they have adequate health care coverage. The state's role should be to facilitate the effective operation of the Risk Pool and to provide basic health care to the genuinely poor and indigent. Beyond this, the state should simply focus on allowing the private health care market to operate as effectively as possible.