TAHP

Texas Association of Health Plans

Texas Health Source Special Edition

Charting the Future of Health Care in Texas

Texas Association of Health Plans
LEGISLATIVE GUIDE

2007

TEXAS ASSOCIATION OF HEALTH PLANS LEGISLATIVE GUIDE

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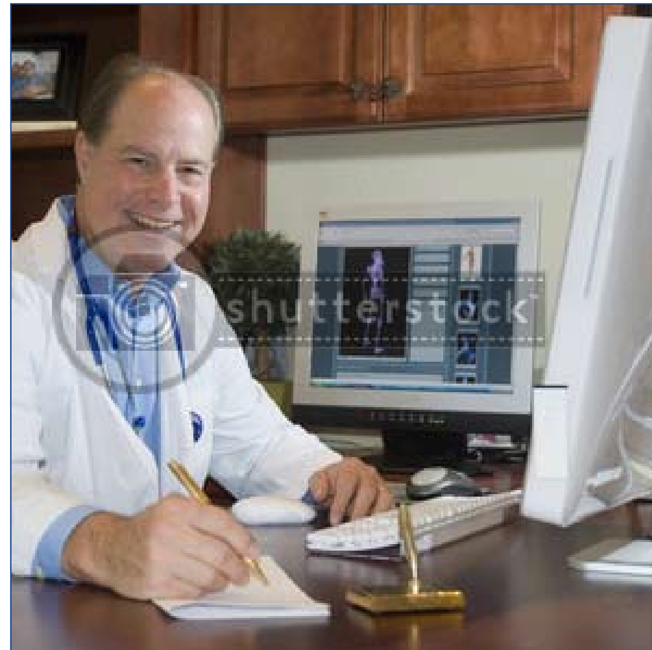
The Texas Association of Health Plans (TAHP) was founded in 1987 as the voice of health plans operating in Texas. Its membership of health maintenance organizations, health insurers, and other health care-related entities include some of our state's top employers. TAHP members provide health coverage for more than 90 percent of insured Texans underscoring the organization's commitment to improving access, value, and quality of health care throughout the state.

TAHP brings together industry leadership to help forge solutions to critical health care issues facing Texas. Through their interaction with employers, consumers, and providers, TAHP members provide unique insight and experience for the state's health care discussions. Serving as a resource to the Texas Legislature is a top priority of TAHP and its membership. It is in this role that TAHP offers its 2007 Legislative Guide. The following pages have been developed with the goal of providing useful and relevant information on key health care issues that will be considered during 80th regular session of the Texas Legislature.



On behalf of it members, and the millions of Texans who benefit from health care coverage, TAHP is committed to strengthening our state's health care system by improving access, increasing affordability and ensuring quality care is delivered.

To improve health care for all Texans by serving as an effective advocate for value, access, quality care and sound public policy in the administration of health care benefits.

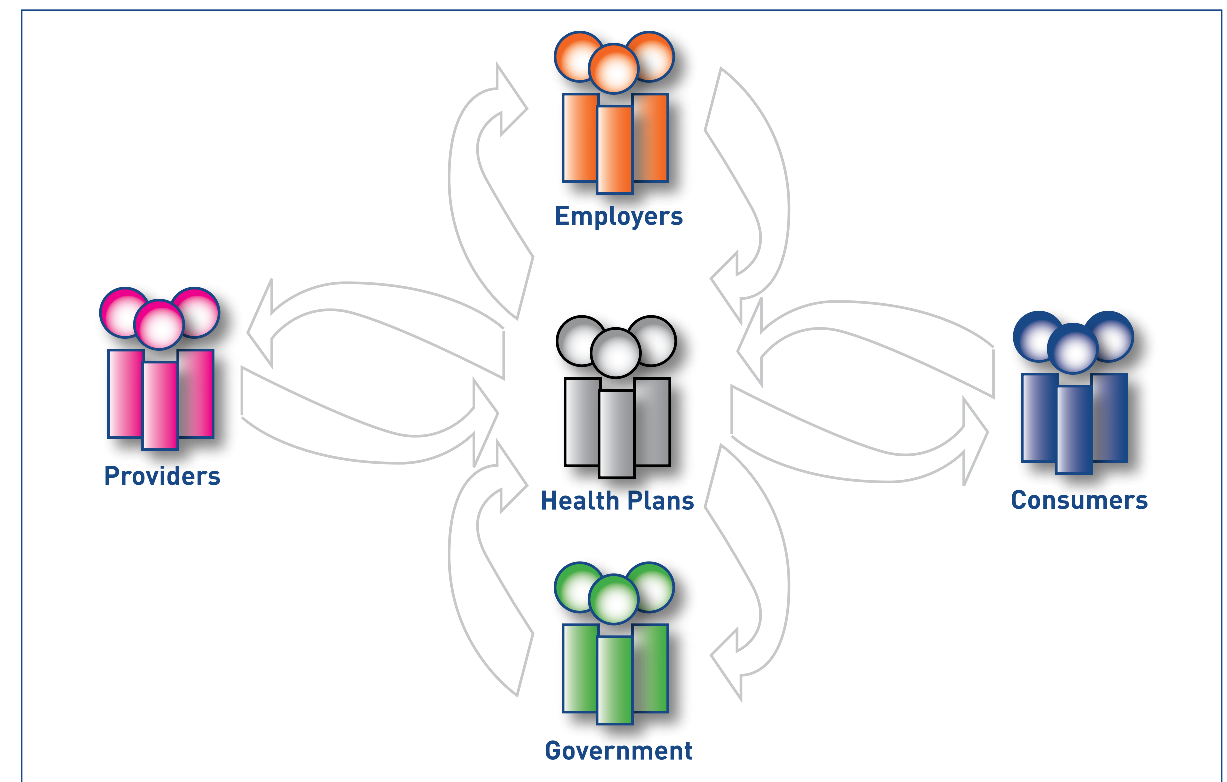
-TAHP Mission Statement

CHARTING THE FUTURE OF HEALTH CARE IN TEXAS: AN OVERVIEW

As legislatures convene across the country, their consideration of current health care issues will not be routine. Perhaps more than ever their decisions on key health care matters will not only shape health care policy but also determine the future of the state's quality of life, the wellness and productivity of its citizens, and the strength and viability of its health care system.

Texas is not unlike many states grappling with a growing uninsured population, rising health care costs, uncompensated care, an unsustainable Medicaid program, and consumer and employer demands for increased transparency and value. The urgency for action on these health care challenges has never been greater. The times call for innovative solutions that test the creative limits of government, business, and the health care community.

Health plans are positioned to play a critical role in helping identify appropriate and cost-effective solutions that address access, affordability, and quality of health care throughout the state. Working with employers, governments, consumers, and providers, health plans have the ability to offer insight into alternatives that balance the cost and feasibility of health benefits for those who purchase coverage.

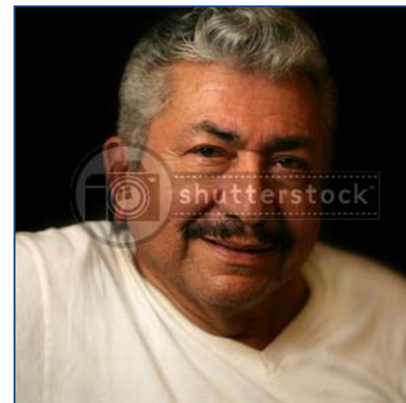


TAHP's commitment to helping chart the future of health care in Texas is driven by three guiding principles:

QUALITY	ACCESS	AFFORDABILITY
Make evidence-based medicine the standard for health care, and advance quality and transparency to improve outcomes, eliminate errors, reduce costs, help consumers make informed health care choices, and promote value.	Use targeted strategies to give all individuals access through public and private coverage and through support for the public health infrastructure.	Maximize the savings that can be achieved through improvements in access and quality and, at the same time, take additional steps to make health care more afford-able through regulatory, legal, and other reforms.

During the 2007 legislative session, TAHP and its members will be working with the Texas Legislature to improve health care for all Texans. Specifically, TAHP will focus on efforts aimed at reducing the uninsured by:

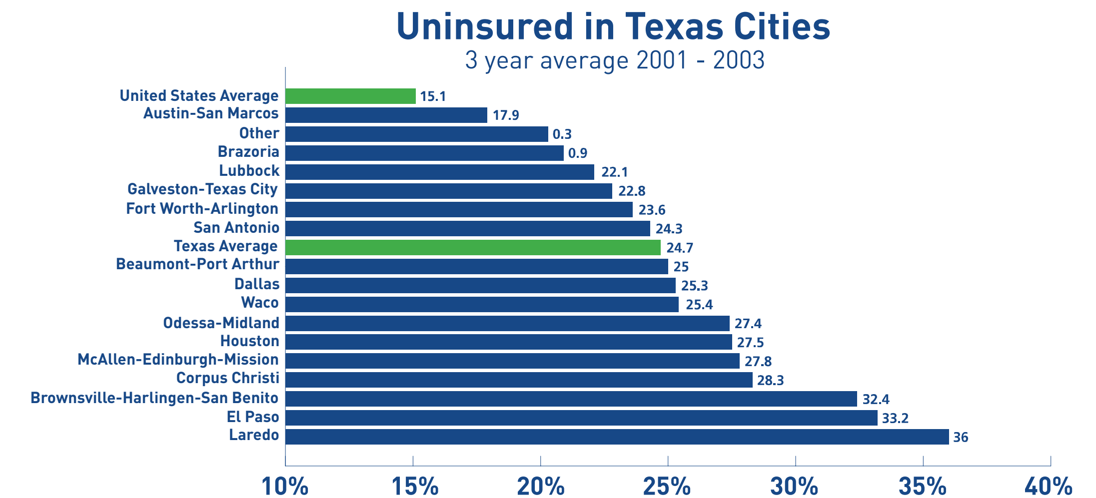
- Improving Access to Private Coverage
- Increasing Transparency in Health Care to Control Costs and Promote Quality
- Modernizing Public Programs



REDUCING THE UNINSURED

THE UNINSURED IN TEXAS: EVERYONE PAYS.

Texas currently ranks as the state with the highest percentage of uninsured people in the United States – over 25 percent. While there is variation among the major cities of Texas, they all have an uninsured rate higher than the national average. In 2004, 13 million Texas residents were covered by private insurance, with an additional 5.25 million enrolled in government programs, such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These numbers essentially mean that more than 5.5 million Texans must either rely on their own resources, or on taxpayers and the insured, to fund their health care.



Sources: U.S. Census Bureau, Texas State Comptroller's Office.

The increasing number of uninsured fuels a costly cycle that includes reduced access for needed health care, increased demands on local taxpayers to pay for uncompensated care, higher premiums through cost shifting for insured consumers, and backlogged emergency rooms caused by the increased number of uninsured seeking care.

According to the Texas Health and Human Services Commission (HHSC), hospitals reported providing approximately $9.2 billion in uncompensated care in 2004 with most dollars going to hospital care. Last year, costs for family health insurance coverage provided by private employers in Texas were projected to be more than $1,500 higher because of the cost shifting that occurs due to caring for the uninsured population. As a result of these higher premiums, many Texans are unable to afford the cost of insurance, causing more people to become uninsured.

REDUCING THE UNINSURED

America's Health Insurance Plans (AHIP) recently proposed a plan at the federal level designed to expand access to health care to all children within three years and to 95 percent of all adults within 10 years. The plan would expand eligibility for public programs, enable all consumers to purchase health insurance with pre-tax dollars, provide financial assistance to help working families afford coverage, and provide funding for states to develop and implement access proposals.

While budget constraints prevent an overnight solution to the state's uninsured challenges, a comprehensive, step-by-step approach, phased in over time can move Texas forward in building the best health care structure possible. As the uninsured in Texas are a diverse group with different health, incomes, and priorities, TAHP believes a "Texas specific" approach that utilizes multiple strategies to reduce the uninsured is the best approach. Such an approach will require efforts to improve access to private insurance, cost containment strategies, and modifications to public programs.

KEY POINTS:

- Reducing the number of uninsured Texans will decrease the uncompensated care provided by safety-net providers, thus reducing the burden placed on Texas taxpayers and decreasing the need for cost shifting to insured Texans to pay for uncompensated care.
- The uninsured are a diverse group that will require a combination of strategies to address.
- Reducing the number of uninsured Texans will decrease the backlog in emergency rooms where overcrowding can affect access to timely emergency care.

A ROADMAP TO REDUCING THE UNINSURED IN TEXAS

IMPROVING ACCES TO PRIVATE COVERAGE

SOLUTION 1: Legislation creating the Small Business Premium Assistance program to provide health benefit options to small employers through a shared premium funding program involving government, employer, and employee contributions.

SOLUTION 2: Legislation to provide a 200 percent tax incentive in year one, and 150 percent in year two for small employers who offer employee health benefit coverage if they have not done so in the last six months, and a 125 percent tax incentive for small businesses who continue to offer employee-based health benefits.

SOLUTION 3: Legislation reforming current laws and regulations that limit advertising options and product benefits such as wellness programs.

SOLUTION 4: Legislation creating the "Insure Texas Kids" license plate program to fund outreach for publicly and privately funded health insurance for children.

SOLUTION 5: Encourage the United States Congress to adopt the AHIP plan to address the uninsured.

RESTRUCTURING THE RISK POOL TO ENSURE ITS VIABILITY

SOLUTION 6: Legislation amending the Texas Insurance Code to create a 100 percent premium tax offset.

SOLUTION 7: Legislation changing the current methodology for calculating Risk Pool assessments from the "covered lives" approach to a "total premium dollars received" formula.

EMPOWERING CONSUMERS THROUGH TRANSPARENCY

SOLUTION 8: TAHP supports additional funding for the Department of State Health Services to enable the collection and public release of information on the pricing and quality of health care in Texas.

SOLUTION 9: TAHP supports additional study of self-referral patterns and ensuring that licensing agencies have appropriate disciplinary authority.

SOLUTION 10: TAHP opposes efforts to reduce transparency by keeping quality information confidential and to limit the ability of health plans to craft networks based on cost and quality.

SOLUTION 11: TAHP supports legislation that will ensure the rapid refund by providers to patients for overpayment of medical services delivered.

PROTECTING PATIENTS FROM BALANCE BILLING

SOLUTION 12: Legislation to prohibit the practice of balance billing by out-of-network hospital-based providers.

SOLUTION 13: Legislation to ban balance billing for emergency services.

SOLUTION 14: Legislation to require the disclosure by participating providers and facilities of instances when they refer patients to out-of-network providers.

SOLUTION 15: Legislation to establish a formal complaint process on provider billing practices.

FEDERAL WAIVER KEY TO CONTAINING FEDERAL COST TRENDS

SOLUTION 16: Legislation supporting the pursuit of a Section 1115 federal Medicaid waiver to protect safety-net hospitals while allowing the state to expand the use of cost savings programs such as capitated managed care.

SOLUTION 17: Legislation that supports the integration of acute and long-term care services in the management of the Medicaid program.

SOLUTION 18: Legislation that incorporates the use of programs that increase personal responsibility, promote prevention, and reward healthy lifestyles among the Medicaid beneficiaries.

SOLUTION 19: Legislation to reduce the state's Medicaid costs through the use of Long-Term Care Partnerships.

CAPITATED MANAGED CARE: THE MOST EFFECTIVE MODEL FOR CONTROLLING MEDICAID

SOLUTION 20: Legislation supporting the use of fully capitated managed care where feasible in administering the state's Medicaid program.

CHILDREN'S HEALTH INSURANCE: PROTECTION FOR KIDS A WISE INVESTMENT FOR THE STATE

SOLUTION 21: Legislation to simplify the enrollment and reenrollment processes for Texas families and children who qualify for the CHIP and Medicaid programs.

SOLUTION 22: Legislation to provide for 12 months of coverage in CHIP and an administrative renewal option for Medicaid.

SOLUTION 23: Legislation to establish "Insure Texas Kids" specialty license plates with funding used for outreach for public and private coverage options for children.

IMPROVING ACCESS TO PRIVATE COVERAGE

ENCOURAGING PRIVATE-BASED SOLUTIONS TO INCREASE ACCESS.
According to the U.S. Census Bureau, approximately 53 percent of Texas citizens received their health coverage through employment-based benefit packages in 2004. While this number represents the primary source of health coverage for most Texans, national trends indicate a decreasing number of employers are providing benefits. The increasing cost of health care is leading many businesses, particularly small businesses, to drop coverage entirely or provide employees a stipend to be used toward the purchase of their own private health plans.

According to the U.S. Census Bureau, approximately 53 percent of Texas citizens received their health coverage through employment-based benefit packages in 2004. **53%**

WHERE TEXANS RECEIVE THEIR COVERAGE

NONELDERLY 0-64	TEXAS #	TEXAS %	US #	RATING
EMPLOYER	10,788,460	53%	156,426,100	61%
INDIVIDUAL	905,330	4%	13,928,090	5%
MEDICAID	2,521,990	12%	34,802,750	14%
OTHER PUBLIC	498,570	2%	6,163,480	2%
UNINSURED	5,493,990	27%	46,118,230	18%
TOTAL	20,208,330	100%	257,442,650	100%

ALL POPULATIONS	TEXAS #	TEXAS %	US #	RATING
EMPLOYER	10,805,450	48%	156,326,430	53%
INDIVIDUAL	928,550	4%	14,162,970	5%
MEDICAID	2,743,730	12%	37,868,010	13%
MEDICARE	2,223,200	10%	34,654,460	12%
OTHER PUBLIC	281,230	1%	3,358,460	1%
UNINSURED	5,537,960	25%	46,577,440	16%
TOTAL	22,520,110	100%	292,947,440	100%

Source: Kaiser Family Foundation, StateHealthFax.org - Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 current population survey. (CPS: Annual Social and Economic supplements).

State business tax reforms adopted in 2006 included incentives for employers offering employment-based coverage. The incentives were seen as step that might encourage the offering of employer-funded benefits. However, many believe that unless the cost of health care is slowed or the tax incentives are enhanced, more Texas employers may join the ranks of businesses eliminating health benefits for their employees. Such a development would contribute to an already growing uninsured population within the state. Additional tax incentives for small employers who offer health insurance could have a meaningful impact.

According to the Texas Department of Insurance (TDI), roughly one-third of uninsured Texans work for small businesses with less than 10 employees, with another 12 percent working at firms with less than 25 employees. Texas is not alone among states seeking to improve access to small employer health coverage. One strategy gaining increasing attention involves a premium assistance program that splits the cost of coverage between government, the employer, and the employee. Such an approach holds promise of providing much needed coverage for one of the largest segments of the uninsured without placing the entire burden for funding on the small business owner.

By creating a Small Business Premium Assistance (SBPA) program for Texas, the state would be attacking the problem of the uninsured by taking advantage of already existing insurance products and addressing affordability for small employers. Data on the uninsured in Texas reveals that the majority of the uninsured are employed. The same data also indicates that a large number of small employers do not offer coverage to employees, with cost being the major issue. Given these facts, providing small employers with an opportunity to purchase affordable coverage could be a key strategy in providing coverage to large segment of the uninsured population.

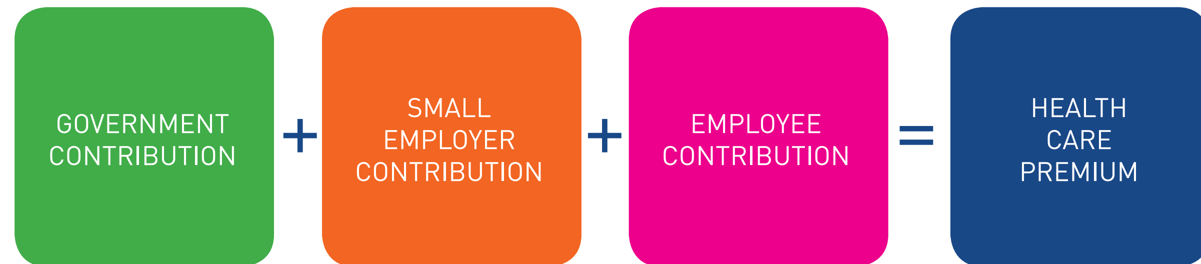
Under the SBPA, small employers (2-25 employees) would be eligible for a premium subsidy from the state if:

- The small employer had been uninsured for the previous 12 months
- The employer agreed to pay at least 50 percent of the employee premium
- The average salary of employees at the business was at or below 300% of the federal poverty level (FPL) (excluding business owners)

The subsidy for qualifying employers would be $50 per employee per month during the first year. The premium assistance would be phased out over time. An enhanced subsidy would be available to employers who promote wellness programs for their employees. Additionally, employer groups that have a catastrophic case in a year would be eligible for an enhanced subsidy. The SBPA program would build off the existing small group market and available products. All carriers offering small group coverage would be required to participate. The state would have the option of limiting enrollment or allotting a set appropriation to ensure that costs are predictable.

The SBPA proposal represents an effort to reduce the number of uninsured by promoting private market options and targeting small employers, where most of the uninsured in Texas work. The proposal also offers the state predictability of costs and the benefit of an already existing product and marketplace.

SMALL BUSINESS PREMIUM ASSISTANCE MODEL



Profiles of the uninsured in Texas also reveal that a number of the uninsured have incomes that would allow for the purchase of coverage. Surveys show that many of these individuals opt not to purchase coverage due to confusion, a lack of knowledge about products that fit their needs, and a perceived lack of value. A combination of approaches including outreach, enhanced benefits, and product flexibility would allow for a targeted approach to individuals currently foregoing coverage.

KEY POINTS:

- One strategy gaining increasing attention as a solution for increasing small business coverage involves a premium assistance model where the cost of coverage is split among the government, employer, and employee.
- Creating a Small Business Premium Assistance (SBPA) program would promote a private market solution for small employer health coverage, provide the state predictability of costs for the program, and utilize already existing insurance products.

ENCOURAGING PRIVATE-BASED SOLUTIONS TO INCREASE ACCESS.

SOLUTION 1: Legislation creating of the Small Business Premium Assistance program to provide health benefit options to small employers through a shared premium funding program involving government, employer, and employee contributions.

SOLUTION 2: Legislation to provide a 200 percent tax incentive in year one, and a 150 percent incentive in year two for small employers who offer employee health benefit coverage if they have not done so in the last six months, and a 125 percent tax incentive for small businesses who continue to offer employee-based health benefits.

SOLUTION 3: Legislation reforming current laws and regulations that limit advertising options and product benefits such as wellness programs.

SOLUTION 4: Legislation creating the "Insure Texas Kids" license plate program to fund outreach for publicly and privately funded health insurance for children.

SOLUTION 5: Encourage the United States Congress to adopt the AHIP plan to address the uninsured.

RESTRUCTURING THE RISK POOL TO ENSURE ITS VIABILITY.

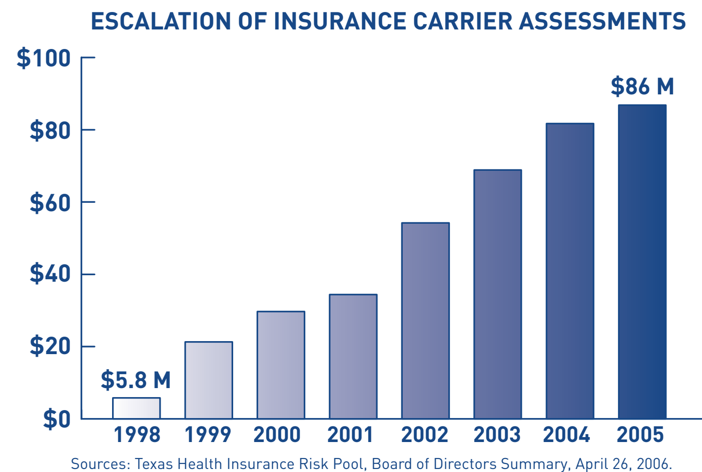
The Texas Health Insurance Risk Pool (THIRP) was created in an effort to extend coverage to Texans who were considered medically uninsurable. In addition to providing much needed coverage to these individuals, the Pool provides a means of reimbursement to physicians, hospitals, and pharmacists for care that may have otherwise been uncompensated. The rate of growth of the Risk Pool has risen from fewer than 3,000 members in 1998 to more than 28,000 in 2006. According to the Texas Department of Insurance, roughly 300 new members per month are added to the Pool.

THE RISK POOL GROWTH RATE

Year	Covered Lives
1998	2926
1999	6600
2000	11,780
2001	16,390
2002	21,245
2003	24,675
2004	26,574
2005	28,132

Because their preexisting conditions often involve costly medical care, individuals who are covered by the Risk Pool are considered "high risk." Premiums for risk pool members are higher than those of the commercial market but fall short of providing the total amount needed to cover their corresponding claims. Texas law requires that Risk Pool losses in excess of premiums collected be funded through assessments on Texas insurers. These assessments are based on the number of covered lives an insurer has in Texas.

Risk Pool assessments to Texas insurers have increased more than 700 percent since 1998. In 2005, the assessments totaled $98 million compared to $61.1 million in 2003. The rapid and dramatic increase in the assessments has created unpredictability for Texas insurers and is ultimately reflected in higher insurance costs paid by businesses and consumers.



Many believe assessing insurers based on covered lives is an unfair method of funding the state's Risk Pool. Not only does such an approach allow self-funded plans to escape making their contribution to the Pool, but the assessments also penalize carriers that offer low-cost coverage to individuals and children.

Currently risk pool premiums are subject to a maximum cost of 200 percent of the cost of a similar policy in the commercial market. An incremental reduction in that ceiling to 150 percent over several years would expand access by making coverage more affordable for uninsured Texans who seek it.

With the increasing demand for Risk Pool benefits and the excessive rise in assessments on insurers, state leaders must explore alternatives that are broad based and fair to ensure the fund's continued viability.

KEY POINTS:

- The Texas Health Insurance Risk Pool was created in an effort to extend coverage to Texans who were considered medically uninsurable.
- In addition to benefiting those individuals who are covered through the Risk Pool, the Pool provides a means of reimbursement to physicians, hospitals, and pharmacists for care that may have otherwise been uncompensated.
- Texas law states that the Pool will be funded by premiums from those who are covered and assessments to Texas insurers based on the per capita membership of the plan in Texas.
- Risk Pool assessments to Texas insurers have increased more than 700 percent since 1998.

RESTRUCTURING THE RISK POOL TO ENSURE ITS VIABILITY.

SOLUTION 6: Legislation amending the Texas Insurance Code to create a 100 percent premium tax offset.

SOLUTION 7: Legislation changing the current methodology for calculating Risk Pool assessments from the "covered lives" approach to a "total premium dollars received" formula.

CONTROLLING COSTS AND PROMOTING QUALITY

TRANSPARENCY IN HEALTH CARE: THE RIGHT TO KNOW

Today individuals and families must make potentially life-altering health care decisions with little or no ability to compare price and performance among Texas' hospitals, outpatient facilities, and physicians. The health care sector may be the only industry in our society where information on the cost and quality of services sought is not readily accessible to the consumers who seek it. This absence of information places individuals at risk of facing excessive pricing and underperforming providers at a time when they are most vulnerable.

As businesses seek more information to help control their health care costs and as individuals increase their involvement in managing their care, both will have a growing need for greater transparency in the pricing and quality of medical services. Empowering health care purchasers with increased information will not only contribute to a reduction in costs but also drive improvement among providers who have a history of poor outcomes.

TRANSPARENCY AND THE PRICING OF HEALTH CARE

A 2005 Harris Interactive poll showed that on average, individuals were able to identify the price of a Honda vehicle within $300, but when asked to identify the price of a four-day stay in a hospital, those responding missed the mark by an average of $8100.

A lack of transparency in health care pricing has not only left consumers in the dark on the cost of services but has also thwarted the ability of market forces to influence the pricing of medical services. A lack of market competition has enabled an increase in the pricing of health care with little, if any, public awareness. While increases in the cost of products and services are a reality for any industry, many believe there is a lack of justification for the level of increases and the disparity in health care pricing that has become common today. A comparison of pricing for similar procedures at separate hospitals illustrates the broad disparity in costs usually hidden from those who seek such services.

PROCEDURE	HOSPITAL A	HOSPITAL B
Pacemaker	$25,000	$125,000
Colonoscopy	$940	$2582
Head/Brain CT Scan	$900	$6600
Abdominal CT Scan	$1,000	$4800
Ibuprofen (per tablet)	$0	$12

T As health coverage options include more consumer-directed models, it is incumbent upon the state and the various health care system participants to ensure that consumers have access to pricing information. Health plans will play an important role in increasing transparency by translating complex data into understandable terms and by building network options with economic incentives based on price and quality.

Transparency can also assist in containing health care costs by ensuring that consumers are aware of possible conflicts of interest. A recent article in *Health Affairs*, a national journal on health issues, found that the fastest growing component of health care costs was outpatient hospital spending. The authors noted that a major reason for the increase was due to the increased presence of specialty hospitals and self-referral to those facilities by physicians with ownership interests in the facilities. Ensuring that consumers and health plans are aware of such conflicts and that appropriate disciplinary options are available to state licensing boards will promote transparency and cost containment.

MAKING THE QUALITY OF HEALTH CARE TRANSPARENT

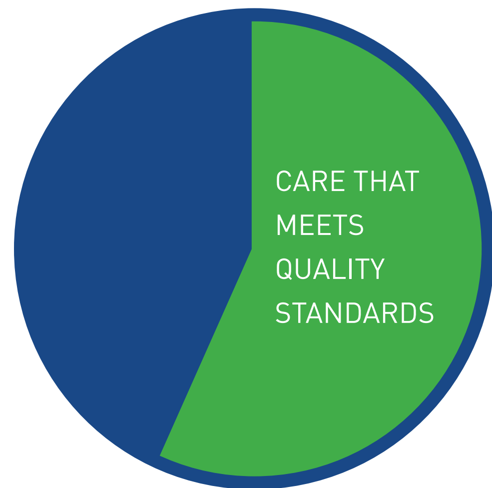
A lack of transparency in the quality of health care has minimized the impact of outcomes in driving providers' efforts to improve performance. This has occurred despite the fact that outcomes and cost are inherently linked in measuring quality. Lack of transparency has also been a likely contributor to the increasing number of medical errors that put patients and their families at risk. According to a report by the National Academy of Sciences' Institute of Medicine, between 44,000 and 98,000 people die each year because of mistakes by medical professionals. These medical errors and other quality indicators have been kept from the public rather than being utilized to improve care.

According to a report by the National Academy of Sciences' Institute of Medicine, between 44,000 and 98,000 people die each year because of mistakes by medical professionals.

98,000

A growing body of research also indicates that patients receive vastly different care and inappropriate care based largely on where they live. Research from the RAND Corporation, the Institute of Medicine, and Dartmouth University has confirmed that variation in care exists and often results in patients obtaining the wrong care. Increased transparency will motivate consumers to seek care from high-performers creating an economic incentive for providers to be recognized for the quality of care they deliver. This movement reinforces the "pay for performance" model that health plans are increasingly utilizing to reward providers for results and create incentives for consumers.

HEALTHCARE FACTS ABOUT COST, ACCESS AND QUALITY.



In the only national study conducted on quality of care, RAND found that American adults were receiving about one-half recommended medical services – that is, services shown in the scientific literature to be effective in specific circumstances and agreed upon by medical experts.

The study used RAND's Quality Assessment (QA) Tools system, a comprehensive method for assessing quality that includes 439 measures of effectiveness for 30 acute and chronic health problems of adults as well as the leading preventive health care interventions.

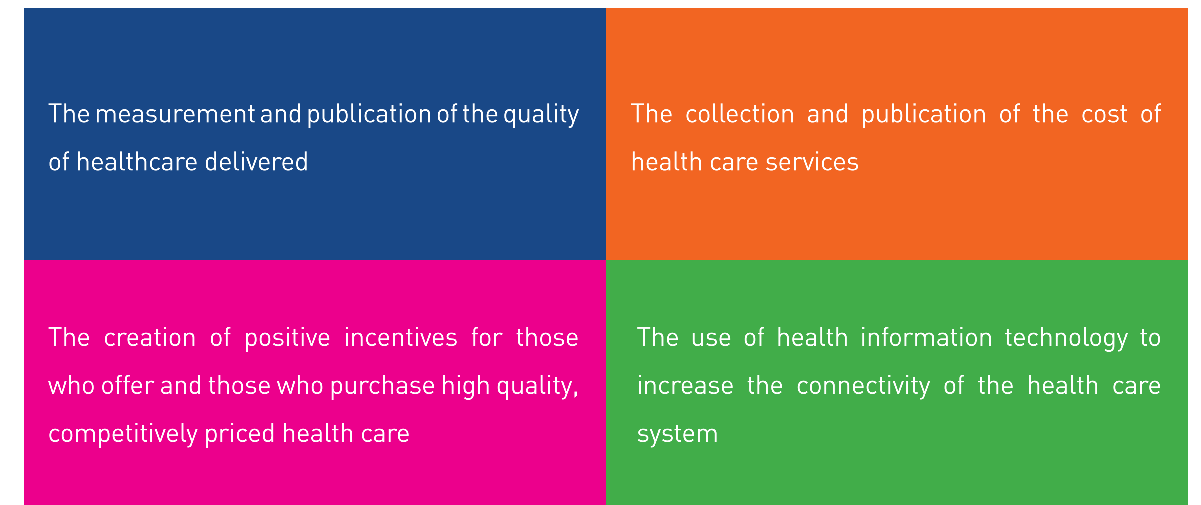
Source: RAND Corporation - 1776 Main Street, P.O. Box 2138, Santa monica, CA 90407-2138.
The Communications Institute - 55 S. Grand Ave., Pasadena, CA 91105

A number of states have taken the lead in collecting and disseminating health care information to the public. Many states, including Texas, already collect certain medical information but have lacked the funding and the impetus to formalize its release in a consumer-friendly format. Costs and average costs of the most common procedures as well as outcomes including mortality, infection rates, readmission rates, and length of stay are included in the information currently being provided by some states.

USING INFORMATION TECHNOLOGY TO IMPROVE HEALTH CARE.

Health plans are taking a leadership role in responding to the increased demands for transparency by developing and piloting their own programs. While these initiatives are providing valuable information to the health plan's members, a lack of access to the information by the public limits their reach and effectiveness. In response to their members' growing expectations for greater transparency, health plans will continue developing tools that will increase access to important health care information while balancing the need and methods for delivering such data with the increasing administrative costs required to do so. Expanding access to health care information to all who seek it will likely require utilizing the role governments play in collecting such data.

The federal government is planning a prominent role in advancing increased transparency by promoting the interconnectivity of four key cornerstones of value-driven healthcare. The cornerstones include:



Government agencies that administer or sponsor federal health insurance programs are being directed to develop and identify approaches that increase the delivery of high quality, efficient care by sharing with beneficiaries information about pricing and quality and increasing the use of health information technology. The federal government believes the use of price and quality information and performance-based incentives will increase the ability of marketplace dynamics to foster an increase in quality-based decisions by patients as well as providers.

State leaders have an opportunity to ensure that Texas consumers receive the information they need to make informed health care decisions. Most believe doing so is good public policy. At a time when there is national attention on improving our health care system, greater transparency can improve the quality of care delivered, bring to focus those areas that should be strengthened to increase access and affordability for all citizens, and help lower costs.

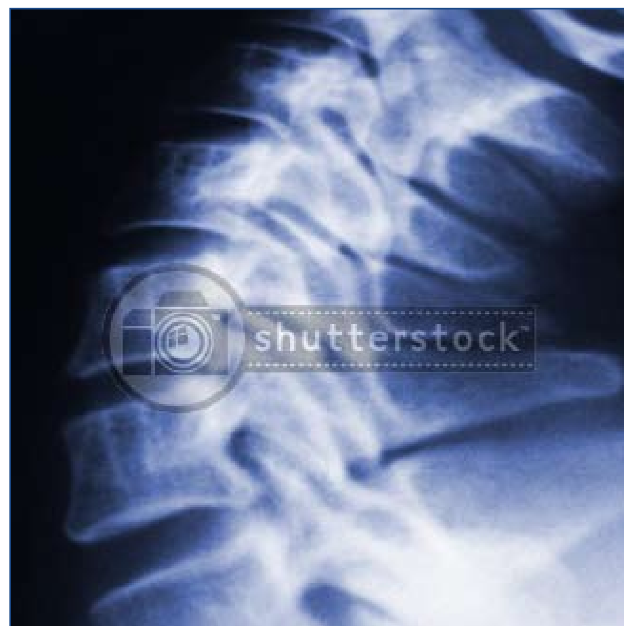
In October of 2006, Governor Perry issued an executive order creating the Texas Health Care System Integrity Authority, a new public-private partnership aimed at increasing the use of health information technology in the state. The Authority's goals include facilitating better use of information technology in health care, empowering consumers with transparent information about the price and quality of care provided by certain providers, and improving health coverage options for small employers.

The advantages of the increased use of health information technology include:

- Providing providers access to the most recent evidence-based treatments available
- Avoiding the duplication of expensive and time-consuming medical tests
- Giving patients the ability to play a more active role in their own care by accessing their records
- Providing better security against unauthorized access of patient records
- Enhancing quality through reduced medical errors
- Reducing administrative costs through mandatory electronic claims submission

The state's leadership in the development of a health information technology strategy for Texas will provide a thoughtful, cohesive, and uniform approach to its creation and implementation. The state's role will ensure all involved in the health care system are working toward the common goal of utilizing today's technology to improve access to and the quality of health care within the state.

Health plans recognize the improvements that can be achieved in promoting effective and quality health care through the development of a comprehensive and connected health information network. In fact, nationwide health plans have made substantial investments in upgrading information technology. TAHP supports the state's efforts to facilitate increased used of technology through collaboration among health care providers and payors.



KEY POINTS:

- Greater transparency will reduce the secrecy and monopolistic nature of today's health care pricing and increase the influence of market forces in determining the cost of medical services.
- Elevating the public's awareness of the quality of care delivered will increase the focus of our health care system on the performance of its providers.
- Comparing pricing and quality of care are not unlike the decisions consumers face on a daily basis.
- Health plans will play a significant role in assisting consumers by translating complex data into understandable terms. Simplifying choices, taking complex data and making it understandable, and compiling provider performance information collected by government will increase an individual's ability to make sound decisions involving health care choices.
- Greater transparency will strengthen the patient/provider relationship by allowing for informed discussions between the two regarding treatment options, facilities, and their costs.

USING INFORMATION TECHNOLOGY TO IMPROVE HEALTH CARE.

SOLUTION 8: Legislation providing "Consumer Right to Know" protections including:

- notice to consumers (prior to non-emergency care) of the right to receive a free copy of a common procedure charge list and free written estimate for the treatment they seek
- creation of a state "Consumer Guide to Health Care" website that would contain a charge list for the top 50 inpatient and top 50 outpatient procedures at facilities operating in Texas.
- disclosure to the consumer of applicability of interest charges by the provider for outstanding balances
- creation of state process for the filing of complaints of improper and/or illegal billing practices
- collection and publication of quality data information

SOLUTION 9: TAHP supports additional funding for the Department of State Health Services to enable the collection and public release of information on the pricing and quality of health care in Texas.

SOLUTION 10: TAHP supports additional study of self-referral patterns and ensuring that licensing agencies have appropriate disciplinary authority.

SOLUTION 11: TAHP opposes efforts to reduce transparency by keeping quality information confidential and to limit the ability of health plans to craft networks based on cost and quality.

SOLUTION 12: TAHP supports legislation that will ensure the rapid refund by providers to patients for overpayment of medical services delivered.

PROTECTING PATIENTS FROM BALANCE BILLING.

Each year millions of Texans turn to their health insurance coverage to help them financially navigate through the health care process as they seek appropriate care. Most insured Texans are comforted by the fact that their health insurance protects them and their families from personal and financial devastation should they face a health care crisis. Unfortunately, there is a trend by certain health care provider groups that is forcing many patients to absorb additional, hidden, out-of-pocket costs in excess of what these expenses are intended to be under their health plan.

This phenomenon, known as "balance billing," involves the practice, by certain physicians, of billing patients for fees that exceed the amount covered by a patient's insurance. This usually occurs for the patient following a procedure administered in a hospital that is in the patient's health plan network, but from providers who were involved in the procedure, who are not in their network.

The purpose of the patient's network is to provide a list of physicians whom each member of a plan can receive care from, at a discounted rate. The health plans, which are responsible for developing these networks, have noticed a recent trend by certain hospital-based providers to refuse to contract with a health plan. Their refusal is encouraged because the provider's group enjoys an "exclusive arrangement" with the hospital; this monopoly within the hospital setting all but eliminates any incentive for these specialty physicians to join a health plan's network. Radiologists, anesthesiologists, and pathologists (RAPs), as well as emergency room physicians are most often the providers who engage in balance billing.

Once care has been delivered, the specialist will bill the patient for the difference between the rate the patient's plan would customarily pay to out-of-network providers and the arbitrary rate the provider chooses to charge. It is not unusual for the provider to charge a rate hundreds, if not thousands, of dollars in excess of rates already paid by the health plan. Health plans report that, on average, the typical bill received by a patient from hospital-based providers is 300 percent of the rate paid by Medicare for the same services. In some cases, providers have charged more than 30 times what Medicare pays since there is no limit to what can providers can charge. Often times, the patient is unaware of the additional charges until after care has been delivered. To add insult to injury, state laws advocated by providers require health plans to pay out-of-network providers directly while still allowing them to balance bill. Providers prefer direct payment from health plans because consumers are often reluctant to pay exorbitant rates.

State leaders have an opportunity to ensure that Texas consumers receive the information they need to make informed health care decisions. Most believe doing so is good public policy. At a time when there is national attention on improving our health care system, greater transparency can improve the quality of care delivered, bring to focus those areas that should be strengthened to increase access and affordability for all citizens, and help lower costs.

KEY POINTS:

- Balance billing is the practice of a physician billing a patient for the difference between the usual and customary rate a health plan pays for services delivered and what the physician chooses to arbitrarily charge for the care delivered.
- Through developing an exclusive arrangement to deliver specialty care within an in-network hospital, hospital-based physicians are creating higher costs for patients by abusing their monopoly status.

PROTECTING PATIENTS FROM BALANCE BILLING.

SOLUTION 13: Legislation to prohibit the practice of balance billing by out-of-network hospital-based providers.

SOLUTION 14: Legislation to require the disclosure by participating providers and facilities of instances when they refer patients to out-of-network providers.

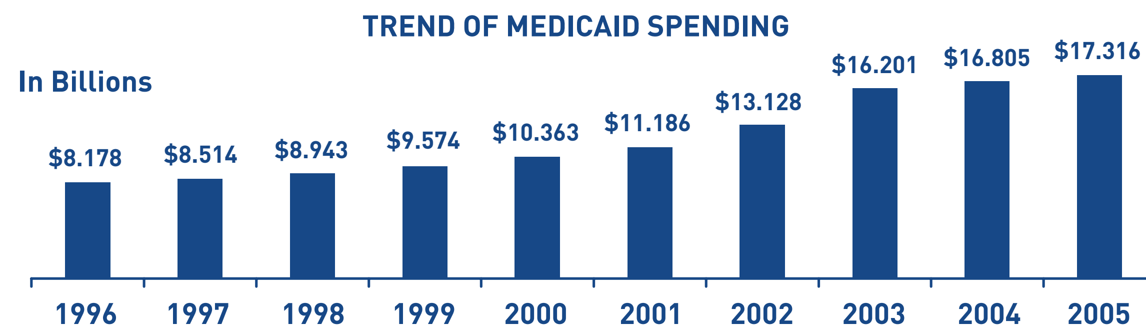
SOLUTION 15: Legislation to establish a formal complaint process on provider billing practices.

MODERNIZING PUBLIC PROGRAMS

MODIFYING GOVERNMENT-BASED COVERAGE TO PROVIDE ACCESS AND CONTROL COSTS

Medicaid continues to be an important and necessary component of the state's health care infrastructure. It plays a critical role in the state's efforts to address the growing uninsured population, individuals with special needs, and rising levels of uncompensated care. Medicaid growth, however, has state leaders concerned about the program's sustainability. Its cost trends have federal and state leaders exploring new strategies to manage its growth while maximizing its effectiveness in providing medical benefits to those it serves. The federal matching dollars available for program funding present Texas leaders a significant opportunity to leverage state resources in their efforts to address the uninsured and uncompensated care issues.

Medicaid costs in Texas have increased from $8.1 billion in 1996 to $17.3 billion in 2005. In fiscal year 2004, state/federal funds for Medicaid comprised 26 percent of the overall state budget while serving as the primary source of health care for almost three million Texans, primarily children.



Sources: Texas Health and Human Services commission, *Texas Medicaid in Perspective*, 5th Edition, (2004), Austin, Texas; and Texas Health and Human Services Commission Staff.

MEDICAID REFORM: THE TIME IS RIGHT

With the passage of the Deficit Reduction Act of 2005 (DRA), the federal government has provided states with additional tools and flexibility to manage the costs of their Medicaid programs. These tools along with the opportunities presented by an expansion of managed care present state leaders with an array of viable and promising options to successfully reform their Medicaid programs without the need to compromise other essential state priorities.

AMONG THE TOOLS NOW ALLOWED BY THE PASSAGE OF THE DRA ARE:

Public/Private Premium Assistance: Allows states to implement premium assistance programs including initiatives known as "three-share" programs. Through these programs, low cost health insurance is offered to small businesses and individuals who have been unable to afford coverage. Premiums for the benefit package are split three ways between the employer, employee, and the government.

Targeted Benefits Package: Allows states to develop different benefit packages for target populations as long as certain mandatory services are covered. States are using this new flexibility to reduce costs associated with benefits by tailoring the services offered to meet the unique needs of those served and to more closely resemble typical employer-sponsored insurance benefits.

Expanded Cost Sharing: Allows states to use various forms of cost sharing like "nominal" co-payments by those served without the need for a federal waiver. The use of cost sharing is intended to promote responsibility, accountability, and perceived value of the program among Medicaid clients. Cost sharing may not be increased beyond the nominal amounts for mandatory populations of children, pregnant women, and disabled and elderly individuals living in institutional settings. Additionally, cost sharing is not permitted for preventive services for certain mandated populations including children and pregnancy-related services.

Defined Contribution: Allows a state to define the amount it will pay per enrollee rather than defining the benefits to be offered. With this approach, a state pays a set or defined premium per enrollee based on their age, unique medical needs, and health care risks. With a defined contribution approach, states rely on health plans to design benefit packages that meet the diverse medical needs of their populations.

Consumerism: Personal Health: Many states are using the flexibility of the DRA to offer programs that allow individuals to choose a health plan that best meets their needs. Additionally, the states are including in their Medicaid programs efforts aimed at increasing the awareness of those served about preventive measures that can be taken while also providing incentives for those who exhibit healthy behaviors and lifestyles. Through these innovations, clients obtain the knowledge to become personally responsible and active in managing their own care, while also helping control the costs of the program.

Long-Term Care Partnerships: Allows the state to form Long-Term Care Partnership programs with the intent of reducing long-term care costs of the Medicaid program by increasing the use of long-term care insurance. Long-term care spending accounts for a disproportionate share of all Medicaid expenditures and represents an area where states have a strong interest in containing costs. By encouraging the purchase of private insurance to help fund long-term care and delaying an individual's use of Medicaid for care, states are able to realize cost savings from long-term care expenses they might have otherwise incurred.

FEDERAL WAIVER KEY TO CONTAINING MEDICAID COST TRENDS.

Central to any Medicaid reform efforts are the issues of reducing the growing level of uncompensated care and protecting the state's safety-net providers. Utilizing strategies outlined above along with the state's pursuit of a Section 1115 Medicaid waiver presents Texas leaders with a promising strategy to gain control of the unsustainable Medicaid spending trend. The pursuit of a Section 1115 waiver can incorporate the use of "low income" or "uncompensated care" pools to preserve federal funding for providers and to slow Medicaid costs through savings realized from the expansion of fully capitated managed care. Additionally, low income pools offer states the flexibility to utilize funds to promote and subsidize private and public coverage for the uninsured, rather than simply paying for the cost of their emergency room care.

Texas is well positioned to reform the state's largest health care program by building on momentum already in place from the efficiencies brought about by the state's use of managed care and its increased use of disease management initiatives, preferred drug lists, and case management. There is great promise that a reformed Medicaid program can be a core strategy to reducing the growing number of uninsured Texans without compromising the state's capability to fund other key programs.

KEY POINTS:

- Managed care is the most effective coordination model to control the costs of the state's Medicaid program and should be implemented where feasible.
- A Section 1115 Medicaid waiver can be used to preserve federal funding for safety-net providers while slowing the growth of Medicaid expenditures from savings realized through the expansion of fully capitated managed care.
- The Deficit Reduction Act of 2005 provides states with new tools and flexibility to reform their Medicaid programs.
- Increasing personal responsibility, promoting prevention, rewarding healthy lifestyles, and facilitating the management of chronic conditions will improve health outcomes of Medicaid clients and help control program costs.

FEDERAL WAIVER KEY TO CONTAINING FEDERAL COST TRENDS.

SOLUTION 16: Legislation supporting the pursuit of a Section 1115 federal Medicaid waiver to protect safety-net hospitals while allowing the state to expand the use of cost savings programs such as capitated managed care.

SOLUTION 17: Legislation that supports the integration of acute and long-term care services in the management of the Medicaid program.

SOLUTION 18: Legislation that incorporates the use of programs that increase personal responsibility, promote prevention, and reward healthy lifestyles among the Medicaid beneficiaries.

SOLUTION 19: Legislation to reduce the state's Medicaid costs through the use of Long-Term Care Partnerships.

CAPITATED MANAGED CARE: THE MOST EFFECTIVE MODEL FOR CONTROLLING MEDICAID.

In 1998, state health care leaders designed and began piloting STAR+PLUS, a Medicaid managed care program in Harris County to provide services to the aged, blind, and disabled population. They did so with the recognition that this segment of the population accounted for more than half of the state's Medicaid expenditures (59 percent), but who comprise only one-fifth of the Medicaid population (21 percent). With STAR+PLUS, Texas led the ranks of a number of states exploring the use of capitated managed care as a means of containing Medicaid expenditures. Through capitated managed care, health plans are paid a pre-determined "per member" or "capitated" amount to provide health coverage for Medicaid recipients. In capitated managed care the health plan, rather than the state, assumes the financial risk for providing health care for the population served. Through this arrangement, the state is provided budget certainty for its Medicaid expenditures and those served receive benefits that exceed traditional Medicaid including unlimited, medically necessary prescriptions and eligibility for unlimited hospital inpatient days.

Because of its unique care coordination, the STAR+PLUS pilot produced significant Medicaid savings for the state, increased access to community care, increased the use of adult day care services, and reduced emergency room visits among the population it served. In addition to the budget savings it produced, STAR+PLUS was known for delivering quality care with high satisfaction rates among its members.

STAR + PLUS - CAPITATED MANGED CARE SATISFACTION SURVEY.

	RATING	SCALE
PROVIDER	8.5	0-10
SPECIALIST	8.4	0-10
OVERALL HEALTHCARE	8.1	0-10
OVERALL HEALTH PLAN	7	0-10
ABILITY OF HEALTH PLAN TO MEET NEEDS	7.5	0-10
GETTING CARE WHEN NEEDED	2.5	1-3
GETTING CARE QUICKLY	3.4	1-4
COMMUNICATIONS WITH PROVIDER	3.4	1-4
OVERALL SATISFACTION	8.4	1-10
SATISFACTION WITH CARE COORDINATION	87%	0-100
SATISFACTION IN OBTAINING ASSISTANCE FROM CARE COORDINATOR	97%	0-100

The success of the program led state health care leaders to recommend that the program be expanded to other urban service areas across Texas. In 2005, the Legislative Budget Board determined that such an expansion would save the state $109.5 million in Medicaid expenditures over the '06-'07 biennium. However, prior to its expansion, state leaders learned that the capitated manner of care the program provided could cost the state's safety-net hospitals federal funding known as Upper Payment Limit (UPL). As a result, plans to expand Medicaid managed care in Texas were delayed.

A scaled-down version of STAR+PLUS is scheduled to be expanded to most urban areas throughout the state in 2007. However, changes to the original program aimed at preserving UPL funding will prevent the retooled STAR+PLUS from generating the maximum savings possible. These lost savings reinforce the case for the state's pursuit of a Section 1115 Federal Medicaid waiver to allow fully capitated managed care without jeopardizing federal funding for safety-net providers.

KEY POINTS:

- STAR+PLUS has successfully contained costs and provided quality health care to the aged, blind, and disabled population - whose health care accounts for more than half of Medicaid expenditures (59 percent), but who account for only one-fifth of the Medicaid population (21 percent).
- There is increasing interest in pursuing a solution, such as an 1115 Medicaid waiver, that will allow Texas to continue to realize the significant budget savings and quality care offered by capitated managed care.

CAPITATED MANAGED CARE: THE MOST EFFECTIVE MODEL FOR CONTROLLING MEDICAID.

SOLUTION 20: Legislation supporting the use of fully capitated managed care where feasible in administering the state's Medicaid program.

CHILDREN'S HEALTH INSURANCE: PROTECTION FOR KIDS, A WISE INVESTMENT FOR THE STATE.

In May 2002, the Texas Children's Health Insurance Program reached its peak enrollment of 529,211. Since that time, cuts in funding to the program combined with changes to the enrollment and renewal processes have resulted in a dramatic reduction in children receiving medical services. While changes to the program were aimed at increasing its accountability and efficiency, the loss in federal funds as well as the resulting increase in uncompensated care have a negative impact not only on the poorest of children and their families but also on local government budgets, which absorb uncompensated care costs.

As children become uninsured, they are less likely to receive the primary or preventive care they need. As they become ill, their conditions can go untreated often resulting in the development of chronic conditions or their families are likely to seek more expensive care through local emergency rooms. In either instance, the social and financial costs are significant.

Through its participation in the CHIP program, Texas receives $2.63 in federal matching funds for every $1 of state funds invested. Federal dollars not used by Texas are ultimately forfeited to other states for use in providing coverage to children in need. Texas remains near the top of states that forfeit federal CHIP funding losing more than $600 million in federal funding to other states between 2000 and 2002. In fiscal year 2005, CHIP funding, for Texas totaled $401.6 million of which $110 million were state dollars. With Texas already leading the nation in uninsured children (22.5%), it is not difficult to see the toll reduced CHIP enrollment has on Texas children, federal funding for the state, and local taxpayers.

The state's Medicaid program is also a critical component of the state's strategy to insure children. While the federal Medicaid match of $1.60 for every $1 of state funds expended is below that of CHIP, the program is the primary source of health care for over 1.7 million Texas children.

Efforts to integrate enrollment for CHIP and Medicaid does provide potential to improve accountability and efficiencies within the programs. However, state leaders would be wise to weigh the benefits of continuous eligibility as well as administrative simplification for enrollment and renewal options. Both options promote efficient use of government resources while also ensuring program integrity.

An administrative renewal option offers lawmakers an opportunity to ensure program integrity while also ensuring that taxpayer dollars are utilized for medical care rather than being used for unnecessary administrative costs. Under an administrative renewal option, the state would determine a child's eligibility for Medicaid at the initial application, as it does today. However, under the administrative renewal option, the state would utilize technology and third-party data brokers to verify eligibility at renewal.

If third-party information indicates that the family's eligibility has changed, then the state would initiate the eligibility process. If the data indicate that the family is still eligible, then coverage would be renewed. Families would still be required to go through the full eligibility determination process once each year. This option preserves the state's ability to maintain program integrity while enabling program funding to be maximized for the delivery of care. By utilizing the CHIP and Medicaid programs as key strategies for insuring Texas children, state leaders will be making wise use of state dollars and providing much relief to local governments, businesses, and Texas families.

Among the strategies recommended for increasing the effectiveness of the programs are:

- Implementing 12 month eligibility for CHIP
- Providing for an administrative renewal option for children in Medicaid.
- Simplified eligibility process for families through increased use of technology to ensure eligibility for services
- Providing for enrollment by telephone
- Revising the asset verification process to avoid inappropriate barriers to enrollment
- Support for HHSC's continued efforts to improve program performance.

KEY POINTS:

- Texas receives $2.63 in federal matching funds for every $1.00 of state funds invested in CHIP. Federal funds not utilized by Texas are redistributed to other states
- Lost federal funding, increased uncompensated care, and social costs associated with childhood illness combine to place a growing burden on families, taxpayers, and local governments.
- Increasing use of technology to simplify enrollment and re-enrollment will save the state money and enhance integrated eligibility efforts.

CHILDREN'S HEALTH INSURANCE: PROTECTION FOR KIDS A WISE INVESTMENT FOR THE STATE.

SOLUTION 21: Legislation to simplify the enrollment and reenrollment processes for Texas families and children who qualify for the CHIP and Medicaid programs.

SOLUTION 22: Legislation to provide for 12 months of coverage in CHIP and an administrative renewal option for Medicaid.

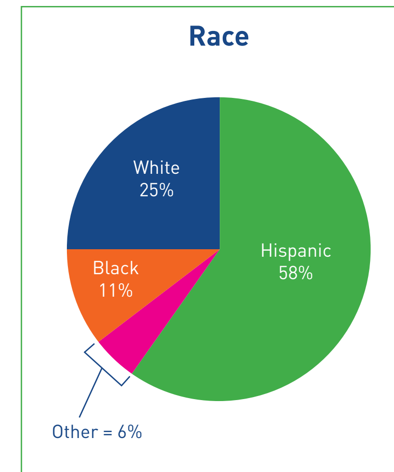
SOLUTION 23: Legislation to establish "Insure Texas Kids" specialty license plates with funding used for outreach for public and private coverage options for children.

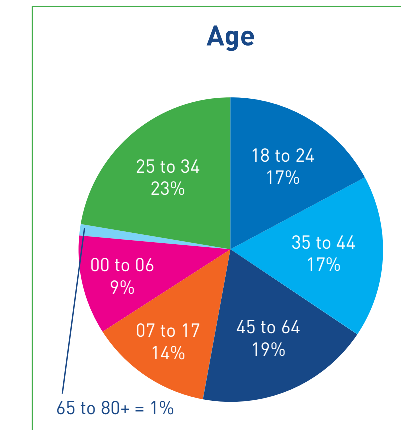
TEXAS HEALTH SOURCE
PUBLICATIONS

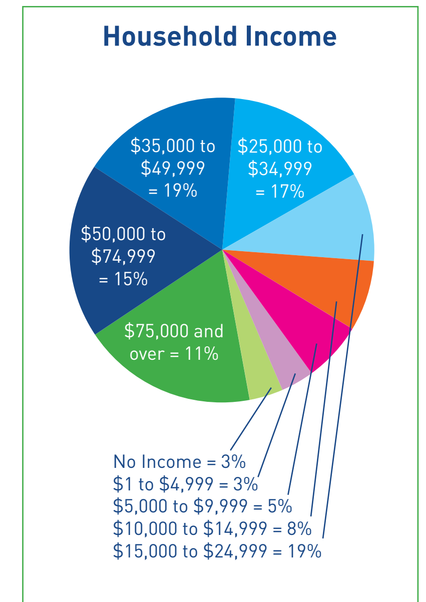
(available at www.tahp.org)

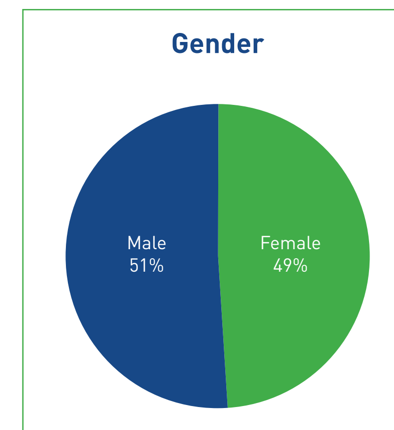
January	Health Plans: Working to Make Quality Healthcare Affordable
February	Prevention: Good Business for Texas
March	The Uninsured in Texas-A Relationship Worth Ending
April	Inside Health Plans: How Managed Care Works
May	Balance Billing: Has It Happened to You?
June	Texas Risk Pool-Is It at Risk?
July	Controlling the Costs of Medicaid: Managed Care at Work
August	Health Plans: Maximizing Care, Minimizing Costs
September	The Case for Medicaid Reform
October	Government Mandated Doctor Contracts: Bad Medicine for Texas
November	Transparency in Healthcare: Lower Costs, Higher Quality
December	2007 Legislative Guide

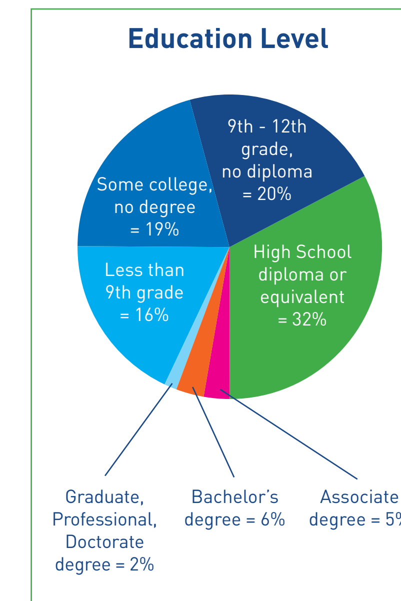
UNINSURED TEXANS
2003 TO 2005 / 3 YEAR AVERAGE

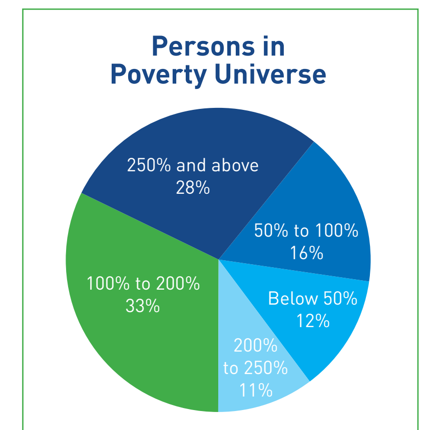


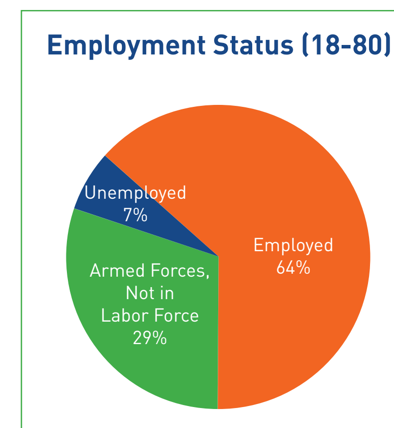












Source: U.S. Census Bureau, Current Population Survey (CPS)

PEOPLE WITH PRIVATE HEALTH INSURANCE COVERAGE

- People Covered by Private Insurance............13,354,000

66% Self-Insured

34% Fully-Insured

PECENT OF EMPLOYERS OFFERING HEALTH INSURANCE

93% Large Employers

28% Small Employers

AVERAGE ANNUAL HEALTH INSURANCE PREMIUMS

- Individual Market Single $2,836
- Individual Market Family............................... $4,940
- Small Group Market Single.............................$4,056
- Small Group Market Family.......................... $10,632
- Total State Premium Taxes Collected from Insurance Companies [1]................$1,167,899,000

JOBS IN HEALTH INSURANCE INDUSTRY[2]

23,677 Direct Jobs

61,066 Other Insurance-Related Jobs

84,743 Total Jobs

- Payroll Direct Jobs.............................$1,192,756,000
- Payroll Other Insurance-Related Jobs....$2,717,033,000
- Average Wage Direct Jobs............................ $50,376
- Average Wage Other Insurance-Related Jobs.....$44,493

STATE HEALTH FACTS

25% UNINSURED

Average Annual Medicaid Payment Per Enrollee............ $3,371

STATE RANKINGS

51st in uninsured rate[3]

39th in Medicaid payment per enrollee

49th in % of residents covered by private insurance

37th in % of employers offering health insurance

[1] Data from the U.S. Census Bureau; includes state premium tax collected from all types of insurance companies, including health insurance.

[2] Data from the U.S. Census Bureau, NAICS reports. Direct jobs include those specifically found in the health insurance industry; other insurance-related jobs consist of those found in all insurance industries, including the health insurance industry *(see page 57 for a full description of job categories)*.

[3] A ranking of #1 indicates the lowest percentage of uninsured.

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