

Texas Health Source – Special Edition **LEGISLATIVE GUIDE**



**Working for Quality and Affordable
Health Care for Texans**

2009

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 bring unique insight and experience to 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 2009 Legislative Guide.

On behalf of its members, and the millions of Texans who benefit from health care coverage, TAHP is committed to enhancing our state's health care system by expanding access, maintaining 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

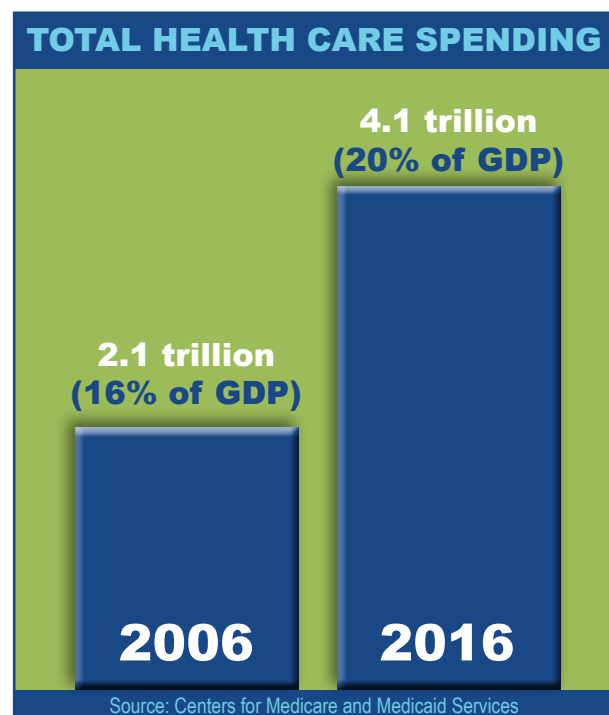
BUILDING THE HEALTH CARE SYSTEM OF THE FUTURE: WHAT TEXAS CAN DO?

With the unprecedented focus on how to reform the country's health care system, a quick review of several statistics underscores the seriousness of the challenge:

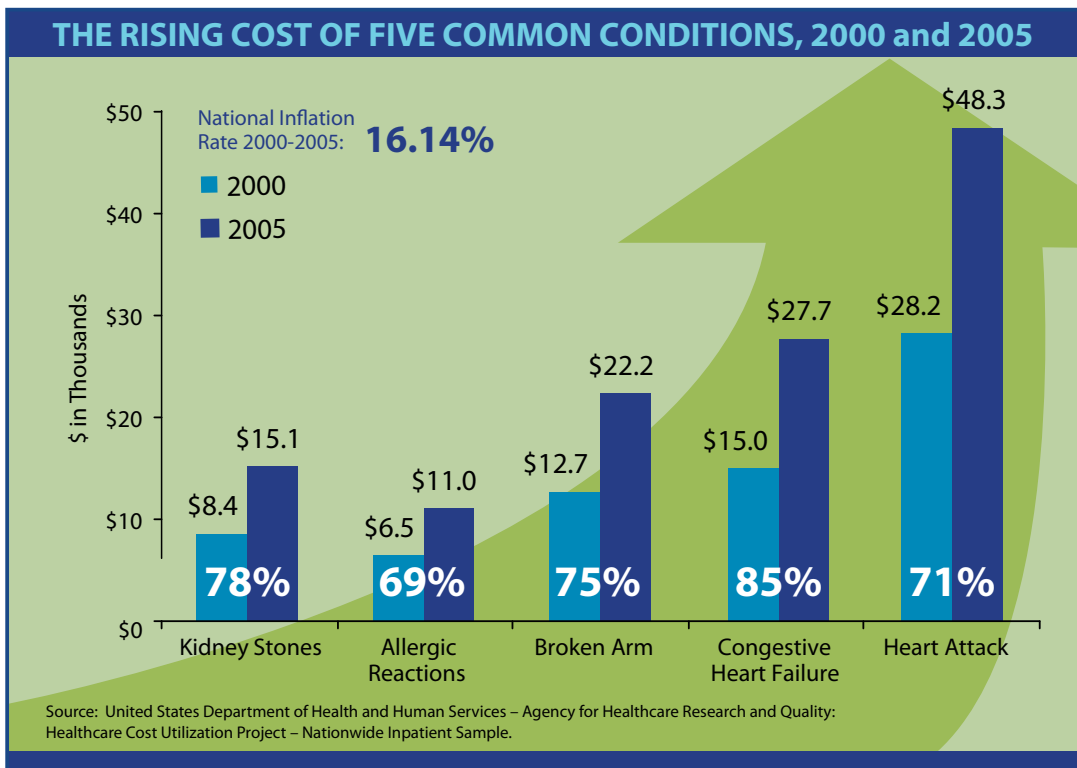
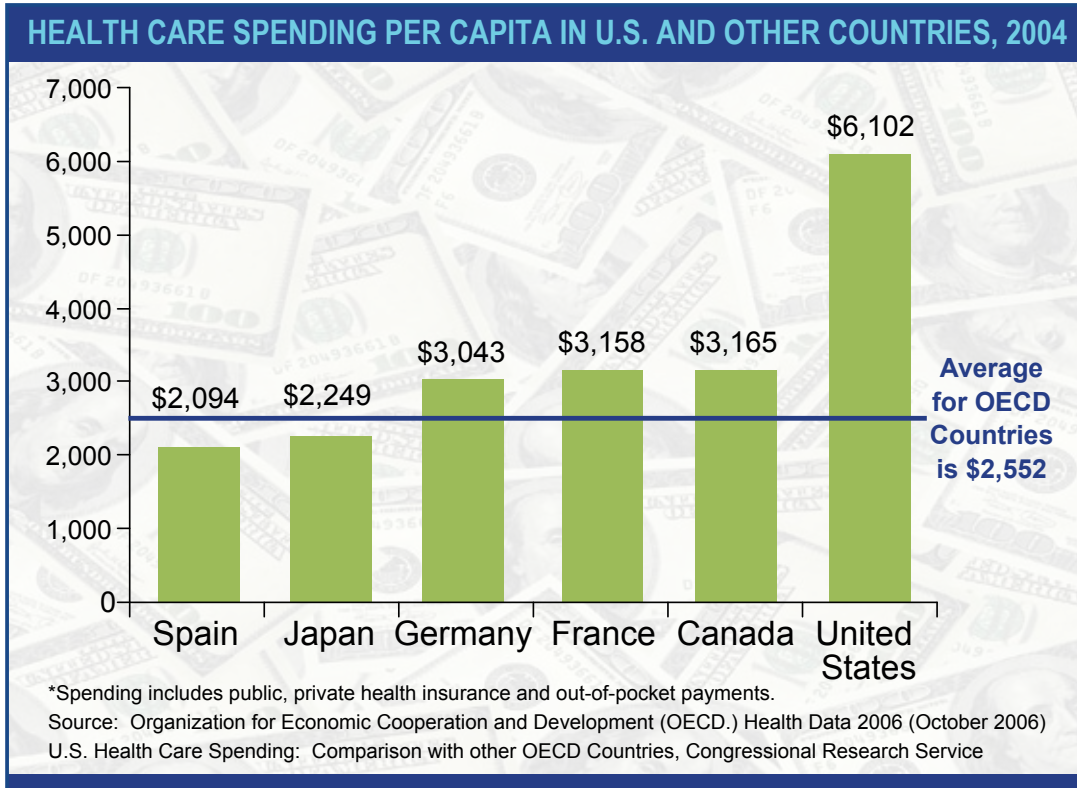
- Total health care spending in the United States for 2006 totaled \$2.1 trillion and is projected to reach \$4.1 trillion, or 20 percent of the GDP, by 2016.¹
- Researchers have projected that up to one-third of all health care spending is estimated to be spent on medical errors, duplicative procedures, unnecessary treatments and prescriptions.²
- For the sixth consecutive year the number of Americans lacking health coverage increased, with 47 million individuals uninsured in 2006. Texas leads the nation, with approximately one-quarter of its population uninsured.³
- Chronic diseases, many related to lifestyle choices, are believed to be the cause of 70 percent of all deaths in America and 75 percent of total health care spending.⁴
- Despite spending almost twice as much on health care as most industrialized countries, leading indicators on quality suggest that the U.S. system may be significantly underperforming. One widely cited study by RAND indicated Americans are receiving recommended care only 50 percent of the time.⁵

Clearly, a cultural change affecting lifestyle choices would have considerable impact on the quality of life and medical costs incurred by Americans. And, while policies and attitudes that favor such a shift are gaining momentum, results will not come overnight. In the meantime, policy-makers and stakeholders must face the glaring reality that soaring medical costs are undermining the nation's health care system.

The rapid rise in medical costs are driving up health insurance premiums, leading many employers to drop their health benefits and causing even more Americans to forego coverage and postpone needed health care.



Local governments are all too familiar with the cost of providing uncompensated care for those who lack insurance. Increasing medical costs places additional strain on public health programs such as Medicaid and CHIP that offer the only hope for health care for thousands. And because of cost, many uninsured who can afford care delay seeking medical attention until a simple matter becomes more complicated, often resulting in costly and debilitating chronic illnesses.



With increasing medical costs reducing access and the affordability of health insurance, the urgency of finding solutions has never been greater. While much of the debate on major health care reform will likely occur at the federal level, there is much that can be done at the state level to create opportunities for access to affordable care, protect and empower consumers and increase the efficiency of state regulatory efforts.

Measures such as ending the practice of balance billing, increasing the transparency of health care cost and quality information, facilitating the expansion of retail clinics, fostering the use of evidence-based medicine and encouraging the use of electronic medical records can be critical components in a state formula to increase access, reduce costs and enhance the delivery of quality health care.

Empowering small employers and low-income individuals to obtain coverage, enhancing the viability of the Texas Health Insurance Risk Pool and effectively utilizing the Medicaid and CHIP programs can also be important elements of a state strategy to increase access and improve public health.

Likewise, modernizing the Texas Department of Insurance's oversight functions, eliminating conflict of interest referrals by physicians to facilities they own, providing the state the authority to review questionable billing practices of providers and providing consistency between federal and state guidelines can streamline regulations and protect consumers.

Reducing unnecessary costs by avoiding overregulation in the insurance market is equally important to maintaining affordable health coverage options for Texans.

In the coming days, state leaders will consider and likely adopt a range of measures that will cumulatively determine the kind of health care system we have in Texas. This guide is intended to provide essential information on key issues central to the 2009 sunset review of the Texas Department of Insurance as well as the broader discussion about the future of our state's health care system.

We hope you find the following pages useful.

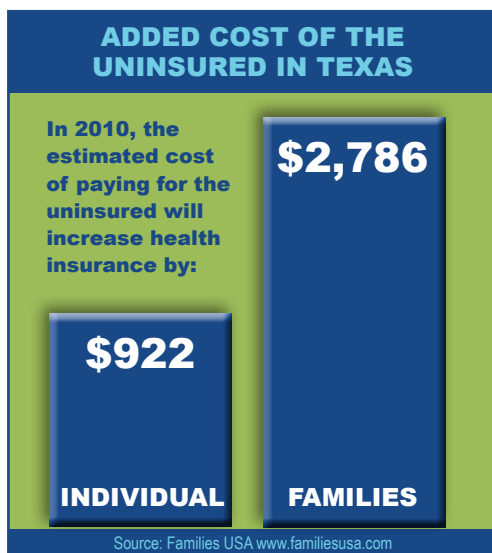


REDUCING THE UNINSURED PROVIDES RELIEF TO ALL TEXANS

Texas continues to rank as the state with the highest number of uninsured citizens. During 2006-2007, 24.9 percent of Texans were without health insurance meaning 5.8 million individuals within the state relied on their own resources, or on taxpayers and the insured, to fund their health care.

While the uninsured challenge is not unique to Texas, it remains a serious economic and social crisis that stifles the potential of individuals, families, and governments within our state. The increasing number of uninsured fuels a costly cycle that includes reduced access to needed health care, increased demands on local taxpayers to pay for uncompensated care, higher insurance premiums through cost shifting for insured consumers and backlogged emergency rooms caused by the growing number of uninsured seeking care.

It is estimated that the cost of paying for the uninsured will increase health insurance premiums in Texas by \$2,786 for families and \$922 for individuals in 2010.



Clearly, the human and financial toll of the uninsured is mounting. Steps to utilize public programs such as Medicaid and CHIP are key components of an overall strategy to reduce the number of uninsured Texans. Both programs should be managed as cost effectively as possible to ensure they remain sustainable strategies to increase access to health coverage. They are also pieces of a larger plan that must be developed to reverse the growing trend of uninsured Texans.

Lowering medical costs, improving quality and promoting wellness are all strategies that must be explored to lower premiums and increase the affordability of health coverage. Without such strategies individuals, families and small employers will continue to forego the cost of health coverage creating burdens for themselves and increasing the cost of care for all.

Past legislative actions demonstrate the understanding and commitment of state leaders to consider a comprehensive approach to reducing the number of uninsured Texans. This session provides the opportunity to solidify a "Texas specific" approach that utilizes multiple strategies to increase access to health coverage for those without it and provide relief to taxpayers and the insured.

WORKING FOR QUALITY AND AFFORDABLE HEALTH CARE FOR TEXANS.

RECOMMENDATIONS:

Effectively using public programs to provide access to care

Ensuring Medicaid Remains a Sustainable Health Care Strategy for Texas

- Expand the use of Medicaid managed care to control program costs, provide the state budget certainty and offer increased benefit options for program members.
- Ensure funding is adequate to guarantee access.

Children’s Health Insurance Program (CHIP): Stay the Course for Healthy Children, a Stronger State

- Provide continued support and funding for the program to increase access to care for Texas children.

Increasing access, reducing cost and improving quality

Balance Billing: A Practice Texas Should Ban

- Prohibit balance billing.
- Amend state law to provide that a physician who accepts payment from a health plan on behalf of an insured cannot balance bill.
- Provide the Texas Medical Board with specific oversight of physician billing practices.
- Amend the state’s outdated law preventing hospitals from hiring physicians directly.

Increasing Transparency in Health Care

- Increase coordination among state agencies of the collection and release of health care cost and quality data.
- Ensure that health plan efforts to promote quality are preserved.
- Study practice variation patterns in Texas.
- Require physicians to report ownership interests in health care facilities.
- Require written disclosure by physicians when referring patients to facilities in which they have an ownership interest.

Ensuring Sustainability and Equity for Risk Pool Funding

- Adopt a limited premium tax credit for Risk Pool assessments paid for nonmandated members of the Risk Pool—those who are eligible for coverage as a result of state policy, not federal mandate.
- Amend the state’s prompt pay laws to subsidize premiums for low income pool enrollees and stabilize Risk Pool assessments.

Improving Health Care and Saving Lives with Electronic Medical Records

- Adopt incentives to encourage increased use of electronic medical records by all stakeholders within the health care system.
- Explore tax incentives for providers adopting EMRs.
- Explore tax incentives for health plans funding or equipping physician offices with EMRs.

Streamlining regulation and protecting consumers

Providing State Oversight of Physician and Hospital Billing Practices

- Provide TDI the authority to protect consumers by accepting and tracking complaints related to physician and hospital billing practices; direct TDI to post complaint information on the agency’s Web site; and provide TDI the authority to obtain data from hospitals and physicians through the use of data calls.
- Grant TMB and DSHS specific oversight related to billing practices of physicians and hospitals.
- Provide TMB and DSHS with authority to collect data from physicians and hospitals.
- Require hospitals and physicians to report consumer complaints, including the number of complaints, the nature of the complaints and the resolution.

Reducing unnecessary costs by avoiding overregulation

Rate Regulation Will Not Lower Medical Costs

- Oppose efforts to establish rate regulation for health insurance. Focus on lowering medical costs that drive up the cost of health coverage.

Government-Mandated Doctor Contracts: The Wrong Prescription for Texas

- Oppose standardized medical contracts. They will increase the cost of care.

A Mandated Medical Loss Ratio Misses the Target

- Oppose medical loss ratio mandates. Focus on what’s driving up the cost of health coverage—rising medical costs.

The Unintended Consequences of Community Rating: A Pitfall Texas Can Avoid

- Oppose a community rating mandate for Texas. Similar proposals in other states have increased the cost of coverage and led many to drop their coverage altogether.

EFFECTIVELY USING PUBLIC PROGRAMS TO PROVIDE ACCESS TO CARE

ENSURING MEDICAID REMAINS A SUSTAINABLE HEALTH CARE STRATEGY FOR TEXAS

Medicaid remains a critical component of the state's health care infrastructure. It plays an important role in the state's efforts to address the growing uninsured population, reduce uncompensated care and provide services to Texans with special needs. With the program currently receiving 18 percent of the state's general revenue, the sustainability of future growth may depend on the state's ability to maximize efficiencies within the program. Medicaid managed care has a record of providing the kind of efficiencies and accountability that will be required to justify future spending. A review of that history highlights why managed care endures as the state's best strategy to manage program costs.

In the 1990s Texas joined the ranks of other states exploring the use of health plans in managing their Medicaid program. The goal was to move away from the open-ended costs of a fee-for-service payment model and into a more comprehensive, coordinated and efficient approach for the delivery of care. To test the concept of Medicaid managed care, state leaders created STAR+PLUS, a pilot program in Harris County to serve the aged, blind and disabled. Since its inception, the program has evolved into a model Medicaid managed care program that now serves over 158,000 aged, blind and disabled individuals in four major urban areas in the state. Today, residents in these four regions have access to Medicaid health plan's patient-focused coordinated care, receiving an increased level of specialized services not available in the state's traditional Medicaid program.

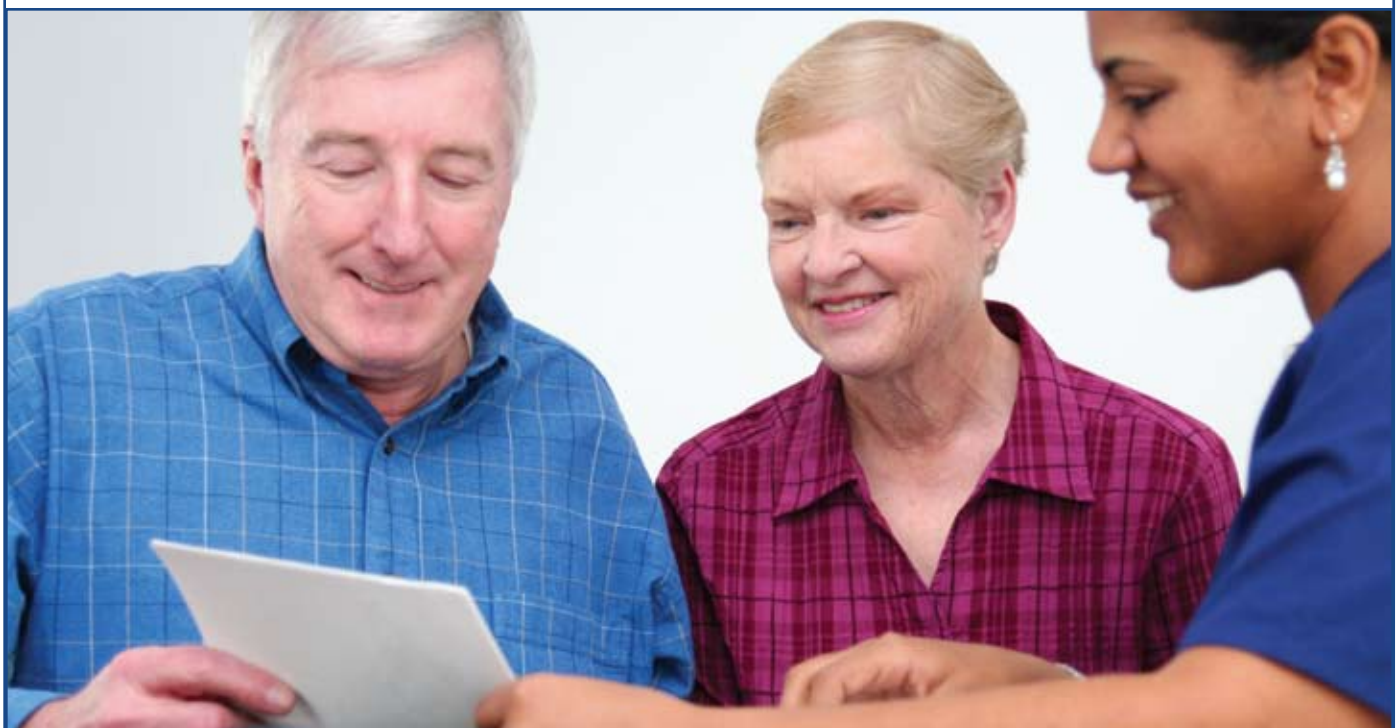


High satisfaction rates among enrollees, expanded care options, and reduced costs were highlights of the pilot's early years. According to an early study of the program conducted by the External Quality Review Organization for the Texas Medicaid program:

- Overall annual health care expenditures were 279 percent higher for a control group of non-STAR+PLUS members than STAR+PLUS members.
- Inpatient rates were 28 percent lower for STAR+PLUS beneficiaries than for a matched control group of non-STAR+PLUS members.
- Emergency room visits were 40 percent lower for STAR+PLUS beneficiaries than for a matched control group of non-STAR+PLUS members.⁶

As reflected in the table below, surveys commissioned by the state from 1999-2004 demonstrate the high satisfaction among STAR+PLUS patients.⁷

Satisfaction Factor	Rating	Scale
Provider	8.5	0-10
Specialist	8.4	0-10
Overall Health Care	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



As the state attempts to balance the priorities of managing program costs while expanding access to care, the use of managed care becomes an attractive tool in meeting both needs. The program works because it contains properly aligned incentives that provide:

- access to comprehensive care for recipients
- protection for taxpayers
- health plan accountability

The program's value-based contracting ensures that the HMOs are held accountable in delivering services needed by the program recipients. Through the program's experience rebate, HMOs' profits are capped and cost savings exceeding the cap are shared with the state. HMOs are required to have fraud detection units to help protect taxpayer dollars. Recipients have a medical home, reducing high medical costs associated with the use of emergency rooms for routine care. By encouraging innovation in the provision of health care, the program's performance is enhanced. And, emphasizing prevention improves the well-being of recipients and helps reduce future health care costs of the population served.

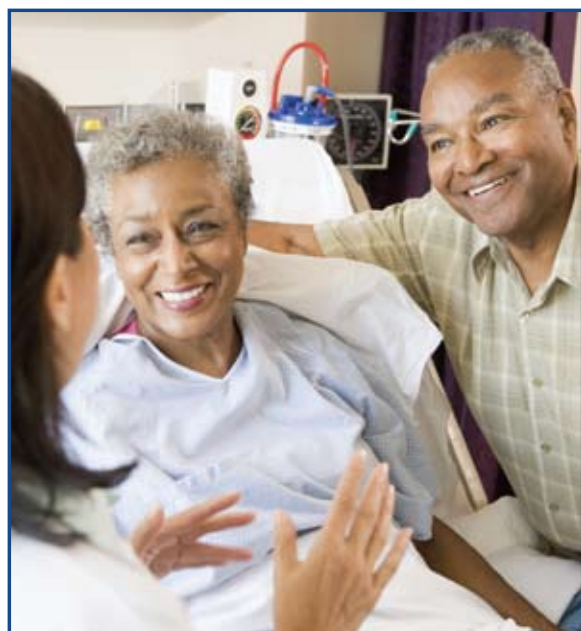
Under a Medicaid managed care model the health plan assumes the financial risk of providing health care for the population served, unlike a fee-for-service structure where the state assumes responsibility for payment of services rendered. Through a capitated payment structure, the state pays a fixed, contracted rate per member to a health plan for the purpose of providing comprehensive medical benefits to qualified individuals. With that payment, the health plan agrees to provide all necessary services covered by the program that a recipient might need. As a result, the state's financial exposure is limited because health plans receive a capitated payment to provide necessary, comprehensive medical benefits.

From the state's perspective there are at least three very important advantages with the HMO capitated model:

One: It provides the state budget certainty.

Two: With capitation, the state transfers full financial risk for the delivery of care to the HMO and the HMO is held accountable.

Three: It is an effective delivery model providing a spectrum of medical services and benefits that exceed those offered in the traditional Medicaid program.



Currently, 10 of the state's 12 most populous counties have some model of managed care serving their Medicaid population. However, many throughout Texas do not. In south Texas alone some 280,000 Medicaid recipients are not afforded the same level of care offered to their counterparts in the state's four major urban centers through Medicaid managed care.

As state leaders consider how to appropriate limited state funds to manage the Medicaid program while also increasing access to care for more Texans, efficiencies realized through the expansion of Medicaid managed care should be considered. The properly aligned incentives of the program make it a prudent choice that provides:

- increased care options for program members
- better management of high-cost services
- increased accountability within the program
- managed care efficiencies

Whether opportunities for Medicaid managed care expansion are pursued within south Texas or other parts of the state, health plans are prepared to continue their work to ensure that quality care, accountability and cost-effectiveness are compelling outcomes of the state's Medicaid program.

ACTION NEEDED:

- Expand the use of Medicaid managed care to control program costs, provide the state budget certainty and offer increased benefit options for program members.
- Ensure funding is adequate to guarantee access.



CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP): STAY THE COURSE FOR HEALTHY CHILDREN, A STRONGER STATE

In Texas, one in five children is uninsured, more than in any other state in the country.⁸ The human and financial cost of failing to address the ongoing problem of uninsured children is enormous. The ramifications reach far beyond individual families, now also grappling with the nation's economic crisis. The ripple is felt across the state by businesses, taxpayers and governments in subsequent costs associated with emergency medical treatment, higher health care costs, education interruption and lost productivity of our future workforce.

The Texas Children's Health Insurance Program plays a critical role in ensuring the health of Texas children, covering families mired in the gap between Medicaid eligibility and the ability to afford private insurance. Yet, cuts in CHIP funding and changes to the enrollment and renewal processes resulted in a dramatic reduction of children receiving medical services. Changes enacted during 2007 helped restore needed health care for thousands of children. But more kids need help.

Of the 1.4 million uninsured children in the state, more than half are eligible for CHIP or the children's Medicaid program, but not enrolled.⁹ That results in ill-afforded losses of federal matching funds that send Texas tax dollars to other states to pay for the health care of their children.

CHIP makes good sense for the state, stretching limited tax dollars by bringing in matching federal funds. Through CHIP, Texas receives \$2.63 in federal matching funds for every \$1 invested. Yet, since 1998, Texas has forfeited to other states approximately \$900 million in federal CHIP funding that could have been used to provide health care to kids of low-income families.¹⁰



For every \$1 spent on children’s health care through CHIP, the state pays only 28 cents. There is no other single strategy currently available that is a better deal in reducing the costly cycle created by a lack of insurance. CHIP allows Texas to insure a child for only \$39 a month.

Keeping lower-income workers and their children healthy is important, for them and the entire state. When a family has no insurance, sometimes care is often postponed until it becomes a true crisis. Or families seek care for minor ailments in the hospital emergency room, a costly and inappropriate solution. By providing these families with more accessible, appropriate health care services—and a medical home—the strain on public resources can be reduced while their medical needs are met.

Productive citizens drive the economic engine of our state. The future of Texas will depend on a stable base of educated and healthy employees. The role of appropriate health care and success in school has been well-documented. Students who are struggling with illness or injury do not learn as well. According to the Centers for Disease Control, “the academic success of America’s youth is strongly linked to their health.”¹¹ CDC further states that “academic success is an excellent indicator for the overall well-being of youth and a primary predictor and determinant of adult health outcomes.”

Actions by state leaders in 2007 to remove the waiting period for services for most recipients, increase the amount of assets a family can claim while remaining eligible, reinstate income disregards for child care and provide a 12-month term of coverage for qualifying families has created opportunities for health care and hope for a brighter future for tens of thousands of children. State leaders deserve credit for their leadership.

CHIP provides the foundation for a healthy future for our children—and the state of Texas. Texas should continue its commitment to providing our children with the greatest possible chance for healthy and productive lives.

ACTION NEEDED:

- Provide continued support and funding for the program to increase access to care for Texas children.



INCREASING ACCESS, REDUCING COST AND IMPROVING QUALITY

BALANCE BILLING: A PRACTICE TEXAS SHOULD BAN

Each year thousands of Texans are balance billed by physicians and hospitals for medical bills they had no idea they owed. This occurs when providers bill patients for amounts in excess of what an individual's health plan pays. Texas should move to protect Texas patients by banning this deceptive practice.

Patients with health insurance who need medical services typically select in-network physicians and hospitals for their care. They are able to determine beforehand whether they will be responsible for a co-pay or deductible, and what that amount will be. Or, at least they think they know.

However, many hospitals or hospital systems have exclusive contractual arrangements with certain physician or specialist groups that are not in-network providers. These specialist groups typically are emergency room physicians, anesthesiologists, radiologists or pathologists. They choose not to be in-network, thereby gaining the ability to charge higher fees than a health plan pays and billing the patient for the difference.

BAN ON CORPORATE PRACTICE OF MEDICINE

Texas is one of a few states that still **prohibits the hiring of physicians by a corporation.**

This outdated law prevents hospitals from hiring physicians as part of their staff and contributes to higher out-of-network charges and balance billing.

When a patient is balance billed, often weeks after the procedure, fees may range from \$200 to \$10,000 or more. These are fees the patient never anticipated and never agreed to pay. To make matters worse, these specialist groups are often very aggressive about seeking payment, and willing to turn accounts over to collection agencies or damage the patient's credit rating if payment is not received in full.

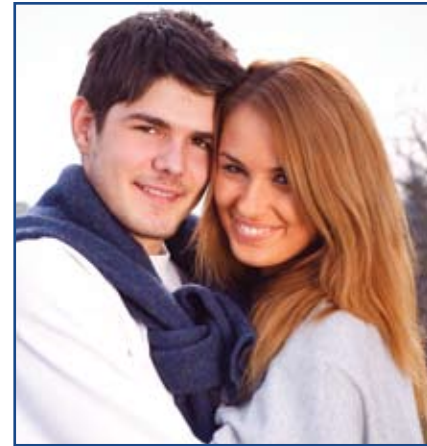
Is there anywhere in the nation's market economy where pricing for a product or service is not made clear and then the purchaser is held accountable for costs for which they did not believe they were responsible?

The vast majority of Texas doctors are under contract with major health plans in Texas. They agree to become a part of a health plan’s network by accepting discounted fees for their services in return for access to the health plan’s members. This structure not only provides a critical link between patients and physicians, but also helps moderate health care costs.

However, the hospital environment is quite different from a physician’s office, regardless of whether the physician provides primary or specialty care. Groups of specialists who secure exclusive contracts with hospitals have no incentive to participate in a negotiated rate with a health plan because patients require their services whether they participate in a plan or not. The monopoly-like status of hospital-based physicians is apparent when one compares the rates charged by hospital-based physicians versus the rates charged by their peers.

COMPARISON RATES	
Type of Physician	Range of Charges as % of Medicare (from examples)
Primary Care Physician	132-162%
Specialist	151-183%
Radiologist	415-1637%
Anesthesiologist	335-598%
Pathologist	549-2319%
Emergency Room Physician	322-524%

Source: TAHP Member Health Plans



Exclusive rights contracts allow these providers unrestricted leeway in the pricing of their services and there are other advantages that enhance their ability to exploit their monopoly-like status. Their services are essential, state law requires health plans to pay them, yet they are free to balance bill unknowing patients, and, by operating out of network, they avoid utilization reviews and other quality measures that health plans use.

The Prevalence of Balance Billing

The prevalence of balance billing in Texas is unknown. Only Texas doctors know how often they balance bill their patients. The Texas Department of Insurance has attempted to collect information on the occurrence of balance billing, but lacks the authority to obtain it. However, the California Association of Health Plans commissioned a 2007 study that showed that “more than 1.76 million insured Californians who visited Emergency Rooms in the last two years received balance bills on top of their co-pays and deductibles.” The study reported that the average bill was \$300, which they calculated meant \$528 million in unexpected charges to insured Californians visiting emergency rooms over a two-year period.¹²

The state of California recently banned balance billing for emergency room services and declared billing in such cases to be an unfair billing practice. The state's leading physician and hospital associations challenged the law in court but the state's Supreme Court upheld the regulation banning balance billing.



1.76 million Californians who had visited the ER in the last two years were **balance billed on top of their co-pays and deductibles.**

A 2007 study commissioned by the California Association of Health Plans

Average bill: \$300

\$528 million burden on insured Californians

The infographic features a green box with white and blue text, and two blue callout boxes with white text. To the right is a photograph of a smiling woman with long dark hair, wearing a light blue button-down shirt, holding several blue folders.

New Disclosure Requirements

In 2007, the Texas Legislature adopted SB 1731 to provide new disclosure requirements for health plans, hospitals and physicians regarding balance billing.

For example, facilities must provide written disclosure at admission that confirms whether or not the facility is a network provider. They must also provide written disclosure that informs a patient that a physician or health care provider at the facility may not be in their health plan's network, and post in the general waiting area a conspicuous notice regarding the availability of the hospital billing and complaint policies.

The legislation, which went into effect September 1, 2008, requires physicians to notify patients that they may file a billing complaint with the Texas Medical Board (TMB). What impact these billing complaints to the TMB will have is difficult to assess. More than 820 complaints of overcharging or over-treating by physicians have been filed with the board since June 2003. To date the agency is unable to determine whether any provider has been disciplined due to a billing complaint.

SB 1731 is a good first step to increase the awareness of balance billing because it makes our health care system more transparent. However, until the practice is prohibited by law or patients are provided alternatives to using hospital-based, out-of-network providers, the harm caused by balance billing will continue.

More and more states are acting to end the practice of balance billing. Florida has created an independent dispute resolution mechanism to resolve health care billing issues. Other states have developed physician payment formulas for out-of-network providers.

TAHP believes that Texans who use in-network facilities should not be subject to balance billing by physicians. Unless action is taken to end this deceptive practice, balance billing will continue to unfairly penalize patients who think they are receiving medical services fully covered by their health plans. Without effective protections against balance billing, the practice will continue to fuel rising health care costs while creating financial burdens for patients and their families that many are unable to overcome.

ACTION NEEDED:

- Prohibit balance billing.
- Amend state law to provide that a physician who accepts payment from a health plan on behalf of an insured cannot balance bill.
- Provide the Texas Medical Board with specific oversight of physician billing practices.
- Amend the state's outdated law preventing hospitals from hiring physicians directly.

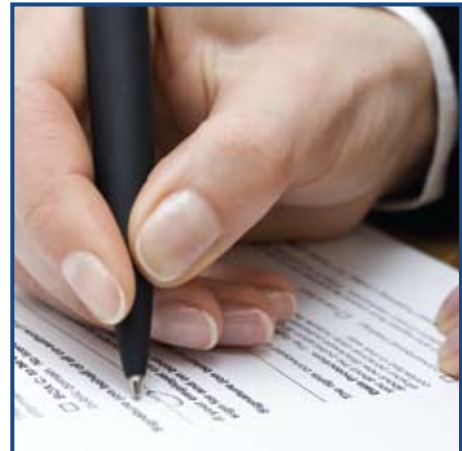


INCREASING TRANSPARENCY IN HEALTH CARE

Whenever the issue of comprehensive health care reform is explored, greater transparency is central to the debate. Improving transparency means increasing the availability of information about health care quality and health care costs. Making available such information will not only provide consumers with insight into the actual cost of a specific procedure, but will also help consumers to assess the outcomes of the providers they may be considering.

When prudent individuals make major economic decisions—buying a house, a car, a new flat-panel television—they typically conduct research, comparison shop, rely on a trusted friend with greater knowledge in that area, or utilize a combination of these resources. Additionally, the Internet provides an unprecedented amount of information about quality and price to guide our economic decisions.

The single exception is health care, and that lack of transparency is a major contributor to higher costs and, often, substandard care.



Consider that when prudent individuals select a primary care physician, they may do so based on how comfortable they are with the physician and how easy or difficult it is to make an appointment. However, is it possible to find out how effective that physician is in terms of providing up-to-date quality care and comparative patient satisfaction rates?

If a loved one needs triple bypass surgery, how easy is it to determine the effectiveness of different surgeons and hospitals in performing such procedures? Some hospitals are the site of many more medical errors than other hospitals. And some hospitals have much higher rates of hospital-acquired infections than others. A 2008 study found that patients experiencing one of 17 procedures and conditions have on average a 70 percent lower chance of dying at the nation's top-rated hospitals compared with lower-rated hospitals.¹³ This type of information should be easily accessible for consideration when making an important medical decision.

State health departments in New York and Massachusetts provide Web sites that show which doctors and hospitals have the highest and lowest death rates for angioplasty and bypass surgery. California's Web site shows how effectively every hospital in the state follows guidelines for heart care, including whether patients receive aspirin, blood pressure medication, and counseling on diet, exercise and smoking. Likewise, consumers in Florida and Pennsylvania can compare medical care at every state hospital, using the Internet to compare costs, lengths of stay and death rates.¹⁴

Health plans have begun to utilize quality and cost data to incentivize patients to use high-quality, efficient providers and to promote the use of evidence-based medicine. Initiatives such as "pay-for-performance" help move the health care system away from a fee-for-service model that rewards volume over quality. The use of high-performance networks offer patients financial incentives when they seek care from high-performing physicians who utilize evidence-based medicine and best practices. Bundled payments between hospitals and doctors can foster joint accountability through the aggregate use of resources among providers involved in a specific episode of care.

"A recent national study found that patients have on average a **70% lower chance of dying** at the nation's **top-rated hospitals** compared with the lower rated hospitals over **17 procedures and conditions.**"

Source: Healthgrades www.healthgrades.com



With compelling data showing one-third to one-half of the care delivered in the U.S. to be inappropriate, wasteful or harmful, the emergence of such efforts to promote quality and efficiency is needed more than ever. Provider reactions to such efforts have been mixed and in many states provider trade associations have attempted to ban the use of quality and cost data by health plans. During the 2007 Texas legislative session there were attempts to ban health plans from utilizing such data. Health plans support appropriate safeguards and standards to ensure that quality remains the goal.

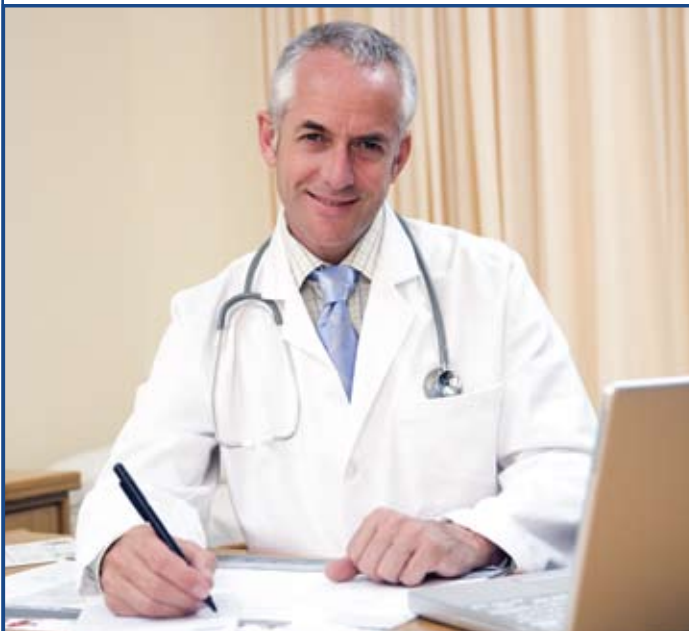
Issues about costs are also more important. How different are the prices charged by different surgeons and different hospitals? Which hospitals rely on out-of-network specialists like anesthesiologists who will bill your family for additional charges over and above the co-pays and deductibles?

The U.S. Department of Health and Human Services reports that Arizona, California, Indiana, Massachusetts, Minnesota and Wisconsin have all established price transparency pilot programs, and several others are considering similar legislation.¹⁵

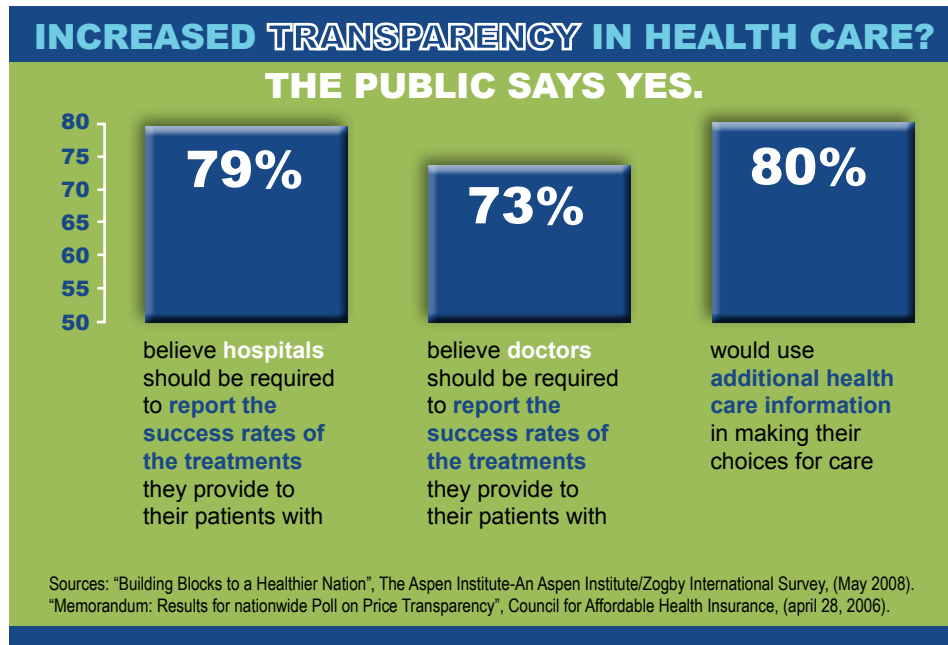
Current law requires the Texas Department of State Health Services to collect and make available hospital data for most Texas hospitals. That information includes length of stay, death rates for different procedures and charges. However, the Web site is difficult to navigate and much of the information is outdated. Few, outside of hospital administrators, seem aware that the Texas Health Care Information Collection (THCIC), created by the Texas Legislature in 1995, gathers information from hospitals and health maintenance organizations.

“People need to know – they have a right to know – the **cost of their care** and the **quality of the care**. Competition and transparency will make the system better”

- U.S. Health and Human Services Secretary Michael Leavitt



Legislation approved in 2007 requires the Texas Medical Board to provide on its Web site a consumer guide to health care that will give patients information on physicians' general billing practices. However, providers are not required by law to post their charges.



Throughout the nation, and in Texas, one of the pervasive problems with health care delivery is the significant variation in cost and utilization in different areas. Why, for example, does one area of the state see significantly more back surgeries than another area. Numerous researchers have found that physician supply actually drives demand. That is, areas with more back surgeons will reflect a propensity for more back surgeries. This is, in part, because the current reimbursement system for physicians rewards volume rather than quality. Because physicians both prescribe and deliver treatment, the current reimbursement system can create incentives to overprescribe certain services. This phenomenon is exacerbated when physicians also own the facilities to which they refer patients.

Examples of Practice Variation Among Selected Academic Medical Centers	
Average Medicare spending per decedent during the last two years of life for deaths occurring 2001-2005	
Hahnemann University Hospital (Philadelphia, PA)	\$117,998
Cedars-Sinai Medical Center (Los Angeles, CA)	\$106,951
New York University Medical Center (New York, NY)	\$105,068
University of Maryland Medical Center (Baltimore, MD)	\$94,901
Jackson Memorial Hospital (Miami, FA)	\$81,695
Northwestern Memorial Hospital (Chicago, IL)	\$77,016
University of Washington Medical Center (Seattle, WA)	\$70,245
Memorial Houston-Texas Medical Center (Houston, TX)	\$69,098
University Medical Center (Tucson, AZ)	\$56,754
University of Mississippi Hospitals and Clinics (Jackson, MS)	\$44,933

Source: Dartmouth Atlas of Health Care (www.dartmouthatlas.org)

*Facility payments only; physician services not included

The proliferation of physician-owned surgical and testing facilities has not only raised serious questions about patient safety but has also reinforced calls for increased transparency regarding referral patterns, disclosure of ownership and billing practices. Their impact on the increasing cost of health care is also an issue for debate. Concerns regarding doctor referrals to specialty facilities have federal and state policymakers questioning whether physicians have a conflict of interest when ordering tests and procedures at facilities they own. As the number of these facilities continues to increase, with virtually no state oversight, the need for guidelines and disclosure laws grows even more critical.

Successfully containing health care costs requires aligning physician reimbursement with incentives to deliver appropriate care. Additionally, ensuring that physicians are free from conflicts of interest when prescribing and delivering care is imperative. By studying the variation in practice patterns in Texas, the state has an opportunity to improve quality while establishing a foundation for containing health care costs over the long term.

While a 2005 Texas law requires physicians to disclose their ownership in certain facilities, records obtained from the Texas Department of State Health Services indicate that only 67 doctors have provided information to the state on their ownership in specialty hospitals. Given the fact that Texas is known to have more specialty hospitals than any other state, the low number of physicians reporting ownership would suggest a lack of compliance in disclosure and a need for increased reporting and regulations.

While past legislative efforts seem to recognize the growing interest in and need for greater transparency of quality and cost information, Texas data available to the public falls short of the level of information consumers need to make sound health care decisions. Greater transparency can be an effective market factor that drives consumers to use higher-quality facilities and forces underperforming hospitals to raise the quality of their services.

ACTION NEEDED:

- Increase coordination among state agencies of the collection and release of health care cost and quality data.
- Ensure that health plan efforts to promote quality are preserved.
- Study practice variation patterns in Texas.
- Require physicians to report ownership interests in health care facilities.
- Require written disclosure by physicians when referring patients to facilities in which they have an ownership interest.



ENSURING SUSTAINABILITY AND EQUITY FOR RISK POOL FUNDING

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires states to offer access to health insurance to individuals within the state who have 18 months of previous health insurance coverage through an employer, church or government. Texas has chosen to meet this federal requirement by offering coverage through the Texas Health Insurance Risk Pool (Risk Pool). In Texas, the Risk Pool exceeds the federal mandate by also offering coverage to eligible Texas residents who are uninsurable or cannot afford private health insurance due to pre-existing medical conditions. It also serves as a means of reimbursement for physicians, hospitals and pharmacies for medical services and products that might have otherwise been uncompensated.

The Risk Pool has grown from a membership of about 3,000 in 1998 to 27,733 in 2007. During 2007, a total of \$242 million was paid in medical and pharmacy benefits on behalf of pool members.¹⁶ Texas law requires that Risk Pool losses—program expenses that exceed member premiums and other available funding—be funded through an assessment on Texas insurance companies. As a result, the Risk Pool collected \$82 million in assessment funding from health insurers doing business in Texas to help cover its 2007 program expenses.¹⁷ Risk Pool assessments paid by Texas insurers are in addition to state premium taxes insurance companies are required to pay.

Since 1998 Risk Pool assessments on Texas insurers have climbed substantially, creating unpredictability for insurers doing business in the state. The rising assessments as well as premium taxes collected by the state represent an increasing cost of doing business that is ultimately reflected in higher insurance premiums paid by Texas businesses and consumers.

TEXAS HEALTH INSURANCE RISK POOL ENROLLMENT

YEAR	YEAR END ENROLLMENT
1998	2,946
1999	6,659
2000	11,783
2001	16,391
2002	21,274
2003	24,675
2004	26,574
2005	28,132
2006	28,206
2007	27,733

Source: Texas Health Insurance Risk Pool

RISK POOL ASSESSMENTS AGAINST INSURANCE CARRIERS

YEAR	REGULAR ASSESSMENT
1998	\$5,810,763
1999	\$21,331,627
2000	\$29,720,542
2001	\$34,399,570
2002	\$54,215,948
2003	\$68,914,359
2004	\$81,735,241
2005	\$86,844,496
2006	\$87,959,047
2007	\$62,849,513

Source: Texas Health Insurance Risk Pool

There is little question about the important and legitimate role the Risk Pool plays as a safety net for uninsurable Texans. Its successful operation and significant cost sharing by its enrollees makes the Risk Pool a model government program. Yet, no state funding is committed to the program and instead rising assessments and taxes paid by Texas insurers are contributing to higher premiums for all Texans.

As rising medical costs continue to force increases in private health insurance premiums, state leaders should consider all possible options to help ensure coverage remains affordable. Reducing the upward pressure on private health insurance premiums resulting from Risk Pool assessments could be a factor in maintaining affordability of coverage.

Currently, numerous states provide insurers a premium tax credit for the funding they provide to risk pool programs. While Texas does not provide such a credit, the contributions of such a proposal to maintaining affordable health coverage make it an attractive policy consideration.

An additional proposal to expand access to the pool and provide long-term sustainability for its funding could include amending the state's prompt pay laws to generate additional resources for the pool. Under current law, health plans are required to pay penalties directly to providers if payments are not made within a certain time frame. However, the penalty amount is, in part, based upon the difference between the contracted amount (what the health plan and the provider have agreed to) and the billed charges (the rate charged by the provider).



PROMPT PAY PENALTY EXAMPLES	
Original Claim Payment	Penalty Payment
\$465.88	\$23,290.46
\$35.00	\$1,971.94
\$4,888.54	\$64,158.43
\$471.98	\$8,076.16
\$98.49	\$10,040.26
\$1,401.58	\$12,718.57

Source: Texas Association of Health Plans

Since the billed charge is determined entirely by the provider, it is possible to manipulate the penalty by simply increasing the billed charge amount. In some instances the penalties are exorbitant and serve only to create windfall profits for providers rather than paying for health care. TAHP recommends that prompt payment penalties in excess of the state's usury laws be dedicated to fund premium reductions for pool enrollees and stabilize Risk Pool assessments thereby decreasing upward pressure on health care premiums in general. Such a move would keep penalties in place and maintain the incentive for health plans to pay promptly, while also ensuring that the penalties create a community benefit rather than simply creating windfall profits.

Ensuring long-term viability of the state's Risk Pool and reducing the upward pressure on private health insurance premiums are important public policy goals. Accomplishing both can provide a major boost to the state's strategy to increase access to health coverage.

ACTION NEEDED:

- Adopt a limited premium tax credit for Risk Pool assessments paid for nonmandated members of the Risk Pool—those who are eligible for coverage as a result of state policy, not federal mandate.
- Amend the state's prompt pay laws to subsidize premiums for low income pool enrollees and stabilize Risk Pool assessments.



IMPROVING HEALTH CARE AND SAVING LIVES WITH ELECTRONIC MEDICAL RECORDS

It has been argued that our health care system is not all that healthy, does not always provide quality care and certainly doesn't function as a system.

One of the biggest criticisms of our current system is the widespread underutilization of electronic medical records (EMRs). Electronic medical records contain a patient's complete medical history and allow authorized primary care providers, specialists and other medical workers access to the patient's medical data from any given location.

Fully integrated EMRs would include automated checks for drug and allergy interactions, computerized orders for prescriptions, lab tests and test results, as well as billing and scheduling opportunities.

Failure to develop an interoperable system means more than the inconvenience of filling out multiple redundant forms every time you visit a new doctor. The U.S. Department of Health and Human Services estimates that widespread use of electronic medical records would save 100,000 lives a year by reducing medical errors and lowering health care spending by as much as 30 percent.¹⁸ The nonprofit RAND Corporation estimates that the widespread use of health information technology (HIT) would reduce annual health care costs by \$81 billion a year over the next 15 years.

The biggest savings, according to the RAND study, would come through better-coordinated hospital care, resulting in shorter stays, and better use of medications in hospitals. In outpatient settings, the savings would accrue through better utilization of drugs, labs and radiology services. Another \$4 billion would be saved by limiting prescription errors.

The RAND study went a step further and looked at the effects of information technology on other industries during the 1990s. The study found that many industries such as telecommunications, retail, manufacturing and securities trading invested heavily in IT and realized annual productivity growth of 6-8 percent annually, and associated at least one-fourth of that growth to their IT improvements.¹⁹



Increased use of health information technology infrastructure will also allow for remote monitoring of patients with chronic illnesses like heart disease and diabetes. If high-speed networks can stream music and video, they certainly can transport electronic test data and facilitate interactive audio and video communication between physician and patient.

With one of the most advanced computerized medical records systems in the country the federal VA prescription accuracy is 99.997 percent. For the past six years the VA has outranked private sector hospitals in patient satisfaction surveys while spending an average of \$5,000 per patient compared to the national average of \$6,300.²⁰

In a 2008 report, the American College of Physicians compared the U.S. medical system with those of other developed nations. The report found that the United States lags far behind other countries “in the implementation of electronic medical record (EMR) systems in office practice and government investments.” In 2005, the total U.S. spending for health information technology was \$0.43 per person, last among six developed countries.²¹

In the 2005 RAND study, the researchers estimated that only 20 to 25 percent of hospitals and 15 to 20 percent of doctors had adopted electronic medical records.²²

While some state leaders may hope the federal government takes the lead in developing HIT standards and processes, and even underwrites much of the cost of developing and implementing the system, other state leaders are not waiting.

Washington Governor Chris Gregoire and the state Legislature support using electronic health records to increase treatment accuracy and reduce costs. Now they are experimenting with a \$1.7 million EMR pilot project.



Starting in early 2009, more than 18,000 Washingtonians in three different communities will have the opportunity to organize and manage access to their own health information under separate health record bank pilot project grants from the Washington State Health Care Authority. Using new technology, patients can view and share their health information—without having to recreate the records from piles of prescription records and medical information.²³

They hope to learn from the project whether a system involving direct consumer management of health data is a viable option.

Cost remains the reason most commonly cited by physicians when asked why they have not adopted electronic medical records. Health plans are equally concerned about investing in such technology without ensuring that appropriate EMR systems will be in place in doctors' offices to provide the efficiencies that such an investment can generate. All parties, however, agree that widespread adoption of electronic medical records has the potential to significantly improve quality while reducing costs over time. Adopting tax incentives for providers to adopt electronic medical records and for health plans that assist provider practices with adoption would speed the development of EMRs.

**ELECTRONIC MEDICAL RECORDS:
IMPROVING THE QUALITY OF HEALTH CARE**

82 percent of doctors who use computerized patient records report improved quality of clinical decisions

85 percent claimed the records improved the delivery of preventive care

86 percent said electronic medical records helped reduce medical errors

Source: "Electronic Health Records in Ambulatory Care – A National Survey of Physicians", New England Journal of Medicine, (July 3, 2008)

As George Halvorson, CEO of Kaiser Permanente, put it, "Health care is in need of an industrial revolution."²⁴

Perhaps Texas can serve as a catalyst for bringing health care into the 21st century.

ACTION NEEDED:

- Adopt actions and incentives to encourage increased use of electronic medical records by all stakeholders within the health care system.
- Explore tax incentives for providers adopting EMRs.
- Explore tax incentives for health plans funding or equipping physician offices with EMRs.

STREAMLINING REGULATION AND PROTECTING CONSUMERS

PROVIDING STATE OVERSIGHT OF PHYSICIAN AND HOSPITAL BILLING PRACTICES

Current law vests oversight of physicians and hospitals in the state with the Texas Medical Board (TMB) and the Department of State Health Services (DSHS), respectively. The oversight provided by these two agencies relates primarily to safety and licensing issues, leaving no entity in Texas with authority over the billing practices of physicians and hospitals. As a result, consumers who have a complaint about a medical bill have no place to turn. This is particularly important in cases of balance billing by hospital-based physicians in which charges can often reach 5 to 30 times the rate paid by Medicare for the same service. Recent news headlines have also highlighted certain hospital practices such as running patient credit scores prior to delivering treatment.

Current state law provides only that hospitals must have a complaint process in place and only in the event that hospitals do not “resolve” the complaint are patients advised that they may file a complaint with DSHS. Even then, there is nothing that DSHS can actually do to resolve the complaint. Because hospitals are not even required to report the number of consumer complaints to DSHS, the state has no ability to track or measure the significance of the problem. Similarly, the TMB has oversight of physician billing in theory, but the agency has declined to intervene on behalf of patients in billing disputes.

Additionally, the lack of oversight of provider billing practices has created difficulty for TDI when mediating disputes between health plans and providers. TDI has authority to compel data from health plans, but no similar authority to collect data from hospitals and physicians. For example, while TDI was directed to conduct an interim study related to balance billing, the agency was unable to collect any data regarding the prevalence of balance billing in Texas, as physicians are not required to respond to such requests.

ACTION NEEDED:

- Provide TDI the authority to protect consumers by accepting and tracking complaints related to physician and hospital billing practices; direct TDI to post complaint information on the agency’s Web site; and provide TDI the authority to obtain data from hospitals and physicians through the use of data calls.
- Grant TMB and DSHS specific oversight related to billing practices of physicians and hospitals.
- Provide TMB and DSHS with authority to collect data from physicians and hospitals.
- Require hospitals to report consumer complaints, including the number of complaints, the nature of the complaints and the resolution.

OVERREGULATION LEADS TO EXCESS COSTS

RATE REGULATION WILL NOT LOWER MEDICAL COSTS

As health care reform has been considered in other states and at the national level, some have suggested that additional regulation of insurance, such as rate regulation, mandated medical loss ratios and underwriting “reforms”, would result in more affordable insurance. Health insurance premiums, however, are driven not by administrative costs or profits, but by the cost of health care services and the rate of utilization.

Regulation of health insurance is often proposed as an attempt to increase access to care. Efforts to expand access to care are often in conflict with efforts to maintain affordability. Striking an appropriate balance between access and affordability is a difficult challenge and while certain regulations may seem to make insurance more affordable at first glance, the consequences can often be the exact opposite.

Health insurance in Texas is already highly regulated. One need only look at the two thousand pages of the Texas Insurance Code to gauge the extensive degree of state oversight, which includes approval requirements for benefits, claims payments, policy forms and marketing. Federal guidelines, including those dictated by ERISA, COBRA and HIPAA, add further guidelines to the extensive state oversight.

Rate regulation does nothing to address the challenge of higher costs for health coverage - soaring medical costs.



REGULATION OF HEALTH INSURANCE IN TEXAS

TDI currently has the authority to disapprove an individual policy form if the commissioner determines that “the benefits provided are unreasonable in relation to the premium charged.”

Actual rate schedules must be filed with TDI for individual plans when an insurer files a new policy form.

For HMO products:

- No schedule of charges may be used until a copy of such formula or method is filed with supporting documentation.
- Each formula or method for calculating the schedule of charges must be accompanied by the certification of a qualified actuary that based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate or unfairly discriminatory.

For small group health benefit plans:

- Rates must be reasonable and reflect objective differences in plan design.
- Rates may not vary more than 25 percent from the index rate for businesses in the same class.
- Rates may not vary more than 20 percent from one class to another; rates may not increase more than 15 percent on renewal based on the experience of the employer.
- Insurers must file annual actuarial certification that rates comply with accepted actuarial practices and must maintain documentation that rates comply with accepted actuarial assumptions and sound actuarial principles.
- Insurers must file changes to rating methodology 60 days prior to use.

For large employer health plans:

- Rates must be uniform among employees and adjustments may not be charged based on individual factors.

State mandates also require insurance companies to provide specific types of coverage, placing further restrictions on the industry.

Unlike auto and home insurance, health insurance is voluntary and not required, creating a smaller market of insured to spread risk. The highly competitive Texas health insurance market requires health plans to operate efficiently and offer their products at competitive prices. Artificial price controls aimed at lowering health care costs are examples of treating the symptom rather than treating the illness. Efforts to lower premiums should focus on reducing medical costs that drive up the cost of coverage, not adding government regulations that could adversely affect the availability of coverage.

Additional regulation will make premiums more expensive and reduce market competition among health plans driving rates even higher. Reducing health insurance premiums will require addressing rising health care costs and rates of utilization, and ensuring that appropriate and effective care is delivered, a job that health plans are uniquely qualified and positioned to do.

ACTION NEEDED:

- Oppose efforts to establish rate regulation for health insurance. Focus on lowering medical costs that drive up the cost of health coverage.

More than **700 insurers and 50 HMOs** were licensed to offer life and health insurance products and an additional **14 HMOs** provided comprehensive health insurance coverage for more than one million Texans covered under fully-insured commercial benefit plans. The state also maintains a competitive insurance market for small employers looking for health insurance options. While some states have reported difficulty attracting insurers for small businesses, Texas continues to have more than **45 carriers** offering small group health insurance.

-Biennial Report of the Texas Department of Insurance to the Texas Legislature



GOVERNMENT-MANDATED DOCTOR CONTRACTS: THE WRONG PRESCRIPTION FOR TEXAS

Government-mandated doctor contracts, also known as standardized medical contracts, are the latest attempt to circumvent market dynamics and strengthen physicians' ability to control prices. The mandated contracts would do nothing to help slow the growth of medical costs and would likely lead to further increases. If standardized contracts were mandated, physicians would likely demand as much as a 10-15 percent increase in their fee schedules based on the historical experience of renegotiation with health plans. The result could be double-digit increases in health care costs paid by Texas businesses and consumers.

Additionally, government-mandated doctor contracts are an indirect attempt to derail the movement to reward physicians based on favorable health outcomes, patient satisfaction and high performance. Health plans seek to increase the role of competition and market factors as a way to slow rising health care costs. It is important that these plans have the ability to create quality initiatives based on local market conditions and the willingness of local providers to participate in the plan.

A government-mandated contract is not necessary to ensure doctors understand the terms of their agreements. The American Medical Association provides contracting guidance for its members, and Texas already has in place rigorous disclosure requirements to ensure

physicians understand their contracts. Current managed care contracts have been revised over time to reflect historical and current practice trends, as well as current law.

Additionally, the cost of administering a "one-size-fits-all" contract, assuring compliance, and modifying the contract based on evolving medical practice and new medical technology could be prohibitive.

Texas businesses and consumers are counting on their elected leaders to find new ways to improve health care quality and manage health care costs. Government-mandated doctor contracts, which would decrease competition and reduce incentives for quality care, are clearly a step in the wrong direction.

Government Mandated Doctor Contracts will increase the cost of health coverage.

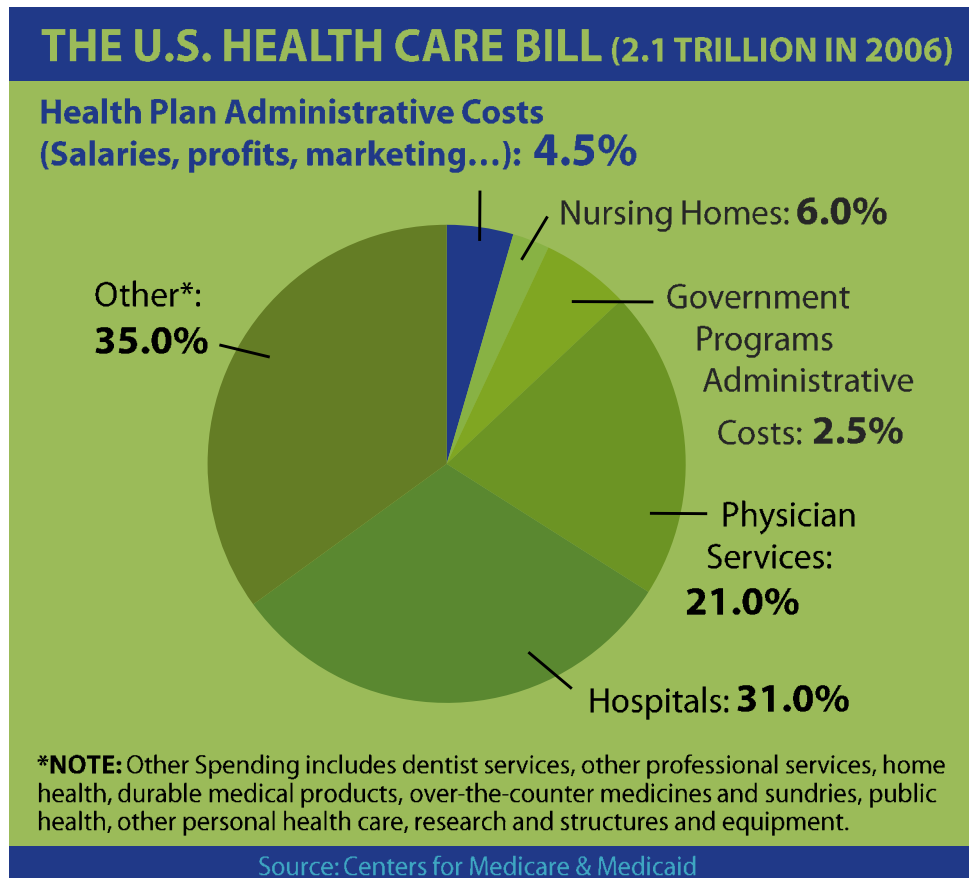
ACTION NEEDED:

- Oppose standardized medical contracts. They will increase the cost of care.

A MANDATED MEDICAL LOSS RATIO MISSES THE TARGET

Some have seized upon the desire to reduce medical costs as an opportunity to extend government control over the health insurance market. Specifically, they suggest that limiting the amount insurance companies spend on nonmedical functions will lower health insurance premiums. A brief analysis of the proposal reveals why such an approach is off base and could have an adverse effect on efforts to reduce health care expenses.

It is rising medical costs, not nonmedical spending by health plans, that is driving up the cost of coverage. To illustrate, consider that total nonmedical spending by private insurers represented only 4.5 percent of the more than \$2.1 trillion Americans spent on health care in 2006.²⁵ Mathematically that makes nonmedical spending by health plans an unlikely source for the \$145 billion increase in total health care spending from 2005 to 2006.



There is also a bit of irony with the suggestion of limiting insurers' nonmedical expenses by mandating a medical loss ratio for health insurers. The proposal is being offered at a time when the benefits of nonmedical services by private insurers such as those provided by disease management and coordination of care are being viewed as attractive, if not essential, components of strategies to reduce rising medical expenses.

Prior to the days of integrated managed care, an indemnity insurer’s medical cost ratio was used to compare the division of revenues between amounts paid for the delivery of care and basic insurance functions. The accounting term “medical cost ratio” is still used to measure the percentage of total premiums health plans pay for medical and nonmedical services, but it provides little statistical validity in measuring quality, efficiency or performance of today’s health plans.

It may be politically useful to portray the medical loss ratio as a means to measure, and even increase efficiency within the health care system, but it is not statistically nor mathematically accurate to do so.

Patient satisfaction, access and use of preventive care, and clinical data measuring outcomes are far better indicators of quality and efficiency of today’s health plans.

NONMEDICAL SPENDING BY HEALTH PLANS

Disease Management Programs
Wellness Programs
Care Management Programs
Pay-for-Performance Programs
High Performance Network Development
Nurse Hotlines
Quality Assurance Oversight
Health Information Technology
Transparency Initiatives
Provider Credentialing
Utilization Review

ACTION NEEDED:

- Oppose medical loss ratio mandates. Focus on what’s driving up the cost of health coverage—rising medical costs.



THE UNINTENDED CONSEQUENCES OF COMMUNITY RATING: A PITFALL TEXAS CAN AVOID

Despite the best of intentions, some states are discovering that their proposals to increase access to health insurance can have unexpectedly negative consequences. One example involves the concept of community rating. As some states have learned, the adverse results from this approach are no longer unexpected. Texas can avoid a similar mistake.

Under community rating laws, health insurers are forced to charge the same premium for each policyholder regardless of age, sex or any other health indicator. In other words, a 65-year-old male would pay the same premium as a 25-year-old male.

A further look at this concept reveals why it doesn't work. By requiring that everyone pay the same, rates for young and healthy individuals increase in order to create subsidies for older or less healthy individuals. Unfortunately, as their premiums go up, young and healthy individuals will drop their coverage, reducing the pool of insured to share in the costs. When this happens the cost of insurance increases for those remaining in the pool, leading more individuals to drop their coverage, forcing further increases. The cycle continues with the pool eventually collapsing or shrinking to include only high-risk individuals.

A report by the National Center for Policy Analysis (NCPA) sheds even more light on the unintended consequences of community rating. The NCPA found that in the first year of New York's community rating law, 30 percent of the population experienced a premium increase of between 20 and 59 percent. A 30-year-old male saw his premium increase by 170 percent. A study by the actuarial firm Miliman and Robertson estimated "500,000 New Yorkers canceled their health insurance because of community rating."

30 percent of New York's insured population experienced a premium increase between **20 and 59 percent** during the first year of the state's community rating law.

Source: National Center for Policy Analysis



According to a NCPA analysis, prior to community rating, premiums for a 25-year-old male on Long Island were \$81.64 a month. A 55-year-old male paid \$179.60. After community rating, the premium for both individuals was \$135.95, an increase of 67 percent for the 25-year-old and a 25 percent decrease for the 55-year-old. The following year both paid \$183.79.²⁶ Both individuals were paying more for coverage than they did before community rating was implemented. The increases are believed to be linked to the rise in medical costs associated with a less healthy population and the large number of individuals canceling their coverage.

According to a 2007 study by Milliman, individual health insurance markets “deteriorated” in states after community ratings laws were approved.²⁷ The market disruption that followed led some insurance companies to stop offering individual policies in those states, reducing available options. Additionally, the study found that enrollment in the individual market decreased, premiums increased and the reforms created no noticeable reduction in the number of uninsured persons.

The unintended consequences that have resulted from community rating led some states to repeal or significantly weaken their laws. Experts seem to agree that unless an accompanying law is passed requiring individuals to maintain coverage, it is unlikely that community rating laws can generate the benefits of access and affordability many hoped they would produce.

ACTION NEEDED:

- Oppose a community rating mandate for Texas. Similar proposals in other states have increased the cost of coverage and led many to drop their coverage altogether.



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