Influential Issues

Health Care

TEXAS PUBLIC POLICY FOUNDATION
By Kalese Hammonds

Talking Points

Medicaid

- By 2009 Medicaid will be providing services to an additional 2.9 million people in Texas.[1]
- The Medicaid program alone has been allocated $39.5 billion dollars for fiscal years 2008 and 2009.[2]
- Medicaid is an entitlement program, meaning Texas must provide medically necessary care to all qualified individuals who seek services.
- Texas should seek a federal waiver for a Medicaid funded block grant, in order to give the state greater certainty in the Medicaid budget from year-to-year, as well as greater flexibility with the structure of the Medicaid program.
- Cost sharing in the Medicaid and SCHIP program should be strengthened to the fullest extent allowed under federal law by using a sliding scale that ties the out-of-pocket cost of medical care to the recipient's income.
- Efforts to extend the period of Medicaid eligibility—including for children's Medicaid benefits—should be rejected.

Children's Health Insurance Program

- The Legislature has approved $2 billion in funding for the program for 2008 and 2009—a $1 billion increase from 2006 and 2007.[3]
- As of June 2008 there were over 444,000 children enrolled in CHIP, of which 26,429 were newly enrolled.[4]
- CHIP is NOT an entitlement program—Texas can limit enrollment, require cost sharing among participants and exercise flexibility in designing the benefits package.
- CHIP serves children under age 18 who are ineligible for Medicaid, but whose families make less than 200 percent FPL; the program also provides coverage to legal immigrant children who are in the country for less than five years, children of retired school employees, and children of state employees who meet income requirements.
- In 2005, the Legislature approved expanding CHIP to include a new perinatal benefit that covers pregnant women up to 200 percent FPL; Medicaid currently covers pregnant women up to 185 percent FPL.
- The CHIP caseload peaked in May 2002 shy of 530,000 children enrolled and then steadily declined, in part due to policies intended to verify and limit eligibility to the truly eligible children. However, lawmakers have expanded the program to boost enrollment to cover 500,000 children in 2009.
- Although CHIP is said to be budget certain, it has required supplemental appropriations to prevent budget shortfalls and the budget has steadily grown since its inception.
- Health and human services agencies account for just more than 60 percent of all federal funds in the state budget due to the matching funds for the Medicaid and CHIP programs.

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- ★ Despite the creation of the CHIP program and coverage of more than 2.2 million children between Medicaid and CHIP, the state's uninsured rate remains relatively unchanged.
- ★ All insurance plans contracting with the state for CHIP coverage should be required to offer some type of coverage on the private market, so that CHIP applicants determined ineligible or disenrolled have access to a health insurance policy similar to the one they were enrolled in through CHIP.
- ★ The reforms passed in 2003 and reversed in 2007, including the 90-day waiting period for benefits, the assets test, and the six month period of continuous eligibility, should be re-instated.
- ★ CHIP benefits should be no more generous than state employee benefits; additional benefits, such as dental and vision services, should come at the family's option with separate cost-sharing requirements.

Health Insurance Regulation

- ★ Texas' insurance plans are subject to 55 mandates, ranking the state as one of the five most heavily regulated states in the country.
- ★ Insurance premiums in Texas have increased 40 percent in five years, the third highest rate of increase in the nation.
- ★ The cumulative effect of mandates drives up the cost of a basic health plan by as much as 50 percent.
- ★ One out of four uninsured individuals does not have health insurance because of the inflated prices resulting from insurance mandates.
- ★ Policymakers should resist recent efforts that require individuals to carry health insurance via an individual mandate. Insurers should not be forced to guarantee issue and community rate policies, focusing instead on efforts to make health insurance a more attractive product and a better value.

Consumer-Driven Health Care

- ★ In September 2004, 438,000 people had an HSA-qualified HDHP and by January 2008, 6.1 million lives were covered by HSA-qualified HDHPs.
- ★ By 2008, combined account balances in HSAs reached $3.2 billion.
- ★ In 2008, 358,000 Texans were enrolled in HSA/HDHP, the fourth highest in the nation.
- ★ Small businesses are strongly embracing HSAs —HSA enrollment in the small group market increased 70 percent over the past year
- ★ State employees should have an option to enroll in an HSA/HDHP.
- ★ Existing state statute should be clarified so that the purchase of individual health insurance, through an HRA, is not subject to small group requirements.

Provider Regulations

- ★ Texas has 226 regions designated as Medically Underserved Areas (MUAs) or as Medically Underserved Populations (MUPs) and nearly 90 percent of rural Texas counties are partially or completely designated as medically underserved.
- ★ Twenty-five counties in the state have no practicing physician at all, and nearly 20 percent of Texans, or 3.2 million people, do not have access to a primary care provider.
- ★ The number of retail clinics is expanding in the 33 states where regulations are more favorable to the development of retail health clinics.
- ★ Texas has one of the most highly regulated environments for nurse practitioners, which makes it difficult to provide alternative, more affordable health care services.
- ★ The state should lift the ban on the corporate practice of medicine, which prohibits the employment of a physician by a corporation.
- ★ Regulations that dictate the collaborative relationship between physicians and nurse practitioners should be eliminated.

Health Care

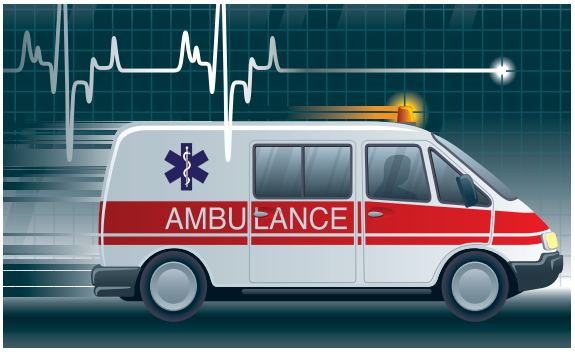
The majority of people are willing to accept, to some degree, the rationale behind free markets and uninhibited competition and their positive impact on the economy; however, when those same principles are ascribed to health care, both critics and supporters of free markets raise a skeptical eye. These critics argue that health care is different from other industries where competition has brought about lower prices and better products; allowing people to make their own decisions about their health care is irresponsible on the government's part, after all, there is no way that individuals know what is best for themselves. For whatever reason, people have come to believe that the immutable laws of economics that support free trade, consumer power, and competition are, in fact, mutable when it comes to health care.

However, evidence of the free market working in health care is manifested in aspects of the industry where competition and consumer demands dictate services. For instance, as the demand for Lasik eye surgery has risen, the technology used for the procedure has evolved to meet and exceed consumers' expectations, and in accordance with the laws of economics we have seen the cost of this service decline as providers compete for clients.

Rather than allowing these principles to have a cost saving impact on the health care industry, government regulations, overutilization, and consumer desensitization have allowed prices to continue to climb, adding unnecessary burdens on taxpayers who are forced to subsidize expensive health care for middle and low-income citizens.

Many policymakers suggest that the solution to the growing burden of health care is to make sure everyone has health insurance. Supporters of this strategy advocate for putting more people on the government's tab and giving the government greater authority over personal decisions, however implementing these types of policies only further perpetuate the broken system we have now while drastically inflating the cost to taxpayers.

Real change for our health care system means addressing the rising cost of health care and making it more accessible by taking actions to lower costs without incurring more government expenses or increasing the burden on taxpayers. The most effective way to do that is to allow competition and market forces to drive down both the price of health care services and health insurance by eliminating government regulations that limit the development of innovative health care services and personalized, affordable health insurance plans.



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Government Programs

Medicaid

In Texas, Medicaid has become the significant budget driver in health and human services spending, as well as the budget in general. According to the Legislative Budget Board, spending on Article II (health and human services) grew by 10 percent, or roughly $4.5 billion between the expended/budgeted for 2004-05 and what was appropriated for 2006-07. Of that, appropriations for Medicaid constituted almost 76 percent of the growth in health and human services spending. Texas Medicaid did not exceed $2 billion in annual expenditures until 1987, 20 years after it was created, though it has since grown rapidly and will meet or exceed $20 billion in annual expenditures when the 81st Legislature convenes in 2009. The program has been allocated $39.5 billion dollars for fiscal years 2008 and 2009,[5] with approximately 40 percent of that coming from the state, while federal matching money accounts for the remaining $23.7 billion.

Much of this increase is driven by the growth of the caseload as a result of policy decisions in Washington and in Austin that have added expanded eligibility for the program. According to the Health and Human Services Commission the Medicaid caseload grew by more than a million people between 1990 and 1995, and again added roughly a million people from 2000-05. Children make up the majority of the caseload, with enrollment of non-disabled children growing 80 percent between 2000 and 2005 to just under 2 million, but the aged, blind, and disabled populations account for the majority of the spending. However, the share of children enrolled in the Medicaid program is declining as aging Baby Boomers fuel an increase in enrollment.

In November of 2007 there were 2.8 million[6] Texans enrolled in Medicaid and HHSC estimates that by 2009 Medicaid will be providing services to an additional 100,000 people.[7] Despite the growing number of enrollees, there are continuously efforts to expand the program to include higher income individuals and offer more extensive benefits.

Eligibility requirements for the program vary depending upon age and family income, but regardless of financial capabilities there is no cost sharing in Medicaid, enrollees pay no copayments and no premiums. The program imposes a heavy burden on Texas tax payers and is simply a redistribution of personal income. Personal taxes, whether paid to the state or federal government are collected and redistributed to lower-income individuals, while those who benefit from the program pay less into the system.

Children's Health Insurance Program

The Texas CHIP program is limited to children under age 18 in families whose incomes fall below 200 percent of the federal poverty level (FPL) and who are not eligible for Medicaid. Some states have tried to extend eligibility to children in families, whose incomes meet or exceed 400 percent FPL, but those efforts have been denied and Congressional SCHIP reauthorization in 2007 failed to allow for such expansion. Some states also extend CHIP benefits to CHIP parents who meet income eligibility requirements.

From its implementation in June 2000 to its peak enrollment of 529,211 in May 2002, the CHIP caseload steadily increased; but the declines that followed prompted lawmakers to reverse course on state law passed in 2003 that required enrollees to prove their continued eligibility every six months, as well as pass an assets test, and a 90-day waiting period before enrollment took effect. Due to the CHIP expansion passed by the Texas Legislature in 2007, the state expects roughly 500,000 children to be enrolled in the CHIP program in 2009. When the 80th Legislature extended CHIP eligibility to one full year without reapplication, it created separate periods of continuous eligibility for children's Medicaid (6 months) and CHIP (12 months), and many people are already advocating Medicaid expansion to match the new, longer CHIP eligibility period.

The Children's Health Insurance Program (CHIP), for all intents and purposes, is an extension of the Medicaid program; however there are substantial differences in the structure of the program that allow the state greater flexibility in administering the program. The program serves children under age 18 who are ineligible for Medicaid and whose family makes less than 200 percent of the Federal Poverty Level (FPL). CHIP also provides prenatal coverage for pregnant women up to 200 percent FPL. Once born the child will continue to receive CHIP benefits for the duration of the 12-month coverage period.

Unlike Medicaid, CHIP is not an entitlement program and as a result the state is able to implement cost-sharing provisions that require enrollees to share in the expense of their care. Additionally, because the program is not an entitlement, the amount of money the state receives is capped and therefore expenditures and enrollees are limited. However, the Legislature has approved $2 billion in funding for the program for 2008 and 2009; a $1 billion increase over 2006 and 2007 funding levels, of which $698.5 million is allocated for the newly implemented prenatal coverage.[8] As of June 2008 there were over 444,000 children enrolled in CHIP, of which 26,429 were newly enrolled.[9]

Private Insurance

Insurance Regulation

In recent years, lawmakers have enacted legislation requiring health insurance plans to cover a variety of conditions and forcing insurers to guarantee access to an array of health care providers. The majority of health insurance mandates fall in to three categories, those that force health plans to cover specific services or benefits, require access to specific health care providers and mandates that guarantee coverage to particular individuals. Of course, there are many motives behind legislation that mandates specific aspects of health care, not the least of which include guaranteeing reimbursement for providers, insuring coverage for individuals with chronic conditions or diseases and extending health benefits to more individuals.

These mandates ultimately harm consumers by making health insurance more expensive and requiring individuals to buy health benefits that they would not choose if left to their own discretion. Legislation that defines the parameters of health insurance policies inflates the cost of health plans by requiring policies to cover an array of services, many of which consumers never use. A prime example is the Texas law requiring all insurance policies to cover in-vitro fertilization, a service that costs around $10,000 and increases the price of insurance plans by as much as 5 percent.

Additionally, these predefined policies limit the opportunity for insurers to develop new and innovative products tailored to the individual and designed to be a valuable investment. Instead, these mandates force consumers to buy all-inclusive, Cadillac health plans and leave them few alternatives to the expensive, heavily mandated plans.

For example, in Texas a 25-year-old male would pay $248 for a basic health insurance plan that he could get in Alabama for only $77 a month, the difference is that Alabama imposes only 19 mandates compared to Texas' 55.

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The increasing costs force many people out of the market by pushing the cost of health insurance out of their reach, a fact demonstrated by the dramatic difference in Texas' uninsured rate and Alabama's, 23.9 percent and 13.5 percent respectively. Although all of the 55 mandates were passed with the intent of making health care accessible to more people, they have actually contributed to the growing uninsured population across the state.

Consumer-Driven Health Care

Consumer-driven health care has become a popular term with the creation and wide spread adoption of personal health accounts, such as Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs). However, as the popularity of these accounts has grown, so have issues that impact the ability of individuals to make decisions about their health care. Issues like price transparency and an emphasis on measuring quality have emerged as central issues in the health care debate, driven largely by the growth of these new methods of paying for health care services.

Health Savings Accounts

HSAs refer to the savings account portion of the combination between a high deductible health plan (HDHP) and a savings account to pay for health care with pre-tax dollars. An HDHP requires participants to meet their deductible by paying medical bills out-of-pocket (presumably with funds in the HSA), rather than co-payments and co-insurance. Premiums are often lower than traditional health insurance plans that feature high premiums and low or no deductibles or cost sharing. The average annual premium for a single person age 30-54 was $2,278 ($189/month).

In September 2004, there were 438,000 people enrolled in HSA-qualified HDHP; that number has rapidly increased to cover 6.1 million Americans in January 2008. Balances in the accounts nationwide reached almost $3.2 billion in 2008, up 60 percent from $2 billion at the beginning of 2007. Recent studies show that roughly a third of the people purchasing an HSA-qualified HDHP in the individual market were previously uninsured, perhaps attracted by the low price and tax benefits.

HSAs are frequently criticized as being only for the healthy and wealthy, but much of the experience disputes this. Indeed, individuals with chronic conditions can benefit from the flexibility that an HSA provides, not to mention a fixed out-of-pocket expenditure and a family deductible, rather than a per person deductible found in other traditional health insurance plans. In addition, the opportunity to save for health care with pre-tax dollars is at least as appealing as the premium savings that an individual (or an employer) would realize from purchasing a high deductible plan, rather than a plan with low or no deductibles and co-payments.

Critics also claim that individuals with an HSA will forego needed care in an effort to save money, which studies have shown to be true, but only in minor circumstances. In fact, it is more reasonable to expect an individual responsible for making choices about their health care would receive screenings or adhere to treatment regimens more closely if failure to do so results in higher out-of-pocket costs.

Overall, HSAs provide individuals with greater control over both health care decisions and the way in which health care services are paid.

Health Reimbursement Arrangement

Another consumer driven alternative to traditional health insurance is the use of a Health Reimbursement Arrangement (HRA) as a means for small organizations to offer health care coverage to their employees. HRAs allow employers to reimburse employees for qualified medical expenses using untaxed dollars and give employers the option of allowing unused funds to accrue from year to year, as an incentive to encourage employees to be price conscious when choosing medical providers and other medical services. A unique feature of HRAs is that the Internal Revenue Code permits funds from an HRA to be used to reimburse employees for health insurance premiums.

These arrangements make health insurance more affordable for employees by subsidizing the cost of premiums and allowing employees to purchase cheaper, individual policies whose prices have not been inflated by the costly regulations imposed on small group health plans like the guaranteed issue mandate. These arrangements give employees the option of buying individual policies or using the funds in the HRA to pay for approved medical expenses.

Recent clarification of the Texas Insurance Code qualifies reimbursements for premium payments as de facto small group policies that are subject to all of the rules and regulations created by the Health Insurance Portability and Accountability Act (HIPAA). By classifying these reimbursements as small group insurance policies, the Texas Insurance Code forces coworkers to share in the cost of insuring fellow employees enrolled in the same plan by enforcing costly mandates such as guaranteed issue to individual plans purchased with funds from an HRA.

Additionally, this interpretation strips employers of one of their most economical options for providing health care coverage and may very likely force many small employers to drop health coverage all together.

Provider Regulation

Corporate Practice of Medicine

As the cost of health care in Texas rises, the prohibition on the corporate practice of medicine has become a hotly contested topic. Questions have been raised about whether physician employment compromises a physician's ability to make medical decisions that are in the best interest of their patients. While hospital districts and other health care facilities argue that employing physicians provides underserved areas and facilities competing for physicians a leveraging tool to attract and retain physicians.

Allowing corporations, other than hospitals, to employ physicians not only creates a competitive market for physicians, but physician employment also reduces physician liability by transferring a significant portion of responsibility to the entity employing the physician. Reducing liability insurance costs allows physicians to pass the savings on to their patients in lower prices.

Additionally, forbidding corporations from employing physicians makes it difficult to provide less expensive alternatives to traditional health care. Although corporations can staff facilities with providers who work as independent contractors, retail corporations in Texas cannot hire physicians to staff the clinic as their employee. The prohibition on the practice of corporate medicine limits opportunities to provide more affordable health care and reduces opportunities to provide alternative services to consumers.

Scope of Practice

Scope of practice regulations limit the diversification of health care services by restricting the services health care professionals are allowed to provide. Texas operates one of the most highly regulated environments for nurse practitioners in the country, greatly restricting the ability of these highly qualified medical professionals to operate effectively and provide alternative health care services to Texas consumers.

Texas statute requires that a nurse practitioner collaborate with a licensed physician in order to operate in a separate facility, additional Texas statute requires a physician to work on site with the nurse practitioner 20 percent of the time and requires that the physician's primary site be no more than 60 miles from the facility where the nurse practitioner works. Further regulation limits the number of nurse practitioners that a physician can collaborate with to three, a regulation that impedes the number of nurse practitioners allowed to offer services in the state.

Bills filed last session by Rep. Rob Orr and Sen. Dan Patrick would have increased the number of APNs or PAs a physician could collaborate with and would have eliminated the requirement that physicians be on the premise at least 20 percent of the time, however both bills failed to pass and the development of retail clinics in Texas has lagged behind the rest of the country as a result.

1 *Recap of 80th Texas Legislature*, Texas Health and Human Services Commission, http://www.hhs.state.tx.us/news/release/80Legilsature.shtml.

2 Ibid.

3 Ibid.

4 *CHIP Enrollment, Renewal and Disenrollment Rates*, Texas Health and Human Services Commission, http://www.hhsc.state.tx.us/research/CHIP/ChipRenewStatewide.html.

5 Supra note 1.

6 *Point in Time Medicaid Enrollment*, Texas Health and Human Services Commission, http://www.hhsc.state.tx.us/research/MedicaidEnrollment/PIT_monthly.html.

7 Supra note 1.

8 Ibid.

9 Supra note 4.

About the Author

Kalese Hammonds is a policy analyst in the Center for Health Care Policy. Originally from a farming family in Tahoka, Texas, Kalese graduated from Texas A&M with a degree in communications and a minor in business. While earning her degree, Kalese was involved in a number of activities, including the highly regarded Texas A&M Muster Committee.

Kalese began working at the Foundation as an unpaid intern assisting with research in the Center for Education Policy. After a few months, Kalese was hired as the interim donor relations manager in the Foundation's development department.

As a policy analyst in the Center for Health Care Policy, Kalese works on issues surrounding health insurance regulations, child protective services, and provider regulations.

About *Influential Issues*

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