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## THE ISSUE

The Employees Retirement System of Texas (ERS) oversees the retirement and insurance benefits of state employees across Texas. ERS operates five retirement plans: state employees, elected officials, law enforcement, and two judicial plans, making up the 53rd largest pension fund in the United States in 2005. In addition to retirement benefits, ERS provided insurance benefits to 504,985 state employees, retirees and their dependents in Fiscal Year 2005. In total, ERS received a five and a half percent increase for the 2006-07 biennium over 2004-05 estimated expenditures.

The cost of providing health benefits to Texas' state employees has been climbing for years, increasing from about 5 to 9 percent a year from Plan Year 2004 to Plan Year 2007. In an effort to control mounting costs and combat a \$10 billion budget shortfall, the 78th Texas Legislature directed significant changes in employee health benefits, including added cost sharing and a 90-day waiting period for new hires. Yet the cost of health benefits for state employees continues to be the full obligation of the state; the state covers the entire cost of state employee's health benefits, and 50 percent of the cost for dependent premiums established by the ERS board.

While individual state employees have not realized any increase in the cost of their coverage, those who share in the cost of dependent coverage have seen their monthly cost rise every year. However, state employees have also experienced an increase of their benefits every year as well.

## THE FACTS

- ★ In FY 2005, ERS provided insurance benefits to almost 505,000 state employees, retirees, and their dependents.
- ★ Texas pays the full cost of the premium for state employees and half the cost of the premium for an employee's dependents, a total appropriation of about \$2.1 billion for the 2006-07 biennium.
- ★ Texas state employees also have the option of participating in the TexFlex program, providing employees a Flexible Spending Account to make pre-tax savings deposits for out-of-pocket health and child care expenditures.
- ★ ERS reports that there were more than 32,000 TexFlex accounts in FY 2005 with a total contribution of \$53 million dollars, for a tax savings of approximately \$76.5 million.
- ★ Overall increases in the cost of health care, running roughly 12 percent, fueled an increase of almost \$200 million in appropriations for the state employees' group health insurance over the 2004-05 biennium.
- ★ In Plan Year 2004, the premium for employee-only benefits was approximately \$298/month, increasing to roughly \$361/month in Plan Year 2007—an increase of more than 20 percent.



- ★ The Federal Employee Health Benefits Plan began offering federal employees the option of a high deductible health plan (HDHP) coupled with a Health Savings Account (HSA) in January 2005; federal employees choosing the HDHP/HSA option had 14 different plans to choose from.
- ★ A survey of state health benefits in Fall 2005 found that state employees in Arkansas, Colorado, Florida, Georgia, Kansas, Mississippi, Oklahoma, South Carolina, and South Dakota all had an HDHP/HSA option, or would have the option in the next benefits year.
- ★ In some states, state employees who smoke pay a higher health insurance premium than their non-smoking co-workers; Georgia charges state employee smokers a surcharge of \$40/month.

## RECOMMENDATIONS

- ★ Readjust cost sharing for state employees, requiring state employees to pay a portion of the monthly premium.
- ★ Offer state employees the option of a high deductible health plan and health savings account to control cost and allow employees to share in the premium savings.
- ★ State employees should have the choice of enrolling in a high deductible health plan with the minimum high deductible allowed under law (\$1,050 for an individual) and a plan with an even higher deductible, in order to give state employees the most choice.

## RESOURCES

- *Health Savings Accounts: Affordable, Portable, and Accessible Health Insurance* by Mary Katherine Stout, Texas Public Policy Foundation (Mar. 2005) <http://www.texaspolicy.com/pdf/2005-03-pp-hsa.pdf>.
- *Survey of State Employee Benefits* by Mary Katherine Stout, Texas Public Policy Foundation (Aug. 2005) <http://www.texaspolicy.com/pdf/2006-08-PP-statebenefitsurvey-mks.pdf>.
- *HSAs for State Employees* by Mary Katherine Stout, Texas Public Policy Foundation (Sep. 2005) <http://www.texaspolicy.com/pdf/2006-09-PP-HSAsforstate-mks.pdf>.
- *Healthy Competition: What's Holding Back Health Care and How to Free It* by Michael Cannon and Michael Tanner, CATO Institute, 2005.
- *Health Savings Accounts: Answering the Critics, Parts I-III* by John Goodman and Devon Herrick, the National Center for Policy Analysis, Brief Analysis Nos. 544, 545, and 546 (Mar. 2006) <http://www.ncpa.org/pub/hea.html>.

THE ISSUE

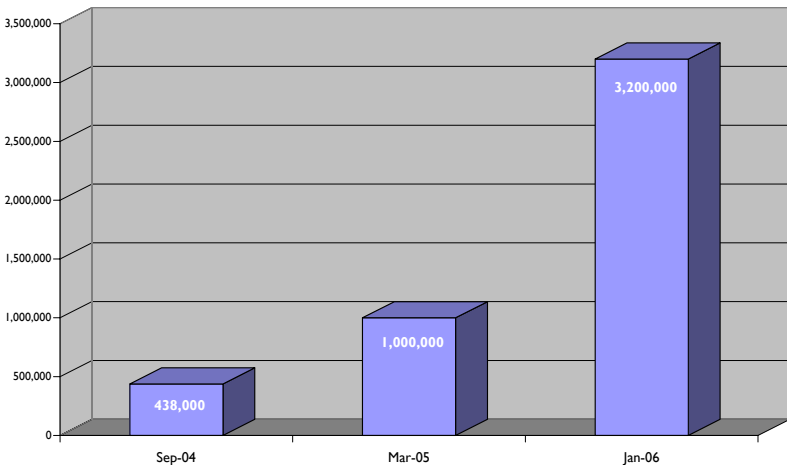
Consumer-driven health care has become a popular term with the creation and wide spread adoption of personal health accounts, such as Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs). However, as the popularity of these accounts has grown, 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**

FSAs and HRAs preceded HSAs, which were created by Congress in 2003 and first became available on the market in 2004. Since that time the use of HSAs has grown rapidly around the country, offering greater patient control and more flexible features than even the other similar accounts offer.

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. By putting the individual's cost sharing obligation up front with a high deductible of at least \$1,050 in 2006 for an individual, premiums are often lower than traditional health insurance plans that feature high premiums and low or no deductibles or cost sharing.

**Number of People with an HSA Qualified High Deductible Health Plan**





In September 2004, 438,000 people had an HSA-qualified HDHP, rapidly increasing to more than 1 million by March 2005, and then tripling to almost 3.2 million people by January 2006. By February 2006, balances in the accounts nationwide reached almost \$1 billion. 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.

HSA's 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 deductible 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 costs.

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

### **Price Transparency**

When individuals are insulated from making health care decisions, they are not sensitive to the cost of their care; however, the new focus on consumer driven health care and the wide spread adoption of HSA's has fueled new interest in the cost of care. As evidence of this trend, a McKinsey & Company survey found that individuals with a consumer directed health plan were 50 percent more likely to ask about cost and 33 percent more likely to independently identify treatment alternatives.

Yet the price of health care services remains a mystery to many. A Harris Poll in July 2005 found that people were able to predict the price of a Honda Accord within \$300 of the actual cost, but missed the price of a four-day stay in the hospital by more than \$8,100. The question of price becomes a particularly important issue not only for those who must meet their deductible out-of-pocket, but even more important for uninsured individuals who are often charged several times more than what a provider would bill or expect to be paid from an insurer. The same Harris Poll found that 63 percent of adults didn't know the cost of their care until after they received the bill, a practice that has been commonplace in an area where consumers have little sensitivity to price.

Yet patients report that when they act like consumers with an interest in price, they can often negotiate lower rates. A Harris Poll in December 2005 found that 70 percent of adults reported that they were successful in negotiating a lower price with a hospital, 61 percent were successful in negotiating a lower price with a doctor, and 45 percent were successful negotiating a lower price with a health insurer.

### Quality Care

One thing has become increasingly clear, patients are concerned about the quality of care that they receive in addition to the price of care. A Harris Poll in 2005 found that only 4 percent of adults ranked cost as the most important factor, while two-thirds of adults said quality was most important. Yet measuring quality becomes difficult, and even publications from the U.S. Agency for Health Quality and Research offer patients basic, common sense advice on how to get good quality care, typically in thorough consultation with their doctor. A Time magazine article from April 2006 found that when patients were in consultation with their doctors, the rate of surgery dropped by 23 percent and outcomes and satisfaction improved.

Interestingly, a recent New England Journal of Medicine article found that health insurance status is largely unrelated to the quality of care a patient receives, but notes that health insurance can help improve access to health care. In many cases, however, quality is measured in quantity of inputs such as access to beds and specialties, rather than the outcomes.

### THE FACTS

- ★ In September 2004, 438,000 people had an HSA-qualified HDHP, more than doubling to more than 1 million in March 2005, and then tripling to almost 3.2 million people by January 2006.
- ★ By February 2006 combined account balances in HSAs reached \$1 billion.
- ★ Almost one third of the people enrolling in an HSA in the non-group market were previously uninsured.
- ★ Individuals with a consumer directed health plan were 50 percent more likely to ask about cost and 33 percent more likely to independently identify treatment alternatives.
- ★ Recent polls have found 63 percent of adults didn't know the cost of their care until after they received the bill.
- ★ Seventy percent of adults polled reported that they were successful in negotiating a lower price with a hospital, 61 percent were successful in negotiating a lower price with a doctor, and 45 percent were successful negotiating a lower price with a health insurer.



## RECOMMENDATIONS

- ★ Offer state employees an option to enroll in an HSA/HDHP.
- ★ Make price and quality information readily available for Medicaid, allowing taxpayers and recipients to compare the prices the government pays for services.

## RESOURCES

- *Consumer-Driven Price Transparency: Making Health Care Prices Transparent Through the Free Market* by Mary Katherine Stout, Texas Public Policy Foundation (June 2006) <http://www.texaspolicy.com/pdf/2006-06-PP-hctransparency-mks.pdf>.
- *HSA's for State Employees* by Mary Katherine Stout, Texas Public Policy Foundation (Aug./Sep. 2006) <http://www.texaspolicy.com/pdf/2006-09-PP-HSAsforstate-mks.pdf>.
- *Health Savings Accounts: Affordable, Portable, and Accessible Health Insurance* by Mary Katherine Stout, Texas Public Policy Foundation (Mar. 2005) <http://www.texaspolicy.com/pdf/2005-03-pp-hsa.pdf>.
- *Healthy Competition: What's Holding Back Health Care and How to Free It* by Michael Cannon and Michael Tanner, CATO Institute, 2005.
- *Health Savings Accounts: Answering the Critics, Parts I-III* by John Goodman and Devon Herrick, the National Center for Policy Analysis, Brief Analysis Nos. 544, 545, and 546 (Mar. 2006) <http://www.ncpa.org/pub/hea.html>.

## THE ISSUE

The uninsured have proven to be a policy issue of particular concern to state and national policymakers, often leading to the creation and expansion of government programs and, more recently, a requirement that all residents of Massachusetts purchase health insurance. The uninsured present serious policy issues and strain on the health care system, as the cost of providing uncompensated care to the uninsured and questions about access and quality of care dominate the debate. However, there are serious questions about how well Texas, as well as the nation, has done in accurately estimating and identifying the uninsured.

How many uninsured people are there? The U.S. Census Bureau estimates the number of uninsured based on survey data that asks individuals about insurance coverage in the previous calendar year, which is thought to underreport insurance coverage as respondents' recollections might not be entirely accurate. In addition, Census numbers often undercount Medicaid and Medicare enrollment when compared to data from the Centers for Medicare and Medicaid Services. Both underreporting coverage and undercounting Medicaid enrollment likely impact the accuracy of the estimate. Statistics show that roughly a quarter of the Texas population is uninsured—the highest percentage of uninsured people in the nation.

Who are the uninsured? Most people think the uninsured are poor, not working, in poor health, and receiving poor care, but the data shows how much more complex this population really is. Studies show that as high as 82 percent of the nation's uninsured are in working families, many employed by small businesses who cannot afford to provide employee health benefits. Research has also shown that many of the uninsured are in middle to upper income families, and that the fastest growing portion of the uninsured are those in households making more than \$50,000. Accurately identifying the uninsured and their reasons for going without health coverage is essential. The statistics show that the uninsured are represented in all income groups and among the healthy and sick alike.

## THE FACTS

- ★ Approximately one quarter of Texas' population is uninsured; out of the roughly 5.5 million uninsured, 1.3 million of those are children.
- ★ The percentage of uninsured Texans has remained largely unchanged over the past decade, despite tremendous growth in Medicaid and the creation of the Children's Health Insurance Program.
- ★ In Texas, the majority of the uninsured are male; 43 percent work full time and only 27 percent do not work at all; 28 percent have a household income of more than \$50,000; and 70 percent are above the federal poverty level.
- ★ Between 1995 and 2004, the National Center for Policy Analysis



reports that the number of uninsured people living in households making \$50,000-\$75,000 a year has increased by 57 percent, and by 153 percent in families making \$75,000 or more.

- ★ The National Center for Policy Analysis also reports that between 1995 and 2004, the number of low income families making less than \$25,000 who have health insurance coverage—often through Medicaid or CHIP—has actually increased by 19 percent.
- ★ One third of immigrants lack health insurance, which is two and a half times the rate of the native-born uninsured (legal and illegal).
- ★ Immigrants and their U.S. born children account for almost 75 percent of the increase in the uninsured population since 1989 (legal and illegal immigrants).
- ★ All of the states on the U.S./Mexico border exceed the national average in their percentage of the uninsured.
- ★ Roughly 70 percent of the uninsured in Texas were born in the U.S.
- ★ A report from the New England Journal of Medicine finds that “health insurance status was largely unrelated to the quality of care among those with at least minimal access to care. Although having health insurance increases the ease of access to the health care system, it is not sufficient to ensure appropriate use of services or content of care.”

## RECOMMENDATIONS

- ★ Promote consumer-directed health care alternatives, such as health savings accounts that offer lower cost health insurance coverage to individuals.
- ★ Reduce the cost of basic insurance by eliminating state regulations that mandate benefits.
- ★ Reduce state regulations that prevent lower cost providers to deliver health care while ensuring the safety and quality of health care.
- ★ Resist recent policy efforts that require individuals to carry health insurance, focusing instead on efforts to make health insurance a more attractive product at better value.
- ★ Form a multi-state insurance coalition between Texas and neighboring or regional states, allowing Texans the option to purchase health insurance across state lines.

## RESOURCES

- *Sorting the Facts About the Uninsured* by Mary Katherine Stout, Texas Public Policy Foundation (May 2006) <http://www.texaspolicy.com/pdf/2006-05-PB-uninsured-mks.pdf>.

## THE ISSUE

When Medicaid was established by Congress in 1965 and in Texas in 1967, the program was originally focused on providing health care benefits to recipients of certain cash assistance programs. However, more than four decades of incremental policy expansion have resulted in the largest government health program—providing benefits to more people and at a higher cost than the Medicare program.

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, projected spending on Article II (health and human services) grew by 10 percent, or roughly \$4.5 billion, between 2004-2005 and 2006-2007. 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 80th Legislature convenes in 2007.

Much of this growth is driven by caseload growth 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 2000-2005. 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. The LBB has reported that the aging population has been going up in real numbers, but going down as a percentage of the caseload, a trend they say will reverse in 2011 with the aging population.

## THE FACTS

- ★ Medicaid is an entitlement program—Texas must provide medically necessary care to all eligible individuals who seek services.
- ★ Health and human services spending represents roughly 35 percent of the state budget, with Medicaid accounting for approximately three quarters of health and human services spending.
- ★ In Fiscal Year 2006, Texas Medicaid is projected to cost taxpayers more than \$20 billion in All Funds, including the Disproportionate Share Hospital funding.
- ★ Medicaid is jointly financed with federal and state tax revenues according to the Federal Medical Assistance Percentages (FMAP), which varies between states and usually changes from year to year; Texas pays roughly 40 percent of Medicaid costs and the federal government pays roughly 60 percent.



- ★ Health and human services agencies account for just more than 60 percent of all state federal funds, and federal Medicaid funding account for more than 80 percent of federal spending for Texas health and human services.
- ★ In FY 2007 it is estimated that the Texas Medicaid program will cover more than 3 million Texans and 2.2 million of those will be children.
- ★ In 2006 Medicaid cost every man, woman, and child in the state of Texas more than \$850.
- ★ Despite large increases in enrollment, the state's uninsured rate remains relatively unchanged.
- ★ Never in the history of the Texas Medicaid program has state spending (general revenue) on Medicaid declined from one year to the next; only in 1982 did total Medicaid spending decline from the previous year as the result of reductions at the federal level.

## RECOMMENDATIONS

- ★ Seek a federal waiver similar to the approved Florida waiver using risk-adjusted premiums to bring increased competition in coverage and greater recipient control.
- ★ Pursue federal approval for Texas to serve as a pilot state for Health Opportunity Accounts authorized under the Deficit Reduction Act passed by Congress in 2006.
- ★ Continue to pursue the most cost effective care settings, offering recipients incentives to share in any resulting savings.
- ★ Strengthen cost sharing in the Medicaid program using a sliding scale that ties the out-of-pocket cost of medical care to the recipient's income, applying the highest level of cost sharing authorized by the Deficit Reduction Act passed by Congress in 2006 to the highest income Medicaid recipients.

## RESOURCES

- *Medicaid: Yesterday, Today, and Tomorrow; A Short History of Medicaid Policy and Its Impact on Texas* by Mary Katherine Stout, Texas Public Policy Foundation (Mar. 2006) <http://www.texaspolicy.com/pdf/2006-03-RR-medicaid-mks.pdf>.
- *Ending the Forty Year Entitlement* by Mary Katherine Stout, Texas Public Policy Foundation (July 2005) [http://www.texaspolicy.com/commentaries\\_single.php?report\\_id=888](http://www.texaspolicy.com/commentaries_single.php?report_id=888).
- *Medicaid's Unseen Costs* by Michael Cannon, The Cato Institute (Aug. 2005) [http://www.texaspolicy.com/commentaries\\_single.php?report\\_id=888](http://www.texaspolicy.com/commentaries_single.php?report_id=888).
- *Reforming Florida's Medicaid Program with Consumer Choice and Competition* by Michael Bond, The James Madison Institute (Feb. 2005) <http://www.jamesmadison.org/pdf/materials/331.pdf>.

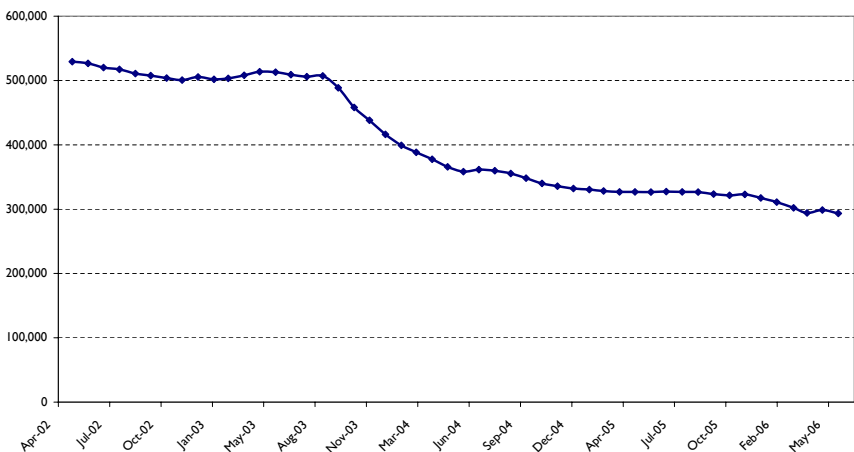
## THE ISSUE

When Congress established the Children's Health Insurance Program (CHIP) in 1997, it did so in response to mounting pressure to address the number of uninsured children in the United States. Proponents of the plan argued that CHIP would deliver health insurance coverage to half of the nation's 10 million uninsured children by 2000. Through Federal Fiscal Year 2005, however, the CHIP program had never reached enrollment of even 4 million children at any given time.

The Texas Legislature established the CHIP program in 1999, though the new program did not begin to enroll children until June 2000. 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 extend eligibility to children in families whose incomes meet or exceed 300 percent FPL, just as states may 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; however, since its enrollment peak, the CHIP program has been in almost constant decline. These declines have been the result of a variety of factors, including a growing economy and policy changes made by the Texas Legislature in 2003 to shorten the eligibility period, tighten enrollment processes and better verify eligibility, and increase cost sharing. Though the Legislature also reduced the CHIP benefits package at the same time, those reductions were restored by the Legislature in 2005.

**Texas CHIP Enrollment by Month  
May 2002-June 2006**





While the CHIP program is for all intents and purposes an expansion of the Medicaid program, it does have fundamental policy differences in comparison to the Medicaid program. There are two main differences:

- 1) CHIP, unlike Medicaid, is not an entitlement, and
- 2) Federal funds that are available to states through a matching arrangement are capped.

Importantly, since CHIP is not an entitlement, states have greater flexibility to design a benefits package and require recipients to share in the cost of care.

## THE FACTS

- ★ 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 and whose family makes less than 200 percent FPL.
- ★ In 2005, the Legislature approved expanding CHIP to include a new perinatal benefit to cover pregnant women up to 200 percent FPL; Medicaid currently covers pregnant women up to 185 percent FPL.
- ★ For the 2006–07 biennium, CHIP funding totaled \$1.4 billion, a 41 percent increase over CHIP's estimated/budgeted appropriation for 2004–05; state general revenue funds account for \$444.4 million of the CHIP total.
- ★ The CHIP caseload peaked in May 2002 shy of 530,000 children enrolled, followed by almost constant decline; in the 47 months following the peak, the caseload declined each month in all but eight months.
- ★ Health and human services agencies account for just more than 60 percent of all of the state's federal funds, and federal Medicaid funding account for more than 80 percent of federal spending for Texas health and human services.
- ★ Although CHIP is said to be budget certain, it has required supplemental appropriations to prevent budget shortfalls.
- ★ Reforms passed during 2003 and implemented since allow the state to direct care to those who are truly eligible, and to limit fraud and abuse.
- ★ In almost every month since the program began in June 2000, the most common reason for disenrollment was the family's failure to renew, followed by a determination that the family was no longer eligible for benefits.
- ★ 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.

## RECOMMENDATIONS

- ★ Maintain identical periods of continuous eligibility in Medicaid and CHIP of no more than six months.
- ★ Maintain reforms passed and implemented since 2003 such as the 90-day waiting period for benefits, the assets test, and income and asset verification.
- ★ 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.
- ★ Texas should reevaluate the CHIP immigrant program, which is funded only from general revenue and cannot be matched with federal funds.

## RESOURCES

- *The Children's Health Insurance Program in Texas* by Mary Katherine Stout, Texas Public Policy Foundation (Apr. 2006) <http://www.texaspolicy.com/pdf/2006-04-RR-CHIP-mks.pdf>.
- *CHIPs Down When Times Are Good* by Mary Katherine Stout, Texas Public Policy Foundation (Apr. 2006) [http://www.texaspolicy.com/commentaries\\_single.php?report\\_id=1085](http://www.texaspolicy.com/commentaries_single.php?report_id=1085).