The Future of Health Care in Texas

By Kathi Seay

A major problem with controlling health care costs is that conventional economic principles do not fully apply. Employers want to keep the cost of insurance down to protect their profits. Doctors and hospitals will not perform services at a loss. Drug and insurance companies want the largest profits possible for their shareholders. The less money people pay out of pocket, the more expensive treatments they demand.

But market forces do not apply to other aspects. Because most bills are picked up by insurance, people pay little attention to the cost of treatment, and they have no way to assess the quality of medical services they receive. Beyond that, for most people, good health is priceless; they are willing to pay whatever it takes for themselves and their families.

So this is the conundrum for politicians. Their constituents will not accept the rationing of their medical treatment. People do not want to be told that good health has a price. On the other hand, neither the politicians nor their constituents want to pay the higher taxes or higher insurance premiums required for unlimited health care.[1]

So concludes an article in the *New York Times* discussing the dilemma that policy makers face in health care reform. Since the defeat of the massive Clinton health care plan in 1994, the public has shied away from overhauls of the health care system. As the writer in the *New York Times* pointed out, "The case seems to be that what is economically rational is politically unacceptable. And what is politically possible does not fit with economic realities."[2]

Meanwhile, many components of Clinton's health plan have been implemented in a piecemeal fashion often at the state, rather than the federal level. With the expansion of Medicaid eligibility standards and passage of programs such as the Children's Health Insurance Program (CHIP), the state has increased its responsibility to provide health care from the elderly and indigent to a much broader base. For the most part, conservatives have had little to say about the changes in health care policy other than, "NO." Rather than articulate effective, free market, limited government ideas that would promote consumer self-responsibility in the health care field, they have abdicated their responsibility to find workable solutions.

Current trends in Texas dictate that those who are opposed to both a government-financed, government-run health care system *and* a personal income tax should take note of the implications of the changes being suggested by many advocacy groups.

Health Care Expenditures In Texas

Texas spends less than the national average on health care expenditures, primarily because the population in Texas is younger and most health care expenditures have to do with aging or end-of-life care. Even so, total estimated spending on health care in Texas is *$71 billion*.

[1] Rosenbaum, David E. "What if There is No Cure for Health Care Ills?" *New York Times* 11 Sept. 2000.

[2] Ibid.

According to the Office of the Texas Comptroller of Public Accounts, in 1998 health care expenditures as a percent of the Texas Gross State Product were 10.9 percent. The average annual cost of health care per Texan was $3,594. The percentage of health care provided by the private sector (excluding charity and some private spending for which statistics are not available) was 56 percent; the public sector was 44 percent; and *e*mployer / employee insurance was 35 percent. A further breakdown of those figures indicate that consumers paid out of pocket for 20 percent of their health care expenditures, while federal spending accounted for 32 percent, state spending accounted for 9 percent and local spending accounted for 2 percent. An additional 3 percent of expenditures were paid by charity or in non-specified categories.

...there exists among many lower income families a desire to take some responsibility for their own health care, rather than becoming dependent on government programs.

The cost of health care is a concern to both the private and public sector. Due to medical inflation, government regulations and increased utilization, the cost of providing health benefits has become prohibitive to many employers. As employer sponsored health benefits have declined and eligibility for government programs has expanded, the state has become more involved in the provision of health benefits through programs such as Medicaid and CHIP.

GOVERNMENT PROGRAMS

MEDICAID

Medicaid is a joint federal/state program created under Title XIX of the Social Security Act of 1965. The program was originally intended to provide individuals who qualified for cash assistance the opportunity to receive health care through the same providers as does the general public. The federal legislation creating Medicaid made it a voluntary program for states, with the condition that if a state chose to participate, it would be required to abide by all of the federal mandates, rules and guidelines governing the program. Texas began its participation in the program in 1967. Then, from that time, it took the program in Texas 20 years to grow to a $2 billion budget item. Indeed, in the 10 years between 1987 and 1997, the Medicaid budget in Texas increased over 400 percent, reaching the $10 billion mark in 1997. Medicaid was 25 percent of all funds (state and federal) in the state budget for the 1998-99 biennium, and 17 percent of state funds.[3]

According to *Texas Medicaid in Perspectives 1999*, a report released by the Texas Health and Human Services Commission, the explosive growth in the Medicaid budget had three driving factors:

- Increased enrollment caused by expansion of federal mandates,
- Medical inflation, and,
- Escalation of Disproportionate Share Hospital payments.

Increased Enrollment

In 1988, Congress dramatically expanded the mandatory eligibility standards for Medicaid recipients. Programs created or expanded due to that expansion of eligibility included:

[3] State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), 74.

- Coverage of prenatal and delivery services for certain pregnant women (and their infants) who had no other insurance,
- Expansion of services to many children in low-income families who do not receive cash assistance,
- Expansion to fill gaps in Medicare services to poor persons who are elderly or disabled and
- Coverage of all federally allowable Medicaid services as medically necessary and appropriate for all children on Medicaid.[4]

Medical Inflation

Medical care is one of the major items within the Consumer Price Index (CPI) that is used annually to determine the national rate of inflation. The costs of medical care services such as professional services, hospital services, prescription drugs, non-prescription medical equipment and supplies are considered when calculating the medical inflation rate. It is projected that the nation's total spending for health care will increase from $1 trillion in 1996 to $2.1 trillion in 2007.[5] During that time frame, health care spending as a percentage of the gross domestic product (GDP) is expected to increase from 13.6 percent to 16.6 percent.

The increase in expenditures in medical costs is caused both by inflation and utilization. Managed care was once considered a potential solution to the over-utilization of services. However, after a brief respite from rising prices for health care benefits in the private sector, costs are once again on the rise. Aetna, the largest U.S health insurer has announced it will raise premiums an average of 13 percent to cover its drop of 17 percent in second quarter profits.[6]

In another effort to help counter the high medical costs, the Texas Legislature passed a tort reform package in 1995 that included medical malpractice reform. This measure resulted in a 17.2 percent reduction in the cost of medical malpractice insurance, with a five-year savings to consumers of $217.3 million.[7]

Escalation of Disproportionate Share Hospital Payments

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such facilities are known as Disproportionate Share Hospitals (DSH) and receive disproportionate share funding. In 1998, 166 Texas hospitals qualified to receive DSH funding.[8]

These funds are an important source of revenue for Texas hospitals and are used to defray the cost of treating the indigent, recruit physicians and other health professionals, obtain equipment and renovate facilities. Funding for the Texas DSH program was capped by federal law in 1991 at $1.513 billion. While funding has been stable since 1991, changes due to the Balanced Budget Act (BBA) in 1997 will cause DSH funding to decrease in the years 2000 – 2002. Those reductions will affect DSH hospitals across the board and the cost of providing services are likely to be shifted to state and local governments, as well as other for-profit and not-

4 Ibid., 21.

5 Health Care Financing Administration, Highlights of the National Health Expenditure Projections, 1997 - 2007, www.hcfa.gov/stats/nhe%2Dproj/hilites.htm, accessed November 8, 2000.

6 *Health Inflation News*, Vol. 9 No. 8, 25 August 2000, p. 1.

7 Texas Department of Insurance, "Tort Reform Savings Total $2.9 Billion, " press release, October 1, 1999.

8 State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), 65.

for-profit hospitals.

CHIP

The Children's Health Insurance Plan (CHIP) is a program to initiate and expand the provision of children's health insurance to uninsured, low-income children. Children in families with a net income at or below 200 percent of the federal poverty level are eligible for the program. The definition of "net family income" includes offsets for such expenses as childcare, work-related expenses and other deductions consistent with Medicaid standards.[9]

Of the approximately 1.4 million Texas children who are reported to be uninsured, it is estimated that 600,000 of them are potentially eligible for Medicaid coverage. Federal law prohibits an individual eligible for Medicaid to enroll in CHIP. However, in the process of applying for CHIP, applicants are screened for Medicaid eligibility and referred for enrollment in that program. It is noteworthy that, so far, Medicaid enrollment has not increased at the rate that might be expected, given the number of referrals from CHIP. In fact, through October 24, 2000, 16,964 referrals for Medicaid from CHIP had been denied because the family failed to keep an appointment to establish eligibility. In other words, 16,964 applicants had applied for coverage in a program where they would share premium costs but, when referred to the "free" government program, they declined to participate in the process. This would seem to indicate that there exists among many lower income families a desire to take some responsibility for their own health care, rather than becoming dependent on government programs. An even stronger indicator that families desire to take personal responsibility for their health care needs is the fact that 1,853 applications for CHIP coverage were from people already enrolled in and receiving Medicaid. Policy makers should take note of that desire in designing reforms to the current government sponsored systems.

The *Frew* decision fundamentally changed the role of the government in the lives of Medicaid eligible children.

FUTURE SHOCK

As alarming as the expenditures for Medicaid and the CHIP program have been in the past, they pale in light of the implications for future budgets. The double-digit medical inflation that was seen in the late 1980's and early 1990's slowed considerably with the advent of managed care, benefitting both the private and public sector. At the same time, a strong state economy and welfare reform served to reduce the enrollment (not the expenditures) of Texans for Medicaid services.

Now, however, in addition to an increasing rate of medical inflation, there are three major factors that are threatening to cause once again exponential growth in the state Medicaid budget. Those factors include increased enrollment due to CHIP screening (discussed above), court-mandated changes in the way services are to be delivered and changing demographics.

Frew vs. Gilbert

In October 2000, the Fifth Circuit Court of Appeals stayed an August 2000 order by Texas Federal Judge William Wayne Justice to produce a corrective plan within 60 days that

9 *State Child Health Plan Under Title XXI of the Social Security Act: State Children's Health Insurance Program*, http://www.hhsc.state.tx.us/ipisi/spasb445fin2.pdf.

would comply with a 1996 consent decree in the *Frew vs. Gilbert* lawsuit. That case, filed in 1993, challenged the state because of its failure to fully implement the Texas Health Steps (THSteps) program that provides health care for Medicaid enrolled children. According to the Texas Department of Health (TDH), the state has been pursuing improvements in providing services. Currently, 66 percent of Medicaid eligible children are receiving regular check-ups, a significant increase over the 29 percent of eligible children who received those services in 1993. Also, in 1993, the state provided transportation for 743,000 Medicaid eligible trips to the doctor. That number has risen to 2.5 million trips in 2000. The TDH indicates that efforts to deliver services to all eligible patients will continue, which indicates that these numbers will continue to grow.[10]

The *Frew* decision fundamentally changed the role of the government in the lives of Medicaid eligible children. Rather than parents being responsible for making sure their children receive appropriate health care, the decision shifted that role to the government. It is not sufficient that the state have an appropriately run and financed program. It has now been made responsible for both the provision of services and for the response of potential recipients of those services. Testimony was offered during the case that "60 percent of respondents reported knowing only 'very little' or 'nothing at all' about the program."[11] The *Frew* decision failed to recognize that a parent's lack of knowledge about THSteps may or may not be the fault of the state. However, it is always the responsibility of the parent to seek appropriate health care for their child.

Considering the projected spike in the elderly population within 25 years, fiscal plans should begin now to accommodate the growth.

Demographic Changes

The potential for 600,000 new Medicaid recipients in the under-19 age bracket as a result of CHIP screening is only one concern of the Medicaid program. At the other end of the spectrum, population projections indicate that the over-65 age bracket will increase 9.3 percent by 2005 and 107.7 percent by 2025 as a result of the aging of the baby boomers.

Texas Medicaid pays for a portion of more than 70 percent of all nursing home residents.[12] Additionally, Medicaid funds, or partially funds:

- Community Care Services as a cost-effective alternative to institutionalization,
- Primary Home Care to assist the individual with daily living activities,
- Frail Elderly Program to allow personal care without other Medicaid benefits to individuals with incomes too high to qualify for Medicaid,
- Day Activity and Health Services as an alternative to nursing homes or other institutions, and,
- Hospice for individuals who have been diagnosed as terminally ill.

While the elderly population accounts for only 12 percent of the Medicaid population, they account for 30 percent of the expenditures.

[10] Mr. Doug McBride, Public Information Officer, Texas Department of Health, conversation with author, October 30, 2000.

[11] *Frew vs. Gilbert*, 2000 WL 1206458 (E.D. Tex).

[12] State Medicaid Office Health and Human Services Commission, *Texas Medicaid in Perspective*, (Austin, Texas, 1999), p. 63.

Considering the projected spike in the elderly population within 25 years, fiscal plans should begin now to accommodate the growth.

THE SOLUTION

The demographic projections in the state for the elderly, coupled with the disproportionate share of Medicaid spending for that population as a percentage of recipients; the potential for identifying and enrolling an additional 600,000 Medicaid eligible children through the CHIP screening process; and the increase in medical costs due to both medical inflation and increased utilization could all converge on the budget in the next five to 10 years, having a significant effect on the state budget. At the same time, there are recommendations by legislators in both the Texas House and Senate to further *increase* eligibility for Medicaid by eliminating the face-to-face interview requirements, eliminating the assets test for children and increasing continuous eligibility from 6 to 12 months for children's Medicaid.

Time is running out for conservative, market-based solutions to be developed and tested in the real world in a way that would demonstrate their merit.

In the early 1990s when the state faced double-digit medical inflation and large enrollment growth, expenditures for Medicaid increased 22 percent a year with a 400 percent increase over 10 years. The majority of that increased enrollment was due to federal mandates. Once again, the state is facing a scenario that could result in high increases in the state Medicaid budget.

With the likelihood of increased enrollment due to changing demographics and expanded standards for Medicaid eligibility, and with the early warning signs that medical inflation may once again be on the rise, the potential for yet another round of dramatic and accelerated growth in expenditures should be considered. With an increase of only 22 percent in Medicaid expenditures over the next five years, the state could experience annual costs of over *$30 billion* a year by 2005. The money for this program could only come as the result of increased taxation or re-prioritization of other state programs. Considering that the current Medicaid budget is $10 billion, the most probable source of revenue to be recommended for such a large increase would be a state personal income tax.

There is no question from any side that the benefits offered by Medicaid represent a worthy goal. However, there is a difference in philosophy regarding how the problems should be resolved. On the one hand, some believe that the state policy should be to dramatically increase the number of persons enrolled in Medicaid in order to ensure that they have access to health care services. Proponents for expanded Medicaid eligibility believe that if the state would only make the eligibility system easier, more people would use the services.

Others argue that the way to address the issue is not by growing government, but rather by:

1. increasing an individual's ownership in their own health status;
2. embracing an individual's desire to become and remain self-sufficient; and,
3. empowering individuals through education.

These outcomes can be accomplished by enacting the following four policy

recommendations. The first recommendation is to begin by implementing cost-sharing mechanisms within the existing Medicaid delivery system to increase recipients' use of primary and preventative care and to discourage the inappropriate use of emergency rooms. For example, co-pays could be redefined so that visits to the emergency room had a higher co-payment than a visit to the doctor's office. Other types of incentives might also be offered, such as awarding pregnant women points for keeping pre-natal appointments that they could redeem for diapers or other necessities. The primary and preventive care received will reduce the use of the emergency room as a doctor's office.

Second, every effort should be taken to give low-income families the opportunity to have more control and responsibility for their health care needs. For instance, within both CHIP and Medicaid, recipients who also receive basic employee benefits at work should be allowed the opportunity to use their state-sponsored benefit to add or increase subsidies for the purchase of family coverage through any available employer-sponsored plans. Additionally, the state should test, through a pilot project, allowing low-income Texans to use a Medical Savings Account as a means to access health care and encourage savings. Such plans, probably funded initially from a combination of public sources, would allow individuals to accrue funds that could be spent only on health care needs. The process of writing checks on this account, rather than having expenses paid by faceless government programs, might encourage participants to use health care resources in a more responsible manner. In any event, this would clearly give participants a sense that they are taking more responsibility for the care of themselves and their families.

Third, public health and welfare education programs should be focused on increasing knowledge of healthy practices and lifestyles. There is abundant evidence that Americans across all income levels engage in a variety of unhealthy eating patterns and lifestyle choices. Education efforts should be stepped up across the board in an effort to dramatize and clarify the benefits of making healthier choices.

Finally, Texas should work at the federal level to change the delivery system for medical assistance to allow for the use of a sliding-scale to help bridge the gap between government-designed health plans and employer or individual health plans. Under such a plan, individuals could be allowed to gradually increase their contribution to cover the cost of their care as their income increased. This would be in contrast to the current system, in which benefits are fully subsidized as long as the recipient remains at or below the income allowable but, when that income exceeds the allowable by even a few dollars, he or she suddenly becomes fully responsible for underwriting the total cost of the family's health care needs. Such a sliding payment scale for low income patients is currently used by the University Health System in San Antonio (Bexar County Hospital District) with great results. Each year the hospital system recovers over $7 million from low income patients. This represents 10 percent recovery of tax supported hospital costs.

The above policy suggestions represent just a few examples in a broad range of possibilities that should be explored in an effort to improve the efficiency and affordability of health care in Texas, as well as nationwide. Time is running out for conservative, market-based solutions to be developed and tested in the real world in a way that would demonstrate their merit. The convergence of renewed medical inflation and run-away demographics will soon force the issue on a playing field where, up to now, advocates of increased government subsidies and socialized medicine have held most of the cards and controlled the debate. Policy-makers, public policy organizations and grass-roots groups must begin now to call for these alternative ideas to be given a fair and thorough evaluation, and be

willing to take responsibility for following through on every opportunity to take even small steps in a direction that is more responsible than the one in which we are now headed. If such initiatives are not pursued immediately, better and wiser solutions may soon be out of our reach.

Kathi Seay is the former executive director of the Texas Conservative Coalition (TCC) and the Research Institute (TCCRI). The TCC and the TCCRI is committed to shaping public policy through a principled approach to government. The organization was founded on the conservative principles of limited government; individual liberties; free enterprise; and traditional family values and is dedicated to the education of the general public and elected officials at all levels of government on the benefits of the application of those principles.