Health Care

Contents

FACTS ABOUT HEALTH CARE IN TEXAS

Who is Uninsured in Texas & Why?

- Texas' uninsured rate of 21.5 percent far exceeds the national average of 14 percent. The uninsured population now exceeds 4 million.

- Of Texas' more than 4 million uninsured, about 1.3 million are in families with incomes more than 2.5 times the federal poverty level. That is just over $44,000 for a family of four. For many of these families, the absence of health insurance is likely due to a lack of perceived *need* for insurance, rather than a lack of *means* to purchase it.

- An estimated 1.6 million Texans ages 18 to 34 lack health coverage. This is just over one-third of the total uninsured population in Texas. Since young people are typically healthy, they often c*hoose* to forgo health insurance when it is not provided by their employer.

- Of the 1.3 million uninsured children in Texas, an estimated 1 million are eligible for, but do not participate in, Medicaid and the State Children's Health Insurance Program (SCHIP). While some parents do not realize their child is eligible for SCHIP, many others choose not to participate in the program because of the stigma attached to welfare, or because they do not have an immediate need for health care services.

Health Insurance Mandates

- Despite political appeal, mandating that health insurance companies provide, or that a consumer purchase, certain health care benefits creates the unintended consequence of increasing the number of uninsured.

- With every mandated benefit, the cost of insurance rises. Thus, by imposing mandates, lawmakers essentially tell some workers that if they cannot afford top-notch insurance, they cannot have any insurance at all.

- According to a 1999 study by Baylor University economists, Texas imposed 63 mandates on group health insurance plans, individual health insurance policies, or health maintenance organizations.

Texas' Duplicative Health Care Bureaucracy

- More than 40 percent of the health care services delivered in Texas in 1998 was publicly funded. That year, taxpayers invested $29.6 billion in various federal, state, and local public health programs, many of which provide duplicative services.

- According to the Texas Comptroller, 14 Texas Health and Human Service agencies employ more than 52,700 people and administer more than 200 programs.

Medicaid

- The state budget stands at $114 billion. Of this amount, $35 billion is dedicated to spending on health and human services. Of the $35 billion, approximately $27 billion will be spent on Medicaid (and it is very likely that this number will be much higher).

- Medicaid covered more than 2.7 million people in 2001, paid for approximately one half of all births in the state of Texas, and covered part or all of 70 percent of the total number of nursing home stays in the state.

- Medicaid provides a benefit package so rich that it is, quite literally, impossible to buy a comparable plan on the private market because it would cost so much.

- Some experts in the state estimate that fraud eats up 30 cents of every Medicaid dollar spent and costs Texas taxpayers an estimated $4 billion per year.

Teacher Health Insurance

- Of the state's 1,041 school districts, 1,024 of them offer employee health benefits; only 17 do not.

- The new Teacher Health Insurance program will cost an estimated $1.24 billion in its first year of existence. Since the program begins in the second fiscal year of a two-year budget, program costs will, at the very least, be double in the next biennium.

- The program will be administered by the same Teacher Retirement System that will require an additional $6.9 billion or face fiscal insolvency in the coming decade.

Medical Malpractice

- Texas was recently evaluated by corporate America as one of the least fair and reasonable litigation environments in the country. States were graded on ten key elements, and Texas ranked worse than 40th in all areas.

- More than half of all Texas physicians had claims filed against them in 2000, almost double the national average.

- The legal environment directly affects physician and overall health care costs. Fearing malpractice lawsuits, physicians often order unnecessary medical tests as protection. Skyrocketing judgments and settlements are also paid by physicians who pass their costs on to consumers.

WHO IS UNINSURED IN TEXAS & WHY?

The Issue:

More than one in five Texans lacks health insurance. The uninsured in Texas exceed 4 million and represent a diverse cross-section of the state's population.

In the Lone Star State, more than 4 million lack health insurance coverage, or every fifth Texan, even though the vast majority of the uninsured is employed. In addition to this staggering statistic, both the nation and state are facing a recession, with many Texans losing both their jobs and employer-sponsored health care coverage; state budget coffers are drying up; and many employers are no longer able to pay ever-increasing health insurance premiums for their employees. There is broad concern from both sides of the aisle on several fronts:

- Texas' uninsured population now exceeds 4 million – and is likely to grow in the current economic recession.[1]
- Texas' uninsured rate of 21.5 percent far exceeds the national average of 14 percent.[2]
- Almost three out of ten Texas employers did not offer health care benefits in 1998.[3] Because this leaves those employees to purchase health care on their own with "more expensive" after-tax dollars, they frequently forgo health insurance altogether.

If these trends continue, lawmakers will soon be forced to confront these important issues. That is why it is essential for lawmakers and the public to understand why many of their recent reform efforts are not only inconsistent with promoting health care access, choice, and affordability, but that many of their approaches will make the problem worse.

The Uninsured: Who is Uninsured and Why?

Workers. Because health care is most often employer-based, work status is an important determinant of insurance status. Those who work full-time, year-

[1] U.S. Census Bureau, "Health Insurance Coverage by State for All People: 2000" Revised December 10, 2001.

[2] Ibid.

[3] Derived from Medical Expenditure Panel Survey data in Texas Department of Insurance, State Planning Grant Division, "Texas State Planning Grant Interim Report," October 2001, Table 2.1A.1, p. 15.

round are far more likely to have insurance than those who do not or who are self-employed.

While it is reasonable to assume that wealth and income also determine insurance status, it is important to recognize that this is not necessarily the case. Of Texas' more than 4 million uninsured, about 1.3 million are in families with incomes more than 2.5 times the federal poverty level (Figure 1).[4] That is just over $45,000 for a family of four. For many of these families, the absence of health insurance is likely to be due to a lack of perceived need for insurance, and would not usually preclude their purchase of health services when needed.

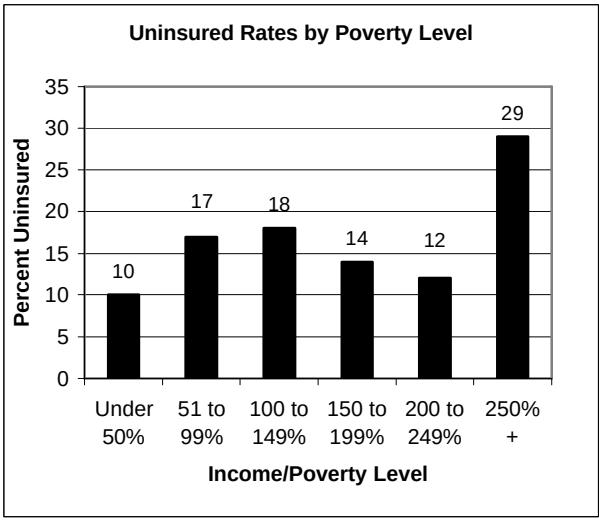

Figure 1
Source: Texas Department of Insurance, State Planning Grant Division, "Texas State Planning Grant Interim Report," October 2001, Table 1.2.2, p. 7.

Immigrants. Of Texas' uninsured population, about every 1 in 5 is a non-U.S. citizen. Health care economist Merrill Matthews cites U.S. Bureau of the Census data to explain that a lack of health insurance can be closely tied to immigrant status where non-citizens are far less likely to have coverage than the native-born population.[5] The same pattern is being observed in Texas where the uninsured rate for non-citizens is much higher than the rate for citizens.

According to the Texas Department of Insurance, the uninsured consist of approximately 21 percent native U.S. citizens, 31 percent U.S. naturalized citizens, and 56 percent those who are not U.S. citizens.[6] While this lack of insurance may be due in part to income, other factors such as culture, unfamiliarity with the insurance system, aversion to public welfare programs such as Medicaid, and use of alternative medical treatments may contribute to being voluntarily uninsured.

Young Adults. An estimated 1.6 million Texans ages 18 to 34 lack health coverage.[7] This is just over one-third of the total uninsured population in Texas. Since health insurance is virtually owned by employers, not employees, this fact should come as no surprise – especially for people in this age group.

A large segment of today's young workers are employed in temporary service jobs and in the restaurants sector where many of the employers do not provide

[4] Texas Department of Insurance, p. 7.

[5] Merrill Matthews, "Is There an 'Uninsured Children's Crisis?" National Center for Policy Analysis, Brief Analysis No. 217, December 20, 1996, p. 2.

[6] Texas Department of Insurance, p. 11.

[7] Texas Department of Insurance, p. 8.

health care benefits. For many of these workers, purchasing health care on their own, with after-tax dollars, can be prohibitively expensive. At the same time, workers in this age group are typically healthy. Thus, it is understandable that forgoing health insurance is a natural option for young people.

Children. Although welfare advocates and the media portray a health insurance crisis among poor and low-income Texas families, most uninsured children qualify for, but do not enroll in, existing government programs, or they live in households with moderate to high incomes.

Of the 1.3 million uninsured children in Texas, an estimated one million are eligible for, but do not participate in, Medicaid and the State Children's Health Insurance Program (SCHIP).[8] While some families do not realize their child is eligible, many families choose not to participate because they are concerned about the stigma attached to welfare, or do not have an immediate need for health care services.

It is important for lawmakers to recognize that a lack of health insurance does not preclude children from receiving health care services. For example, undocumented immigrants and legal immigrants are eligible for state-provided emergency health care services. Moreover, even when a child derives healthcare benefits from a federal program such as Women, Infants, and Children (WIC), a state public health initiative funded by federal block grants, or private charities, the child remains technically uninsured. In fact, one study estimates that uninsured children receive about 70 percent of the outpatient services that insured children do, and up to 85 percent of the inpatient care.

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[8] Texas Department of Insurance, p. 13. It must be noted that these eligible children, although not participating, are technically insured. In the event of a medical emergency, they will be automatically enrolled in these programs.

HEALTH INSURANCE MANDATES

The Issue:

Although well-intended, health insurance mandates increase employer and consumer costs and increase the number of uninsured.

Despite political appeal, mandating that health-insurance companies provide, or that a consumer purchase, certain health care benefits creates the unintended consequence of increasing the number of uninsured. With every mandated benefit, the cost of insurance rises. Thus, by imposing mandates, lawmakers essentially tell some workers that if they cannot afford top-notch insurance, they cannot have any insurance at all.

State laws requiring that certain treatments and procedures be included in health insurance coverage have emerged as a trend. Under the federal Employee Retirement Income Security Act of 1974 (ERISA), businesses providing health coverage for their employees through a company-financed plan, also called self-insured plans, are exempt from state insurance regulations. As such, state-mandated health benefits apply to those who are the most vulnerable to increasing costs: the group market and individual markets, typically smaller businesses and individuals purchasing health care on their own.

For some businesses, the cost of providing mandated benefits leaves them with a difficult decision: cut other health care benefits, cut other fringe benefits or cash wages, or drop the health benefit altogether. Individuals face similar decisions.

Health mandates harm individuals who purchase health care on their own or who purchase health care for other family members through their employers. Evidence shows that, as the cost of health care coverage rises, young people and people with low incomes are the first groups to drop coverage for themselves and their family members.

While there is disagreement among academics regarding the number of uninsured that will result from each additional health mandate, there is virtually no disagreement that the number of uninsured will increase as a direct result of imposing them. In 1996, the American Legislative Exchange Council (ALEC) analyzed the impact of state mandates on Florida, New York, and Washington and concluded that efforts to provide more affordable and accessible health insurance through regulation has been "disastrous."[1] Another 1996 study found that the number of uninsured in the 16 most

[1] Kristin Becker and Greg Scandlen, "Lessons from the States: An Overview of Government Mandated Health Care Reforms in Three States: Florida, New York, and Washington," The State Factor, vol. 22, no. 4, July 1996.

regulated states increased at eight times the rate of the 34 lesser-regulated states between 1990 and 1996 (Figure 1).

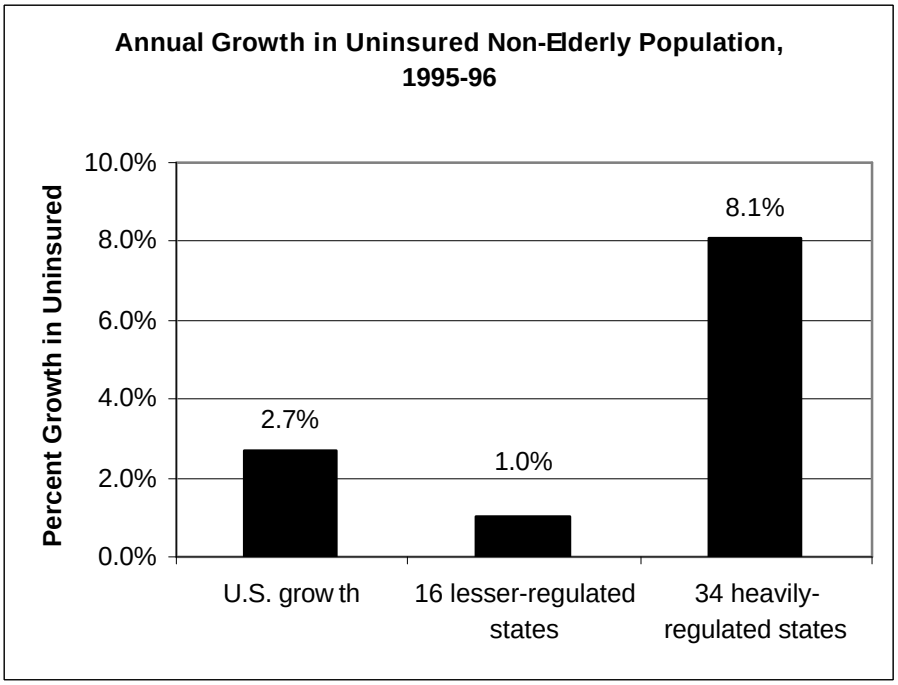

Figure 1
Source: Melinda L. Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Heritage Foundation Backgrounder, no. 1211, August 14, 1998, p. 17.

According to a 1999 study by Baylor University economists, Texas imposed 63 mandates on group health insurance plans, individual health insurance policies, or health maintenance organizations (Table 1). The study, commissioned by the Texas Association of Business,[10] estimated that about 275,000 Texans lacked health insurance because of these mandates.

The Baylor study estimated that mandates add slightly more than 17 percent to the cost of premiums and that wages for employees with traditional insurance coverage are 3 percent lower than they would be without mandates. The study also notes that if national patterns hold in Texas, an estimated 18 percent of Texas firms will choose to self-insure because of mandates.

[10] J. Allen Seward and James W. Henderson, "Report on the Cost of Health Care System Mandates," Texas Association of Business and Chambers of Commerce Report, January 1999, p. 25.

Table 1
Texas Health Insurance Benefit Mandates
(as of January 1, 2000)

	Group Health Insurance Policies	Individual Health Insurance Policies	Health Maintenance Organizations	Mandates that benefit must be offered**
Mandates Access to Specialty Treatment Facilities:				
Chemical Dependency Treatment Facilities	×			
Crisis Stabilization Units & Residential Treatment Centers for Children& Adolescents	×		×	
Direct Access to Services of Obstetrician/Gynecologist	×	×	×	
Psychiatric Day Treatment Facilities	×		×	
Public Institutions		×		
Mandates Access to Practitioners:				
Podiatrists	×	×	×	
Optometrists	×	×	×	
Chiropractors	×	×	×	
Dentists	×	×	×	
Audiologists	×	×	×	
Speech-Language Pathologists	×	×	×	
Master Social Workers	×	×	×	
Dieticians	×	×	×	
Professional Counselors	×	×	×	
Psychologists	×	×	×	
Marriage and Family Therapists	×	×	×	
Chemical Dependency Counselors	×	×	×	
Hearing Aid Fitters and Dispensers	×	×	×	
Psychological Associates	×	×	×	
Occupational Therapists	×	×	×	
Advanced Practice Nurses	×	×	×	
Physician Assistants	×	×	×	
Mandates Coverage for Specific Diseases, Medical Conditions or Services:				
Chemical Dependency (drug and alcohol)	×			
Childhood Immunizations	×	×	×	
Diabetes	×	×	×	
Home Health	×			×
HIV, AIDS & HIV-Related Illnesses	×	×		
In-vitro Fertilization	×			×
Mammography Screening	×	×		
Mastectomy Hospital Stays & Reconstructive Surgery	×	×	×	
Maternity Benefits		×		
Maternity Stay	×	×	×	
Mental Health	×			×
Oral Contraceptives	×	×	×	

Table 1
Texas Health Insurance Benefit Mandates
(as of January 1, 2000)

	Group Health Insurance Policies	Individual Health Insurance Policies	Health Maintenance Organizations	Mandates that benefit must be offered**
Phenylketonuria	×		×	
Pre-Existing Conditions Upon Replacement	×			
Pregnancy Benefits		×		
Pregnancy Complications	×	×		
Prostate Tests	×	×	×	
Serious Mental Illness	×			×
Speech & Hearing	×			×
Telemedicine	×	×	×	
Temporomandibular Joint (TMJ)	×	×	×	
Transplant Donors		×		
Mandates Coverage of Specific Persons				
Adopted Children	×	×		
Certain Grandchildren	×	×		
Continuation of Coverage after Divorce		×		
Continuation of Coverage for Certain Dependents	×			
Continuation of Coverage During Labor Disputes	×			
Handicapped Dependent	×			
Newborn Children	×	×	×	

****Mandated offerings are benefits that HMOs and insurance companies must offer, but group policyholders (including employers or organizations sponsoring a group policy) do not have to include in their health plans**.

Source: Texas Department of Insurance, "Accident and Health Insurance: Texas Mandated Benefits / Offers / Coverages," January 1, 2000 and J. Allen Seward and James W. Henderson, Report on the Cost of Health Care System Mandates, Texas Association of Business and Chambers of Commerce Report, January 1999 as cited in Carole Keeton Rylander, Texas Comptroller of Public Accounts, "Recommendations of the Texas Comptroller," December 2000.

A Milliman & Robertson study conducted for the Texas Department of Insurance (TDI) examined 13 mandates and estimated that they increased premium costs 7.6 percent for large group health insurance and 6.4 percent for small group health insurance.[11]

While these benefits are certainly appealing, they do not come without cost. Health mandates create "over-insurance" where individuals may actually receive health benefits that exceed what they would otherwise purchase on their own.

[11] Milliman & Robertson, Inc., Cost Impact Study of Mandated Benefits in Texas, Report to the Texas Department of Insurance, 2000.

In fact, health mandates force consumers to pay for benefits they may not even desire.

Finally, health mandates have made it "illegal" for individuals between jobs and workers who do not receive employer-based health insurance to purchase basic, low-cost policies that would protect against a catastrophic accident or illness. As a result, many are forced to forgo health insurance altogether.

Between 1984 and 1992, 17 states enacted laws to evaluate the impact of health insurance mandates. Another 13 required studies of mandated benefits starting in 1998. Seven states have adopted legislation requiring some type of impact statement before any new mandate can be adopted. Legislators in these states use the studies to debate whether to approve or modify new mandates.[12]

For example, the Maryland Health Care Access and Cost Commission hired a firm that specializes in health care financial estimates to study the financial, social, and medical costs of a series of mandates.[13] The Texas Teacher's Retirement System (TRS) also contracted with a consulting firm specializing in this kind of analysis to estimate the costs of proposed legislative changes, including health insurance mandates. Consultants such these also examine the social costs of mandates, including:

- ✯ the extent to which the service is generally used by a significant portion of the population.
- ✯ the extent to which insurance coverage already is generally available for the service.
- ✯ the extent to which inadequate coverage results in people avoiding necessary treatments.
- ✯ the level of public demand for the service.
- ✯ the level of support for inclusion of the service in group contracts.

To help reduce the cost of health insurance in Texas, lawmakers should require the Legislative Budget Board to conduct an analysis of the impact of proposed health insurance mandates. Such an analysis would provide vital information on the cost and need of mandates before they are promulgated.

Additionally, all new health insurance mandates should have a six-year "sunset" date. Every six years, the mandates would come up for review by the Legislative Budget Board to ensure they still make sense in light of current medical practice.

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[12] Texas Association of Business and Chambers of Commerce, Report on the Cost of Health Care System Mandates, pp. 39-40.

[13] Maryland Health Care Access and Cost Commission, Mandated Health Insurance Services Evaluation, by William M. Mercer, Inc. (Baltimore, MD, December 15, 1998), pp. 1-50.

THE HEALTH CARE BUREAUCRACY IN TEXAS

The Issue:

More than 40 percent of the health care services delivered in Texas in 1998 was publicly funded. That year, taxpayers invested $29.7 billion to finance the 28 bureaucracies in Texas which administer Medicaid, the Children's Health Insurance Program and numerous duplicative health service programs.

Rather than establishing a transparent, efficient health safety net, federal and state lawmakers have created, over the past several decades, multiple bureaucracies and duplicative programs that often fail to meet the needs and preferences of the patients they were designed to serve. The federal government operates more than 40 major health care programs. This is in addition to the numerous programs administered by state and local governments. In fact, most Texans might be surprised to learn that more than 40 percent of health services delivered in Texas is paid by taxpayer dollars. In 1998, federal, state, and local governments paid 43 percent of Texas' health care (Table 1).

Table 1
Public Health Care Spending in Texas: 1998

		Percent of Total Spending
Federal	$22,890,874,340	33.5
State	$5,595,313,580	8.2
Local	$1,174,355,126	1.7
Total	**$29,669,543,046**	**43.4**

Source: Carole Keeton Rylander, Texas Comptroller of Public Accounts, "Texas Health Care Spending," March 2001.

According to the Texas Comptroller, there are 35 major federal, state, and local health care programs and 28 bureaucracies operating in Texas (Tables 2 and 3). The state of Texas maintains 14 state Health and Human Service agencies that employ more than 52,700 people and administer more than 200 programs.

In contrast, the strong and vibrant charity care sector in Texas is often overlooked when seeking solutions. Programs and

services provided by the United Way, Shriners' Hospitals, and Children's Miracle Network Hospitals serve as powerful reminders that government approaches should not be presumed to hold a monopoly on compassion.

Table 2
Major Health Care Programs Operating in Texas

Program	Description
State Employee Health Insurance	Finances 50 percent of the total cost of health coverage for spouses and dependent children of all active and retired state employees enrolled in the plans. The remaining 50 percent is paid by the employee or retiree.
Public School Employee Health Insurance	Most school districts offer multiple health and life insurance plans. In general, school districts pay 85 percent and employees pay 15 percent of the health coverage premiums.
Workers' Compensation	State-regulated program that pays medical bills and replaces some lost wages for employees who are injured at work or who have work-related illnesses or deaths.
State Office of Risk Management (SORM)	Administers the workers' compensation program.
Medicare Expenditures	The federal government spent almost $12.6 billion in Texas under the Medicare program in fiscal 1998.
U.S. Department of Defense	Finances TRICARE, a medical program for active-duty members of the U.S. military, qualified family members, retirees and their family members and survivors.
U.S. Department of Health and Human Services	Administers health care spending programs through the Health Resources and Services Administration (HRSA), Centers for Disease Control (CDC) and Indian Health Services (I.H.S.) grants.
U.S. Department of Veterans Affairs	Provides hospital, nursing home, domiciliary care, and outpatient medical and dental care to eligible veterans.
Medicaid	Serves the poor, elderly, and people with disabilities and is financed by both state and federal subsidies. In fiscal 1998, the match was 62 percent federal and 38 percent state.
Texas Department of Health Medicaid Acute Care Programs	Responsible for Medicaid acute care services, the Vendor Drug program, Medicaid Family Planning, Medicaid Medical Transportation, Texas Health Steps and the Medically Dependent Children Program.
Texas Department of Human Services Medicaid Long-Term Care Program	Includes nursing facilities and community care programs.

Table 2 Major Health Care Programs Operating in Texas	
Program	**Description**
Texas Department of Mental Health and Mental Retardation Medicaid Expenditures	The Texas Department of Mental Health and Mental Retardation, Community Mental Health and Mental Retardation Centers and State-Operated Community Services purchased Medicaid services in 1998.
Other State Agency Medicaid Programs	The Texas Department of Protective and Regulatory Services (DPRS), Texas Rehabilitation Commission (TRC), and the Texas Interagency Council on Early Childhood Intervention (ECI) purchased Medicaid services in 1998.
Medicaid Disproportionate Share Hospital Program	Provides Medicaid financial assistance to hospitals that care for large numbers of patients who do not have health insurance.
Texas State Teaching Hospitals	Provide inpatient and outpatient care.
Texas Department of Mental Health and Mental Retardation Residential Mental Health Programs	Provides inpatient hospitalization for people with severe mental illness needing both short-term and long-term intensive treatment.
Texas Department of Mental Health and Mental Retardation Residential Mental Retardation Programs	Operates 11 state schools which provide residential care to people with mental retardation.
Texas Department of Mental Health and Mental Retardation Community Mental Health Programs	Provides Community Mental Health and Mental Retardation Centers (CMHMRCs) and State-Operated Community Services (SOCS), community hospitals, and private providers.
Texas Department of Mental Health and Mental Retardation Community Mental Retardation Programs	Provides individual needs assessment, living support, vocational training, and other community services for people with mental retardation
Texas Department of Health Non-Medicaid Expenditures	Provides health-related services and administers a wide variety of non-Medicaid programs, including maternal and child health, family planning, breast and cervical cancer control, special supplemental nutrition for the Women, Infants and Children (WIC) program, immunizations, dental care, primary health care, indigent care, and a variety of programs related to a specific disease.
Texas Department of Criminal Justice Inmate Health and Psychiatric Care Program	Operates 113 correctional facilities housing 130,000 inmates.
Texas Department of Criminal Justice Private Prison Facilities Health Care Program	Contracts with correctional corporations to incarcerate approximately 16,000 inmates.
Texas Department of Human Services Non-Medicaid Expenditures	Provides health-related services for the poor, elderly and people with disabilities. These programs include community care, in-home and family support, and other support services.
Texas Rehabilitation Commission Non-Medicaid Expenditures	Purchases several types of rehabilitation services for people with disabilities.

Table 2 Major Health Care Programs Operating in Texas	
Program	**Description**
Texas Youth Commission	Serves youthful offenders who are 10 to 21 years of age; purchases medical services for its institutions and halfway houses.
Texas Commission on Alcohol and Drug Abuse	Provides chemical dependency prevention and treatment services through contracted vendors and other state agencies.
Texas Commission for the Blind Independent Living and Rehabilitation Programs	Provides comprehensive rehabilitation services to blind or visually impaired residents of Texas.
Texas Juvenile Probation Commission	Provides training, technical assistance, monitoring, and partial funding for county juvenile probation departments.
Texas Department of Protective and Regulatory Services Substitute Care and Protective Services Health Programs	Provides financial assistance to children, other adults, and people with disabilities for substitute care and protective services.
Texas School for the Deaf Classroom, Residential, and Extended Year Services	Provides academic, vocational, and life skills education and training to deaf and multi-handicapped deaf children across the state.
Texas School for the Blind and Visually Impaired School Health Program	Provides visually impaired students and often those with multiple disabilities age 6 to 21 with a solid education.
Hospital District Property Taxes	Texas' hospital districts levied approximately $730 million in 2001. Of that total, more than $561 million came from Bexar ($104 M), Dallas ($171 M), Harris ($158 M), and Tarrant ($128 M).
Local Health Departments	Provide an array of public health services, including maternity, family planning, child health services, sexually transmitted disease (STD) detection and control, HIV testing, tuberculosis control, and immunizations.
Federally Qualified Health Centers	Provide health care to low-income people in medically underserved areas.
Children's Health Insurance Program	Helps families purchase insurance through managed care organizations for children under age 19.
Source: Carole Keeton Rylander, Texas Comptroller of Public Accounts, "Texas Health Care Spending," March 2001.	

Table 3 Federal, State & Local Health Care Bureaucracies in Texas	
1	Employees' Retirement System of Texas
2	Texas school districts and public school employees
3	State Office of Risk Management
4	Medicare
5	U.S. Department of Defense

Table 3 Federal, State & Local Health Care Bureaucracies in Texas	
6	U.S. Department of Health and Human Services
7	U.S. Department of Veterans Affairs (VA)
8	Medicaid
9	Texas Department of Health
10	Texas Department of Human Services
11	Texas Department of Mental Health and Mental Retardation
12	Texas Department of Protective and Regulatory Services
13	Texas Rehabilitation Commission
14	Texas Interagency Council on Early Childhood Intervention
15	University of Texas System
16	Community Mental Health and Mental Retardation Centers
17	State-Operated Community Services
18	Texas Department of Criminal Justice
19	Texas Youth Commission
20	Texas Commission on Alcohol and Drug Abuse
21	Texas Commission for the Blind
22	Texas Juvenile Probation Commission
23	Child and Family Services
24	Texas School for the Deaf
25	Texas School for the Blind
26	Local Health Departments
27	Federally Qualified Health Centers
28	Children's Health Insurance Program
Source: Carole Keeton Rylander, Texas Comptroller of Public Accounts, "Texas Health Care Spending," March 2001.	

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MEDICAID: CRISIS AND SOLUTIONS

The Issue:

The Medicaid program was a $27 billion state budget expenditure in Texas in 2001-2002. Although reform is sorely needed on the federal level, there are also actions that can be taken on the state level to control program costs and provide essential health services to those most in need.

At the beginning of the 2001 Legislative Session, there was much wailing and gnashing of teeth about how Texas would have to "tighten its belt" and emerge with what would surely be the leanest budget in years. As it turns out, "tightening" the state's belt meant increasing the budget to $114 billion, an increase of $16 billion from the previous budget.

Nationwide, many states are reporting that budget surpluses are gone and that health care costs are driving their budgets. While each state has its own unique budget system and budget woes, there is one common thread – Medicaid. Texas is no exception.

As mentioned above, the state budget stands at $114 billion. Of this amount, $35 billion is dedicated to spending on health and human services. Of the $35 billion, approximately $27 billion will be spent on Medicaid (and it is very likely that this number will be much higher). When people in Austin talk about spending on health and human services, they are really talking about Medicaid.

Medicaid is, as Texas House Appropriations Chairman Rob Junell has said, the "900-pound gorilla" (as opposed to the 800-pound one) in every state's budget. Most people have heard of Medicaid and know that it provides health care to the poor and to the elderly. However, few people really have a working knowledge of the program. The health and human services arena has been described as one in which the boring meets the complex. Medicaid is the actualization of this idea.

What Is Medicaid?

What, exactly, is Medicaid? Why should anyone care about Medicaid? Whom does it cover? Why does it cost so much? What is driving the program's costs? Can Texas do anything to improve it?

The answer to why people should care about Medicaid is simple: If the state of Texas does not do something during the next legislative session to control Medicaid program costs, there will almost certainly be a tax increase.

Medicaid is basically a government-run health insurance program for the poor, the elderly, and the disabled. It began in the late 1960s as part of the continuing "War on Poverty," and it operates as a state-federal partnership. Loosely defined, "partnership" means the federal government tells Texas what it must cover, and the state then pays its share of the program.

To get an idea of the size and scope of the program in terms of people rather than dollars, consider that Medicaid covered more than 2.7 million people in 2001, paid for approximately one half of all births in Texas, and covered part or all of 70 percent of the total number of nursing home stays in the state.

Medicaid is an entitlement program. That means that if someone is eligible for Medicaid services, the state must cover that person regardless of whether or not it has the money to do so. Eligibility for Medicaid is based upon age, income as a percentage of the Federal Poverty Level (FPL), assets, and disability. Eligibility levels in Texas are as follows:

- Pregnant Women and Infants (185 percent of the FPL)
- Children ages 1-5 (133 percent of the FPL)
- Children ages 6-15 (100 percent of the FPL
- Parent with TANF Children (17 percent of the FPL). TANF – Temporary Assistance for Needy Families – is the state's welfare system.
- SSI, Aged and Disabled (73 percent of the FPL)
- Long-Term Care (223 percent of the FPL)

In 2001, the FPL was $17,650 for a family of four.

While the majority of Medicaid enrollees are children, they are also the least expensive to cover. The aged and disabled, on the other hand, make up a smaller portion of the overall caseload but are much more costly to cover.

Why Is Medicaid So Expensive?

As mentioned earlier, both the state and the federal government pay for Medicaid. The federal government's contribution or Federal Matching Assistance Percentage (FMAP) is determined by comparing each state's economy to the national average. States are obligated to pay the remaining percentage. In Texas, the federal-state ratio hovers right around 60/40. However, it is important to note that a small change in the state's FMAP can result in a substantial amount of money being lost or gained.

There are a number of reasons that Medicaid costs so much. First, Medicaid covers two groups of people who are in the most need of expensive health care treatment and services – the elderly and disabled. While the elderly and disabled constitute only about 25 percent of the overall Medicaid population, they ac-

count for nearly 70 percent of the program's costs.

Second, Medicaid covers a lot of people who live in Texas. As mentioned earlier, Medicaid covered more than 2.7 million people in 2001, well over 10 percent of the State's population.

Third, Medicaid provides a benefit package so rich that it is, quite literally, impossible to buy a comparable plan on the private market because it would cost so much.

Fourth, fraud is a huge cost driver in Medicaid. Some experts in the state estimate that fraud eats up 30 cents of every Medicaid dollar spent and costs Texas taxpayers an estimated $4 billion per year.

Finally, Medicaid is not immune from the unlegislated laws of economics. Medicaid recipients pay nothing for services. There are no co-payments, premiums, or cost-sharing requirements whatsoever. At zero cost, demand for service tends to run high.

Health care costs nationwide are rising, and Medicaid, despite the government's efforts to the contrary, is not immune. Whether rationing takes place in the form of higher costs or fewer services, something is likely to happen.

Currently, the major cost drivers in Medicaid are increased caseloads, the caseload mix (more pregnant women and more disabled), increased usage and cost of pharmaceuticals, and a lower FMAP (federal portion of costs).

Why Care About Medicaid?

On a day-to-day basis, very few people should care about Medicaid. In a larger sense, we need to care about Medicaid because it does affect all of us.

Health care costs have skyrocketed in the United States since the advent of Medicaid and Medicare. Everyone is affected by the rising costs of health care. Business owners may drop coverage; many people may choose to go without insurance coverage due to prohibitive costs; emergency rooms are forced to tend to the uninsured; and increased health care costs take away from a family's ability to provide other needs.

Medicaid has become an increasing portion of the state's budget, and the specter of an income tax or major tax increase to pay for these costs is very real. Medicaid, in a very real way, affects our health care system adversely while imposing huge costs upon real people.

Recommendations

- **Medicaid needs a realistic sliding scale to determine eligibility.** Texas provides the richest benefit package known to man to those who qualify for Medicaid, but if recipients cross the income threshold by $1, they lose their benefits altogether. Is it that ridiculous to suggest that people should pay more for their own health care as their income grows?

- **The benefit package in Medicaid needs to match the real world.**

Medicaid pays for anything and everything, while most private insurance caps benefits or refuses to cover certain services. The Bush Administration recently unveiled a new waiver option that allows states to scale back Medicaid benefit packages in certain cases. Whether or not Texas can take advantage of this program remains to be seen.

- **"Block grant" Medicaid to the states.** As recently as 1993, this idea was actually being discussed. The argument that states lack the technical expertise to run these programs may have been true 20 years ago. Today, however, states are the ones responsible for running Medicaid and have proven through welfare reform that we can do it better than the federal government. Texas is a border state with a vastly different population than a state like Minnesota, yet Texas lives under the same rules.

- **Take a closer look at what Medicaid does.** Arguing that government should pay for health care for the poor and disabled should not give the federal government license to micro-manage an entire health care system. It is an argument (if we accept the premise that we should do it at all) to give people money or a tax credit to purchase coverage. Bill Bradley suggested such an idea during his 2000 presidential campaign and nearly got lynched by his own party. That means the idea must have some merit.

- **Texas should implement and administer the market-oriented consumer choice plan using a defined contribution approach.** In a defined contribution program, costs and eligibility are constant and benefits are variable. A variant of this approach has been used in the 40-year-old Federal Employees Health Benefit Program (FEHBP), a popular and successful program that covers Members of Congress, congressional staff and about nine million federal workers and retirees. In contrast to the Medicaid program, FEHBP provides high levels of patient satisfaction at a controllable cost.[14] Medicaid consumers could purchase personal insurance from a variety of state approved plans (including medical savings accounts, fee-for-service and managed care) through an independent broker. Since these policies would be personally owned, they would be fully portable to the private sector.

- **Texas should apply for Section 1115 waivers under HIFA to implement a pilot research program**. If the Congress is unwilling or unable to reform the Medicaid program, then state officials should take the lead. They can accomplish on health care reform what then-Governor Tommy Thompson accomplished on welfare reform. State officials could apply to the federal government's Centers for Medi-

[14] Carrie J. Gavora. "Medicare Minus Choice," Heritage Foundation Backgrounder, No. 1218, September 1, 1998, pp 4-5.

care and Medicaid Services (CMS, formerly the Health Care Finance Administration or HCFA) for a section 1115 waiver to implement the reforms outlined here. If CMS blocked innovative attempts to expand and improve health insurance coverage for low-income people, the very conflict itself would raise the profile of state officials and help them to frame a new national health care debate on their own terms. Using the new HIFA initiative should help in this process.

There are some restrictions on the use of the Medicaid waiver. But essentially a state can change all benefits in eligibility and reimbursement rules with a few exceptions. If CMS officials can overcome their institutional bias against consumer choice reforms that rely on private sector alternatives and can be convinced of the value of the research project, and states ensure budget neutrality to the federal government, the Medicaid waiver could be granted. The consumer-based model, as opposed to the regulatory models that CMS has supported in places like Tennessee and elsewhere, is certainly worthy of serious research. And because it is a defined contribution program, budget neutrality can be assured.

- **Rather than pursuing fraud on a large-scale, policymakers should instead focus on consumer-driven reforms where the Medicaid patient, for example, has the responsibility and incentive to prioritize his own health care needs and preferences.** After all, it is far more difficult to defraud a consumer with a vested interest in the transaction.

These reforms certainly do not constitute a comprehensive list of the improvements we could make to Medicaid, but they are a starting point. It is going to take time, patience, and, most importantly, the energy of conservatives and the willingness of people to demand that their state representatives, state senators, governor, U.S. senators, and congressional representatives pay attention to this matter.

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Excerpted from "The Medicaid Problem in Texas," State Rep. Arlene Wohlgemuth (R-Burleson), VERITAS, Texas Public Policy Foundation, January, 2002. Also adapted from "The State Factor: Abolishing the Medicaid Ghetto: 'Putting Patients First,'" by Richard Teske, American Legislative Exchange Council, April 2002, available from the American Legislative Exchange Council, 910 17th Street, N.W., Washington, D.C. 20006, (202) 466-3800, http://www.alec.org.

MEDICAL SAVINGS ACCOUNTS & DEFINED CONTRIBUTION PLANS

The Issue:

One-size-fits-all, top-down government solutions to health care have been unsuccessful in the Lone Star State. Texas lawmakers should adopt innovative options in all state public health care programs and to all state employees that offer patient choice, control and flexibility in meeting consumers' individual health care needs and preferences.

Medical Savings Accounts

One of the most promising innovations in health coverage is the Medical Savings Account (MSA). MSAs combine a high-deductible catastrophic insurance policy (to pay for high cost or "catastrophic" health care expenses) with an individually owned savings account (to pay routine medical expenses). By allowing consumers to directly pay for medical expenses up to a specified deductible level and accumulating any unspent funds for future years, consumers have an incentive to spend their funds wisely - because they are spending their own money.

Moreover, expenses paid out of the medical savings account would entail no insurance administrative cost. Insurance is a very inefficient way to pay for small or routine health expenses. It costs approximately as much to process a $50 claim as it does to process a $50,000 claim. MSAs would cut insurance companies out of the majority of health care transactions, thereby reducing both the overall cost of health care and the paperwork burden on doctors.

Other Advantages of MSAs

1. **Restoring the doctor-patient relationship.** Bureaucratic efforts to control costs are increasingly interfering with the doctor-patient relationship. With MSAs, patients and doctors would be encouraged to mange care and would probably do a much better job.
2. **Maintaining the quality of care**. Bureaucratic efforts to reduce costs are also threatening the quality of patient care. To the degree that patients are spending their own money, patients and doctors will make the decisions.
3. **Encouraging rationing by choice**. Unless someone makes the difficult choice between medical care and other uses of money, health care will be unaffordable for the employers as well as the majority of American workers. MSAs allow individuals, rather than large, im-

personal bureaucracies, to make those decisions.

4. **Creating a competitive marketplace**. Most patients cannot discover the price of routine procedures before entering a hospital and cannot read the bill when they are discharged. With MSAs, as with cosmetic surgery in the United States and privately paid surgery in England, a single-package price stated in advance would become the norm.
5. **Providing funds for preventive care**. MSAs would be a source of funds for services not covered by health insurance.
6. **Providing funds for health insurance premiums**. MSAs would provide funds to continue health insurance coverage when people are unemployed.
7. **Providing funds for long-term care.** MSA funds not spent during a person's working years would be available for long-term care, long-term care insurance, and other post-retirement medical needs not met by Medicare.
8. **Creating personal and portable employee benefits.** MSAs would be private property of the individual account holder. Their establishment would be a movement in the direction of a worthwhile social goal: making all employee benefits personal and portable.

The federal Health Insurance Portability and Affordability Act (HIPAA) of 1996 allowed for a four-year MSA demonstration project. MSAs received preferential federal tax treatment, where deposits and withdrawals for health care were made on a tax-free basis, and unspent funds could grow tax-free. The demonstration was re-authorized in late 2000.

Despite their promise, MSAs have not been an overwhelming success. Not only did Congress severely limit the number of available MSAs, Congress set several restrictions on their availability and design. They were only available to the self-employed and small employers (with fewer than 50 employees). Congress also set strict limits on deductible and contribution levels. While the original demonstration project expired on December 31, 2000, Congress extended MSAs for another two years.

Defined Contribution Plans

"Defined contribution" plans for health care are similar to 401(k) or 403(b) plans, where an employer might agree to contribute a specified dollar amount to an employee's private retirement plan. In the same way, employers could "cash out" their health care premium contributions, allowing the employee to purchase health care on their own.

Under this arrangement, employers could continue to sponsor health plan choices, but the employee would "shop" for the plan that best meets his or her needs and preferences. Under current tax law, an employer may extend the advantages of the current tax exclusion to defined contribution arrangements only when the employer pays an insurer directly.

While the employer may choose to reimburse employees for some or all of the health insurance premium expenses they incur when employees select health plans that are not sponsored by the employer, this defined contribution remains tax advantaged only if the employer makes premium reimbursement payments directly to the employee's insurer – without the money passing through the employee's hands.

Texas lawmakers should take these innovative approaches and them available in public health care programs and to all state employees. Promoting Medical Savings Accounts and Defined Contribution Plans will promote patient choice, control, and flexibility to public benefit recipients and employees – at a lower cost to Texas taxpayers.

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TEACHER HEALTH INSURANCE

The Issue:

Establishing medical savings accounts for school employees would lower the state's cost of the new Teacher Health Insurance program and give employees more flexibility in choosing physicians and health services.

One of the biggest challenges for lawmakers will be to pay for the newly created Teacher Health Insurance program. The same Teacher Retirement System that will require an additional $6.9 billion or face fiscal insolvency in the coming decade will administer this new program. The program will cost $1.24 billion in its first year alone. Since the program begins in the second fiscal year of a two-year budget, the program costs will, at the very least, be double in the next budget cycle.

Rather than providing direct assistance to the 17 school districts (of the 1041 school districts and 142 charter schools) that do not offer health insurance, lawmakers created a fiscal time bomb and are pushing a one-size-fits-all benefits package for these employees.

The law guarantees that at least $308.33 a month will be available to each employee (the plan covers all employees who work 20 or more hours per week): $75 per month in dedicated state aid to the employee's district, $150 per month in required local spending, plus another state contribution of $1,000 a year, or $83.33 a month.

The state will provide $1,000 per year ($83 a month) for each active school employee that may be used to pay for additional employee coverage, dependent coverage, or taken as compensation, depending on the employee's choice. This will be paid regardless of whether the employee participates in the state program or a local district insurance program. All districts will receive an additional monthly contribution from the state of $75 per employee.

Districts must contribute at least an additional $150 per active employee per month for the employee's coverage that may be, in some cases, funded by state supplemental assistance.

Given the wide array of innovative and consumer-driven insurance options that are currently available in Texas, it is surprising that Texas lawmakers opted for this one. While insurance premium rates have not been revealed under the new plan, the state's benchmark plan, HealthSelect, is a point-of-service plan. The state pays $250 per month for employee-only coverage. For the family plan, the state pays $487 of the $725 monthly premium, and the employee pays $238. While this state program is not financially stable, it is being used as the benchmark plan that is now imposed

is now imposed on school districts across the state (and soon on Texas taxpayers).

Beginning September 1, 2002, school districts with 500 or fewer employees will be required to participate in the new active public school employee health care risk pool unless they are already participating in a similar risk pool or are self-insured providing similar benefits and opt not to participate.

Districts with 501 to 1,000 employees on January 1, 2001 may elect to join the program in 2002. Districts with more than 500 employees will be required to join the program as of September 1, 2005, unless they are already providing similar insurance coverage.

Cost-Effective Alternatives

The new Teacher Health Insurance Program mandates that districts participate in the insurance pool or an equivalent plan. It is believed that pooling will enable the state to obtain more favorable rates. While this is often true, a better approach to reducing overall health plan costs is to put the employees in charge of first-dollar coverage. Not only does this reduce plan costs through lower premiums, it can also provide employees greater flexibility in selected health care services and choosing doctors.

For example, $5,000 will provide a self-employed Dallas-area family of four with a PPO or a tax-qualified MSA plan in the year 2000 (Table 1). (The "pass-through money" under the teacher plan is not tax-qualified and is, therefore, taxable.)

Table 1
Self-Employed Dallas-Area Premium Comparison, 2000

	Co-Pay Plan	MSA Plan
Annual Premium – Full PPO	$5,049.36	$2,684.64
MSA Deposit (100% tax deductible – employee may keep)	$0.00	$2,325.00

Source: Golden Rule Insurance Company, Lawrenceville, Il. January 6, 2000 as cited in Bunce, Council for Affordable Health Insurance.
Note: This comparison is for a self-employed, non-smoking family of four living in Dallas, TX.

While health insurance premium rates vary by age, it is almost inconceivable that a medical savings account approach would not provide comparable, if not superior coverage, at a lower cost to the state and the many small school districts. Here is one way the plan could be structured:

An annual premium of $3,700 ($308.33 per month) will more than cover the entire insurance premium for every employee age group. The plan deductible is $2,250 per year (Table 2).

But rather than spend $308.33 per month on every age group, districts could, for example, provide the equivalent premium contribution every month plus additional supplements that could defray the deductible down to $1,250 from $2,250 by contributing $1,000 into every employee's MSA account, or could be contributed to a family plan. Under the new law, districts and the state will be spending $3,700 per year for health care. Under the MSA approach, the annual cost to the district and state would range from $1,852 to about $3,424 per year for every female employee, depending on the

teacher's age (Table 3). Actuarial analysts estimate that one-quarter of employees reach their deductible level in any given year, so most employees would have unspent funds in their account at the end of the year that could accumulate in their accounts over time or could be used for health care expenses and family member premiums.

Table 2
SAMPLE TEXAS MSA -- MONTHLY PREMIUM RATES ($)

The Single-Party Deductible is $2,250; Multi-Party Deductible is $4,500

Rating Group	Age	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male	Under 30	62	55	53	50	47	42
	30-34	68	60	58	55	51	46
	35-39	75	66	64	61	56	51
	40-44	91	80	77	74	68	62
	45-49	112	99	95	91	84	76
	50-54	127	112	108	103	95	86
	55-59	172	151	146	139	129	117
	60-64	226	199	192	183	170	154
Single Female	Under 30	71	62	60	58	53	48
	30-34	82	72	70	66	62	56
	35-39	95	84	81	77	71	65
	40-44	111	98	94	90	83	75
	45-49	127	112	108	103	95	86
	50-54	154	136	131	125	116	105
	55-59	172	151	146	139	129	117
	60-64	202	178	172	164	152	137
Subscriber/Spouse	Under 30	112	99	95	91	84	76
	30-34	118	104	100	96	89	80
	35-39	132	116	112	107	99	90
	40-44	158	139	134	128	119	107
	45-49	190	167	162	154	143	129
	50-54	216	196	184	175	162	147
	55-59	280	246	238	227	210	190
	60-64	346	304	294	280	260	235
Subscriber/Child	Under 30	108	95	92	87	81	73
	30-34	119	105	101	96	89	81
	35-39	132	116	112	107	99	90
	40-44	148	130	126	120	111	101
	45-49	164	144	139	133	123	112
	50-54	191	168	162	155	143	130
	55-59	209	184	178	169	157	142
	60-64	263	231	224	213	197	179
Subscriber/ 2Children	Under 30	146	128	124	11	110	99
	30-34	157	138	133	127	118	107
	35-39	170	150	145	138	128	116
	40-44	186	164	158	151	140	126

Table 2
SAMPLE TEXAS MSA -- MONTHLY PREMIUM RATES ($)

The Single-Party Deductible is $2,250; Multi-Party Deductible is $4,500

Rating Group	Age	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Subscriber/2 Children	45-49	202	178	172	164	152	137
	50-54	229	202	195	185	172	156
	55-59	247	217	210	200	185	168
	60-64	301	265	256	244	226	205
Subscriber/ 3+ Children	Under 30	183	161	156	148	137	124
	30-34	194	171	165	157	146	132
	35-39	207	182	176	168	155	141
	40-44	223	196	190	181	167	152
	45-49	239	210	203	194	179	163
	50-54	266	234	226	215	200	181
	55-59	284	250	241	230	213	193
	60-64	338	297	287	274	254	230
Family/Child	Under 30	149	131	127	121	112	101
	30-34	155	136	132	126	116	105
	35-39	169	149	144	137	127	115
	40-44	195	172	166	158	146	133
	45-49	227	200	193	184	170	154
	50-54	253	223	215	205	190	172
	55-59	317	279	269	257	238	216
	60-64	383	337	326	310	287	260
Family/2 Children	Under 30	187	165	159	151	140	127
	30-34	193	170	164	156	145	131
	35-39	207	182	176	168	155	141
	40-44	233	205	198	189	175	158
	45-49	265	233	225	215	199	180
	50-54	291	256	247	236	218	198
	55-59	355	312	302	288	266	241
	60-64	421	370	358	341	316	286
Family/3+ Children	Under 30	224	197	190	181	168	152
	30-34	230	202	196	186	173	156
	35-39	244	215	207	198	183	166
	40-44	270	238	230	219	203	184
	45-49	302	266	257	245	227	205
	50-54	328	289	279	266	246	223
	55-59	392	345	333	318	294	267
	60-64	458	403	389	371	344	311

Area 1: Zip Codes – 770, 772; **Area 2**: Zip Codes – 752, 753, 774, 775; **Area 3**: Zip Codes – 750, 751, 773, 776, 777; **Area 4**: Zip Codes – 754, 760, 761, 762; **Area 5**: Zip Codes - 755, 756, 757, 758, 759, 763, 764, 766, 767, 768, 769, 778, 779. 780, 782,783, 784, 785, 786, 787, 789, 791, 792, 793, 794, 795, 796, 797; **Area 6**: Zip Codes – 765, 781, 788, 790, 798, 799

Source: UNICARE Texas Individual MSA Monthly Rates.

Table 3 Sample Reform Plan For Teacher Health Insurance Program			
Age	**Annual Premium**	**$1,000 MSA Deposit**	**Total Cost**
Under 30	$852	$1,000	$1,852
30-34	$984	$1,000	$1,984
35-39	$1,140	$1,000	$2,140
40-44	$1,332	$1,000	$2,332
45-49	$1,524	$1,000	$2,524
50-54	$1,848	$1,000	$2,848
55-59	$2,064	$1,000	$3,064
60-64	$2,424	$1,000	$3,424
Source: Author's calculations derived from Table 3. These premium rates assume single females living in Area 1, the area in the state with the highest premium rates.			

In cases where medical underwriting (such as pre-existing conditions) prevents coverage at these rates, options such as medically-adjusted premiums or the state risk pool might provide alternative options. Approaches that put consumers in charge of first-dollar coverage not only benefit state and district coffers, they also give employees more direct control over their health care decisions.

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MEDICAL MALPRACTICE

The Issue:

More than half of all physicians in Texas had claims filed against them in 2000. A properly-functioning legal system is vital to containing health care costs and limiting physician exposure to malpractice lawsuits.

Texas' reputation as the Wild West reaches beyond its cowboy culture. It extends to the "wild west" nature of lawsuit abuse in the state. While Texas lawmakers have made significant progress in reforming the state's court system, Texas continues to face enormous costs imposed by the state's litigious environment.

According to a recent report by the U.S. Chamber of Commerce and Harris Interactive, Texas was evaluated by corporate America as one of the least fair and reasonable litigation environments.[1] States were graded on ten key elements, including punitive damages and scientific and technical evidence. Texas ranked worse than 40th in all ten areas.

The legal environment directly affects physician and overall health care costs. Fearing malpractice lawsuits, physicians often order unnecessary medical tests as protection. Skyrocketing judgments and settlements are also paid by physicians who pass their costs on to consumers. According to Dr. Darius Maggi of Texans for Lawsuit Reform, a retired physician, health care costs include a hidden "tort tax."[2] For example, he attributes $8 of a $11.50 DPT vaccination to the tort tax.

Many physicians in Texas face malpractice insurance premium increases of 30 to 200 percent in 2002.[3] While some have attributed these large increases to a post-September 11 insurance industry, it should be noted that malpractice claims in Texas have increased an average of 87 percent since 1995. More than half of all Texas physicians had claims filed against them in 2000, which is estimated to be almost double the national average. While Texans who have been injured due to malpractice should be able to seek legal remedy, the current system allows far too many unwarranted malpractice suits.

[1] United States Chamber of Commerce and Harris Interactive, "U.S. Chamber of Commerce State Liability Systems Ranking Study," Final Report, January 11, 2002.

[2] Martha McCool, "Dr. Maggi calls for Medical Lawsuit Reform," Gainesville Register, November 29, 2001.

[3] Patricia V. Rivera, "Malpractice rates take a feverish leap," The Dallas Morning News, January 20, 2002.

Recommendations

Texas' legal system is wreaking havoc on the state's physicians. Physicians are avoiding complicated procedures in order to limit exposure to lawsuits; others are leaving practice altogether due to annual malpractice premiums that can exceed $100,000. The time has come for lawmakers to resist the howls of protest from trial lawyers and enact tort reforms based on proven success.

California's Medical Injury Compensation Reform Act (MICRA), passed in 1975, demonstrates how such reforms can allow patients injured through negligence to get their day in court while protecting physicians from unrestrained lawsuits. The centerpiece of the law – caps on non-economic damages and legal fees – has proven effective. (Texas does impose higher limits on non-economic damages, but does not limit attorney fees.)

Key features of MICRA include:

- a $250,000 cap on non-economic damages;
- a sliding-scale cap on contingency fees for plaintiff attorneys;
- periodic payments of future economic damages in excess of $50,000; and
- a one-year statute of limitations for adults from discovery or three years from the date of the alleged injury, and a special statute of limitations for minors.

Texas should also consider allowing doctors and patients to negotiate a lower fee if the patient agrees to arbitrate liability claims. This is not legal in Texas unless the patient's attorney has also signed the agreement.

A health care system that protects both patients and doctors is essential to permanent, long-term reforms. California's long experience shows that a properly-functioning legal system can be an important component of meeting these goals.

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HEALTH CARE PUBLICATIONS & EXPERTS

Other TPPF Health Care Publications:

The following publications can be downloaded from the Texas Public Policy Foundation's website at www.tppf.org:

The Medicaid Problem in Texas
by State Representative Arlene Wohlgemuth
VERITAS, Winter 2002

The Future of Health Care in Texas
by Kathi Seay
VERITAS, Winter 2001

Meeting the Challenge of the Uninsured
by Grace-Marie Arnett
VERITAS, Spring 2000

Medical Perspectives on Clean Air Health Effects
- Testimony by John Dunn, M.D., J.D. to the Texas Natural Resources Conservation Commission
VERITAS, Spring 2000

Anti-Plastic Agenda: Health Care With Harm
by Angela Logomasini and Tracy Wates
September 2000

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