Employers & Health Care: Crisis and Solutions

2006 Report

TEXAS ASSOCIATION OF BUSINESS
Dear Business Leader:

Although employers received good news this year—average health insurance premium increases are the lowest since 2000, no one is celebrating.

Health care costs and premium increases have outpaced GDP growth, wages and inflation causing employers and employees to dig deeper into their pockets to pay for coverage.

Health insurance premiums average $11,000 per family. Even when an employer offers coverage, an increasing number of employees are declining employer-sponsored coverage due to the rising cost of enrollment. As a result, only 60 percent of employers offer health insurance to their employees, down from 69 percent in 2000.

Government-sponsored programs are equally troubled, consuming more tax dollars than ever before. The cost of Medicaid has risen at an average of 8.2 percent each year since 1995, far outpacing states’ revenue growth.

As health care spending continues to grow at unsustainable rates, employers must stand united in asking the Texas Legislature to bring sanity and stability to private- and government-sponsored health insurance.

The Texas Association of Business, representing thousands of large and small employers, has developed priorities to rein in the cost of health care and to help get more Texans insured. The following report outlines the crisis, and offers specific solutions that we urge the Texas Legislature to address. They include:

- Expansion of Consumer-Directed Health Plans that allow employers to purchase low-premium, high-deductible policies coupled with a medical savings account. This approach encourages consumers to approach health care with a concern for price and value.

- Increased information on costs and quality measures so consumers can make educated decisions regarding the cost and quality of health care services. This is particularly critical as employers shift from traditional insurance options to high-deductible plans such as consumer-choice health plans.

- Prohibition of balance billing, sensible penalties for waiver of co-payment and reforms to physician self-referral will protect consumers and restrain increases in the cost of health care.

- Expansion of Medicaid managed care. The State should apply to the Center for Medicare and Medicaid Services for a Section 1115 Waiver, which will allow for the most cost-effective, high-quality care to be implemented in Texas.

In past sessions, the Texas Legislature began the framework for true reform. It is time now to deliver more effective models of care to relieve the strain on the budgets of Texas government, employers and families.

We hope that you join us in providing a united voice to the Texas Legislature and that this report is used as a blueprint for reform.

Sincerely,

Bill Hammond
President
Part I: The Growing Crisis

Health Care Spending

Over the past decade, health care spending in the U.S. rose 44 percent per capita in real terms. The average American now spends $6,500 each year on health care – a staggering 16 percent of U.S. per capita gross domestic product (GDP). If the current trend continues, health care spending in the U.S. will increase to 22 percent of GDP by 2025. This level of spending will either drive up labor costs – making American business less competitive – or result in greater tax burdens, depending on how health care is financed in the future.

Private and Government-Sponsored Insurance

The alarming growth in health care spending has been financed in part by increasingly expensive government-sponsored health insurance programs. Texas and other

<table>
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<tr>
<th>Texas Medicaid Spending</th>
<th>Medicaid Budget (in billions)</th>
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<tr>
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DSH payments to hospitals are excluded. Source: www.hhsc.state.tx.us/Medicaid/reports/PB/pb_pdf/chapter5.pdf

states are particularly concerned about the Medicaid program, which they fund jointly with the federal government. The cost of Medicaid has risen at an average of 8.2 percent each year since 1995, far outpacing states’ revenue growth. In 2004, total Medicaid spending nationally reached $292 billion. The average state covered 40 percent of the tab, spending more on Medicaid than on public education. If these spending patterns persist, annual Medicaid expenditures will reach an untenable $670 billion per year by 2015. According to the Pacific Research Institute, “states will continue to face difficult decisions as fiscal limitations and growing Medicaid demands squeeze out other important state priorities, such as education, transportation, and law enforcement.”

For those Americans who do not qualify for Medicare or Medicaid, the skyrocketing cost of private health insurance (also fueled by the growth in spending) is of primary concern. Premiums for private health insurance policies have risen at double-digit rates since 2001, with
the exception of 2005 and this 2006. In 2005 and 2006, the average business watched the price of employer-sponsored health care rise by 9.2 and 7.7 percent respectively—still two to three times the percentage increase in real wages and other consumer prices. Today, premiums for employer-provided insurance average $11,000 per family. As a result, only 60 percent of employers offer health insurance to their employees, down from 69 percent in 2000. Even when employers offer coverage, an increasing number of employees are declining employer-sponsored coverage due to the rising cost of enrollment. The high cost of coverage fuels a troubling trend: more and more Americans, even those in higher income brackets, are joining the ranks of the uninsured.

The Uninsured

Today, 46.6 million Americans (or 15.9 percent) live without private- or government-sponsored health insurance. Regrettably, Texas leads the nation in the percentage of uninsured persons. According to a 2005 survey conducted by the Centers for Disease Control and Prevention, one-fourth of all Texans lacked even the most basic health insurance.

Inability to afford private insurance is not limited to households with below-average income. Surprisingly, the households in which the percentage of uninsured is growing at the fastest rate are those whose annual income exceeds $75,000, followed closely by those in the $50,000 to $75,000 bracket. Over the past decade, the number of uninsured persons in these two segments increased by eight million—that’s a 153 percent increase in the $75,000+ group and a 57 percent increase in the $50,000-$75,000 bracket. Although these households account for a small part of the total uninsured population, this trend concerns many experts. These figures will only worsen as the cost of insurance climbs even higher, forcing both employers and employees to cancel their health plans.

On the other hand, those earning below-average wages are seeing positive improvements in insurance status because of government-funded programs. Nationally, the percentage of low-income households without health insurance declined over the past 10 years. For households earning below $25,000, the percentage with health care coverage increased by 19 percent during this period. These gains are due to the expansion of Medicaid and the Children’s Health Insurance Program (CHIP). As noted above, however, such expansion strains state and federal budgets. Until 2005, growth in enrollment in public programs had offset the decline in the number of persons covered by private insurance. In 2005, however, this was not the case, and the percentage of the population without insurance rose.

Still, the National Center for Policy Analysis reports that ten to 14 million adults and children who qualify for government health insurance programs have not enrolled.

Another 16 million of the uninsured live in a household with an annual income of $50,000. In most cases, these individuals can afford health insurance but choose to go without. These statistics illustrate the disturbing fact that many Americans simply choose not to have health insurance. The two distinct groups mentioned above—those who qualify for government programs and those who can likely afford private insurance—decide to forgo coverage for different reasons.

Many of the uninsured, especially those who qualify for government programs but decline coverage, tend to utilize their local hospital emergency room for primary care. This practice is facilitated by federal law, which requires hospi-
tals to assess and stabilize all emergency patients regardless of their ability to pay. As a result, the uninsured are able to access limited health services through hospitals at little or no personal cost. With “free” health care, these individuals perceive little benefit in obtaining government health insurance – even if that insurance is free.  

However, the hospital emergency room is a poor substitute for the routine care that insured patients enjoy. People without health insurance do not receive the same quality of health care as those with insurance. The Institute of Medicine published a series of reports showing that uninsured children and adults are three times as likely as those with coverage to “lack a regular source of care.” Moreover, the uninsured are half as likely as the insured to receive treatment for “serious medical conditions” and often forgo preventive care. As a result, Americans without health insurance are more likely to have poorer health and die prematurely than those with insurance. All social and economic factors being equal, the uninsured still miss more days of work and school. The annual cost to society of these discrepancies is enormous. Economic losses and inefficiencies are estimated to total in the hundreds of billions of dollars. The cost of treatment for the uninsured is ultimately passed along to the payors of care, reaching employers and insured employees in the form of higher health insurance premiums.

In Pursuit of a Solution for the Crisis

Our health care system is in a state of crisis. Employers and employees alike have dug deep into their pockets to pay for private health insurance, and many cannot dig deeper. Government-sponsored programs are equally troubled, consuming more tax dollars than ever before. And what does the U.S. have to show for all this spending? The answer: almost 47 million uninsured Americans. Reversing this troublesome trend is beyond the power of state government acting alone. However, Texas state government must do its part to tackle the underlying problem – the rapid growth in health care spending and the growing number of uninsured citizens in the Lone Star State. This report discusses the root cause of this growth in both sectors – private and public – and proposes solutions for each.

Part II: Private Sector Problems and Solutions

The Problem with Traditional Insurance

A new study confirms that excessive consumer demand – fueled by the third-party insurance system – is responsible for a substantial part of the increase in health care expenditures. According to Amy Finkelstein of Massachusetts Institute of Technology, “the spread of health insurance between 1950 and 1990 may be able to explain about half of the six-fold rise in real per capita health spending over this time period.” This is because the traditional high-premium insurance policies covered most medical expenses, encouraging enrollees to consume an inordinate number of health care services.

John Goodman of the National Center for Policy Analysis explains: “On the average, every time an American spends a dollar on physicians’ services, only 10 cents is paid out of pocket; the remainder is paid by a third party.”

“From a purely economic perspective, then, our incentive is to consume these services until their value to us is only 10 cents on the dollar.” The subsequent over-utilization of health care means greater spending and even higher insurance premiums. The cycle is a vicious one.

Traditional employer-sponsored health care is in jeopardy. Health care costs and premium increases have outpaced the general rate of inflation, the rate of GDP growth and the rate of increase in median household income. The simple fact – perhaps too difficult for many to accept – is that the current health care funding model can no longer sustain itself. An alternative system must be made available to the insured today to prevent them from becoming the uninsured tomorrow.

An Alternative Model: Consumer Driven Health Care

As health insurance premiums continue to rise, many employers face a difficult decision: make significant changes to current health plans or cut benefits altogether.
While a growing number of employers (especially small business owners) no longer offer health insurance, of those that still do, many are embracing the consumer-driven health care (CDHC) model. In the CDHC model, employers purchase high-deductible health plans (HDHPs) for their employees, instead of the traditional high-premium, low-deductible policies. The relatively high annual deductible – $1,050 for individuals and $2,100 for families in 2006 – significantly lowers the premium, making these policies more affordable. To help employees pay for deductible expenses, an HDHP is coupled with a medical savings account, usually a Health Reimbursement Arrangement (HRA) or a federally qualified Health Savings Account (HSA). Employers and employees can make pre-tax contributions to these accounts, which are used to pay for routine and other medical expenses that fall within the deductible. An annual out-of-pocket maximum protects the policy-holder from excessive financial hardship in the event of a catastrophic medical emergency.

Proponents of the CDHC model argue that the wasteful, indiscriminate consumption of health care products and services can be curtailed by putting consumers in charge of their health care dollars. While a low-deductible policy creates little incentive for individuals to forgo unnecessary treatment or question the cost of services, an HDHP + HRA/HSA combination encourages consumers to approach health care with a concern for price and value. Many experts hope that, with the right tools, cost-conscious consumers will make health care decisions with the same cost/benefit considerations that govern efficient markets in other industries. In theory, these individuals will “shop” for low-cost, high-quality care, thereby introducing competitive pressures into the industry. These market forces will curb the soaring price of health care services by prompting providers to reconcile cost and quality.

According to the Government Accountability Office, five to six million Americans now hold a high-deductible HRA- or HSA-eligible plan, up from three million in January 2005.17

A recent study found that 31 percent of new HSA account holders were previously uninsured, demonstrating that these affordable plans encourage more employers and employees to purchase coverage.18 Driven by lower premiums, this rapid expansion will hopefully continue into the future.

The Need for Transparency in Competitive Markets

With CDHC, employees are expected to take greater responsibility for their health care costs. With this new responsibility comes new consumer needs. First among them is the need for cost and quality transparency in health care. If consumers are to introduce competitive forces into the health care industry by choosing providers and treatments based on value considerations, they must have access to accurate, comparable measures of performance and price. However, a 2005 survey compiled by the Employee Benefit Research Institute (EBRI) and the Commonwealth Fund found that the vast majority of insured adults lack this information. The survey reported that only “14 to 16 percent of insured individuals – whether enrolled in a comprehensive plan or a high-deductible health plan – had information from their health plan on quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.”19 These information insufficiencies prevent even cost-conscious consumers from assessing and comparing the value of a provider’s services, fatally undermining the promise of the CDHC model.

A 2006 Zogby America poll found that most consumers want information on the price of health care services before heading to the doctor or deciding on treatments.

2006 Zogby Poll Shows Americans Favor Transparency on Medicare Costs, Physician Charges

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<td>The federal government should make doctors who accept Medicare/Medicaid payments publish their prices</td>
<td>77%</td>
<td>19%</td>
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Of those interviewed, 84 percent believe that health care providers should publish price information for all goods and services, and 79 percent say they would use this information to “shop around for the best price.” Consumer willingness to shop bodes well for the CDHC model, but only if the necessary information is made available to the public.

Transparency Initiatives

Many states now require hospitals and other providers to report general cost and quality information to designated agencies. In some states, including California, Minnesota, North Carolina and Pennsylvania, transparency laws require health care facilities to report average charges for the most common inpatient and outpatient procedures. Some also mandate the disclosure of general quality indicators, including re-admission, infection, and mortality rates. Several state governments then publish this information in user-friendly reports or online databases, making it easier for consumers to assess and compare information on value. For example, the Wisconsin Hospital Association’s PricePoint and CheckPoint services enable Wisconsin residents to access basic price and quality indicators by hospital. This service is made possible by a contract with the state.

On August 22, 2006, President George W. Bush issued a landmark Executive Order “to promote federally led efforts to implement more transparent and high-quality health care.” This order requires the U.S. Department of Health and Human Services (which administers Medicare) and three other federal agencies to measure and report on the quality of their beneficiaries’ medical services. The quality metrics are to be developed by “multi-stakeholder entities,” a collaboration that may remedy the problematic lack of universal quality measurements. The agencies must also publish price information, including the “overall costs of services for common episodes of care and the treatment of common chronic diseases.” Most of the major insurers and providers will be affected by this order, as the government is the single largest purchaser of employer-sponsored health care through the Federal Employees Health Benefit Program and the TRICARE program.

However, the measures of cost and quality now made available by federal and state entities do not give the consumer the same degree of price information they have for other major purchases. For example, the average cost information provided by Wisconsin’s PricePoint does not reflect out-of-pocket expenditures, and the quality metrics used in CheckPoint only assess a hospital’s response to heart attack, heart failure and pneumonia patients. Also, most of these state-sponsored resources do not provide information on procedures performed in physician offices and outpatient facilities (e.g., surgery centers, imaging centers and rehabilitation clinics) where an increasing percentage of treatment is delivered.

In response to consumer demand for such information, several private insurers have begun to publish more comprehensive data on the price and quality of care. For example, Aetna, a health benefits company with 30 million policy-holders, became one of the first national insurers to provide its clients with physician-specific information on healthcare costs and, in some cases, clinical quality and efficiency. By August 2006, Aetna had published rates for up to 30 of the most common medical services by specialty for 70,000 physicians in nearly a dozen states (not including Texas). Members in these states can access the information via the company’s website, allowing them to determine out-of-pocket expenses for office visits, diagnostic tests, minor and major procedures and other services. This pricing information is especially valuable to the 600,000 Aetna members who hold an HRA- or HSA-compatible HDHP. In addition, Aetna provides quality data – including patient volume and prevalence of complications and repeat procedures – for 15,000 physicians, enabling many members to choose a provider based on overall value. Aetna plans to expand its transparency initiative to additional markets and to eventually include information on hospitals and ancillary providers.

Congress is considering the Health Care Transparency Act of 2006 (HR 6053), which TAB will be monitoring closely. It is critical that any transparency legislation give consumers adequate information to make cost and quality decisions about their own health care.
Barriers to Transparency

Price information is relatively easy to prepare for many medical services, including office-based procedures and minor elective and diagnostic surgeries. However, structural impediments and provider policies can make it difficult for a consumer to understand personal costs before the point of service.

For example, consider a patient who is preparing to undergo an outpatient surgical procedure. This patient holds a high-deductible insurance policy, so he or she is interested in knowing the total cost. While the surgeon may be able to disclose his or her rates, the patient will not know the facility fee, the charges for the anesthesiologist and pathologist, or even the cost of the implant. Thus, the total cost of even a simple procedure may be several times the surgeon’s charge. And unless every doctor involved in the surgery has a negotiated rate with the health plan, the patient’s insurer may not be able to tie up the loose ends. These complications will not be fully resolved by the current laws requiring general price and quality disclosures.

Data on cost and quality needs to be organized and analyzed to present usable information to the consumer on what the cost of an episode of medical care will be.

Beyond logistical complications, other factors hinder the further spread of transparency in the industry. On the quality side, the Commonwealth Fund reports that “The greatest barrier to generating the kind of information that is needed is the resistance of providers to making quality information available.” For example, a poll taken by that organization in 2003 found that two-thirds of physicians definitely or probably would not make quality information available to the general public. In addition, one-third of hospital CEOs in the U.S. believe that information on mortality, error, and infection rates should not be available to consumers. A similar reluctance complicates efforts to improve price transparency.

Solutions to Improve Transparency

There are several steps that the Texas Legislature can take to improve the transparency of health care. However, it is important to keep in mind that consumer-driven health care is in its infancy, and employers, health care providers, and health insurance plans are still searching for solutions to several complicated problems. All stake-holders will have to do their part to bring useable cost and quality information to the consumer. At this time, TAB asks the Legislature to (1) broaden the state government’s transparency initiatives while (2) examining legal impediments that keep employers, insurers, and providers from sharing better price and quality information with consumers.

We note that the State of Texas itself operates one of the state’s largest employer-sponsored health plans for state employees and retirees through the Employee Retirement System (ERS). Covering almost 190,000 Texans, the ERS is in the perfect position to take a leading role in CDHC and transparency initiatives. We recommend that the Texas Legislature move all ERS enrollees to high-deductible health plans with HSAs. In addition, the ERS should work to collect, arrange, and publish consumer-friendly information on the price and quality of provider services. With access to hundreds of thousands of claims reports and other data, the ERS could develop a trailblazing approach to true transparency in the health care industry by testing and reporting on the effectiveness of different information systems.

First, the Texas Legislature should enact laws that make basic information on the price and quality of health care available to consumers. In 1995, the Legislature created the Texas Health Care Information Council. The council’s functions were transferred to the State Department of Health Services in 2001 and, along with several other data programs, became part of the State Center for Health Statistics. The center has developed considerable expertise in the collection and organization of hospital discharge data. However, its ability to collect outpatient data from hospitals and other facilities, and its ability to analyze and distribute this data has been limited by inadequate funding and a weak mandate. Certain provisions of the statute need to be revised to allow more timely distribution of useful data:

- Transfer the Center of Health Statistics from the Department of State Health Services to the Health and Human Services Council to better support state-funded health plans and to increase opportunities for federal matching funds.
- Require the Division of Workers’ Compensation and the Employee Retirement System to contract with the Center to manage their health care databases and to make data and analysis available to policy makers and the public.
- Increase collection of data on outpatient services from hospitals, ambulatory surgery centers, imaging centers and other outpatient facilities.
Revise the statutory data review procedures to allow more timely release of data to the public.

Provide small rural hospitals that are now exempt from reporting data with one-time grants to implement systems necessary to report data and eliminate the exemption.

Provide Texas consumers with a website similar to the one provided by the State of Wisconsin that will give Texas consumers easy access to general information on price and quality data.

Expand the longstanding Annual Hospital Survey program to require all ambulatory surgery centers, imaging equipment, and other outpatient facilities to report data on price, volume, ownership and quality that can then be made available to consumers.

Second, to discourage practices that undermine transparency and to aid in the development of information that most benefits consumers, the state should:

Hold hearings before or during the 2007 session to identify any statutory impediments to providing price and quality information to consumers.

Require the Employee Retirement System to develop procedures and systems to make price and quality information available to state employees and enrollees to enable them to determine the complete cost of services to themselves and to the state by 2009, and report back to the Legislature.

Require the Texas Health Policy Council to monitor the information requirements of consumer directed health plans and the efforts of health plans, health care providers, government and other organizations to meet these requirements. Have the council prepare a report to the Governor and the Legislature regarding actions the Legislature and the Executive Branch could take to improve the information available to consumers. The Governor’s Health System Integrity Partnership should assist in the study. The council should be provided with adequate funding and staff to carry out the monitoring and prepare the report.

TAB is under no illusion that these recommended actions will correct the current problems with the privately funded portion of the health care system. As noted above, Texas state government acting alone does not have the power to fix the problems. These recommendations are for immediate steps to improve the chances for the Consumer Directed Health Plan model to control costs and improve quality. They are reasonable next steps.

Part III: Ending Abusive, Costly Business Practices in Health Care

TAB has identified three practices by health care providers that undermine current cost-containment efforts. These activities enrich a few health care providers at the expense of taxpayers and consumers. In the following sections, we describe the three problems and propose legislative solutions. The Texas Legislature should implement these proposals to protect consumers and to restrain increases in the cost of health care.

1) Balance Billing – Three Scenarios

Private health insurers generally provide for their enrollees’ care by contracting with physician groups, specialty practices, hospitals and other providers. In exchange for the high volume of patients that this contract brings, the “network” of providers agrees to perform services at a specified, discounted rate. When a service is rendered, the provider collects the co-payment/deductible from the patient and bills the insurance company at the negotiated rate. Thus, financial liability to the patient for in-network services depends solely on the co-payment and deductible provisions of the health plan.

However, patients sometimes receive a bill with additional charges from the in-network provider. This bill charges the patient for the difference, the account balance, between the negotiated and billed rates – a practice known as “balance billing.” A “holds harmless” provision in Texas law protects patients from this practice, specifying that a patient cannot be held responsible for charges that an HMO does not pay to providers under contract. Preferred Provider Organizations (PPOs) place similar restrictions in their contracts with providers, prohibiting them from billing patients for the difference between billed charges and negotiated rates. However, the law puts little emphasis on the
provider’s role in making sure that a patient understands this provision. As a result, thousands of Texans pay balance bills each year with little or no understanding of their right to not pay. Where there is a negotiated contract between the health care provider and the patient’s health plan, balance billing by the provider is a fraudulent and deceptive trade practice that asserts the patient owes the provider money when the provider clearly knows the patient does not.

Balance billing occurs in a second situation when an insured patient receives emergency treatment at an out-of-network hospital. The hospital and the physicians send bills at their billed charges. How high the billed charges are set is totally under the control of the health care providers. When the insurance company pays only the portion of the bill the policy requires it to pay for out-of-network care, the out-of-network providers send a bill for the balance of their charges to the patient. These bills can be for tens of thousands of dollars. The patient has a legal obligation to pay.

Patients may also receive a bill from out-of-network providers who participated in non-emergency treatment performed by an in-network physician. Consider this scenario in which an insured patient in need of heart surgery is referred to an in-network heart surgeon. The operation is performed at an in-network hospital. The heart surgeon and the hospital perform the life-saving operation at their negotiated rates, but out-of-network anesthesiologists and pathologists also participate in the treatment. Because these hospital-based physicians have exclusive contracts with the hospital to provide all anesthesiology or pathology services, they have no incentive to contract with the health plan at a negotiated rate. These specialists, invisible to the patient, can then set their rates as high as they please. When the health plan pays the required portion of the bill, the physicians can take legal action against the patient to collect the balance.

The Texas Legislature should protect consumers from unfair balance bill charges with the following legislative action.

The Texas Legislature should require the Texas Department of Insurance to collect a civil fine or administrative penalty sufficient to deter the behavior if, contrary to the terms of its contract with a health plan, or contrary to rates for emergency care established by state law, a health care provider bills a patient for the difference between its billed charges and the amount it is due by contract or statute.

When a patient uses out-of-network providers for emergency treatment, as defined by statute, the Legislature should prohibit a provider’s ability to balance bill consumers directly.

When the patient uses an in-network treating physician and an in-network facility but receives services from out-of-network facility-based physicians (e.g., anesthesiologists, pathologists and radiologists), the Legislature should limit the out-of-network facility-based physicians ability to bill patients. TAB recommends the Texas Legislature prohibit these providers from balance billing consumers.

A referring and/or treating physician must advise his/her patient that the recommended treatment and/or provider may not be in network and, as a result, the patient may be balanced billed by that provider. The patient should be allowed sufficient opportunity and time to request and receive treatment by a provider or treatment that is in his/her health plan network.

The Legislature should amend the statutes relating to corporate practice of medicine to eliminate any impediments to employment of physicians by hospitals or health systems that own and operate hospitals. This will allow hospitals to ensure that their hospital-based physicians are covered by contracts with the health plans with which the hospital contracts, protecting consumers from costly balance bills.

2) Waiver of Co-Payment and Deductible by Out-of-Network Providers

Some providers decline to contract with health plans, but then try to attract patients enrolled in the health plans by waiving co-payments and deductibles. For instance, an out-of-network provider charges a relatively high rate for a particular service – such as $2,000 – but attracts patients by waiving the out-of-network deductible of 50 percent (or $1,000). The patient will choose this provider over the in-network provider who charges a $50 co-pay, even though the in-network provider would perform the same procedure for a negotiated rate of only $800. The out-of-network provider then bills the insurance company for the full $2,000, and the insurer pays 50 percent – much more than it would have paid the in-network provider. While the
patient saves money in the short run, he or she will pay later in the form of higher premiums.

Texas law is clear on the issue of waiving co-payments and deductibles. Without evidence of financial hardship, it is illegal. However, the punishment outlined in statute is a criminal penalty, and prosecutors are unlikely to enforce the law. It is necessary for the Legislature to establish civil and administrative penalties to make enforcement practical.

The Texas Legislature should take action to prevent providers from inappropriately waiving co-payments and deductibles by:

- Requiring the Texas Department of Insurance to collect a civil fine or administrative penalty sufficient to deter the behavior, and to void any right of payment from the health plan and patient if an out-of-network provider waives or offers to waive a patient co-pay or deductible to obtain a patient.

- Allowing all state-regulated insurance plans to use exclusive provider networks and to have no financial liability when the patient knowingly chooses to use an out-of-network provider in a non-emergency situation in preference to similar in-network providers in the same geographic area. All ERISA plans have this ability today. This will eliminate the financial incentive for out-of-network providers to waive deductibles and co-payments.

3) Physician Self-Referral

Direct physician services account for a small part of total health care costs – only about 20 percent. However, add to that the cost of all goods and services ordered or prescribed by physicians and they control 80 percent of health care spending. Thus, a physician has greater financial impact as a “purchasing agent” than as a direct service provider.

No company would allow one of its purchasing agents to place orders with a vendor that in which the agent has a direct or indirect financial interest. The conflict of interest is clear, the purchasing agent will place his economic interests ahead of the company’s. Unfortunately, physicians are not immune from conflicts of interest when they have a financial stake in the services they are ordering. For example, a number of studies have found that non-radiologists who perform their own imaging services are up to seven times more likely to order expensive imaging procedures than physicians who refer these services to an independent radiologist. Referral rates are also significantly higher when the physician is referring the patient to a facility in which the doctor has a financial interest. Similar patterns of over-utilization have been shown when physicians order lab tests, physical therapy, durable medical equipment, and surgical implants. These unnecessary and expensive referrals benefit physicians at the expense of consumers.

To discourage the adverse consequences of excessive self-referral, the Texas Legislature should:

- Establish licensure standards for magnetic resonance imaging and other imaging equipment to protect patients from low-volume and outdated imaging operations by self-referring physicians.

- Examine the restrictions on self-referral, false claims, and fraud and abuse applicable to the Medicaid program and review how those restrictions could be applied to all health care services provided in Texas. The Health and Human Services Commission (HHSC) should be given the authority to investigate and enforce any new law and collect civil fines or administrative penalties sufficient to deter the restricted behavior.

- Require physicians to disclose to HHSC and to any health plan with which they contract all direct and indirect financial interests in facilities and services to which they refer patients. Require the Texas Department of Insurance to collect a civil fine or administrative penalty sufficient to deter the behavior, and to void any right of payment from the health plan and patient if the provider fails to make required disclosures within a specified time.

- Require disclosure of the interest in writing to patients each time a referral is made, and require HHSC to collect civil fines or administrative penalties for failure to disclose.
While the CDHC model may help curb the rising cost of private health insurance, government programs will still be needed to offer coverage to the low-income and elderly. As discussed in Part I, current program costs have skyrocketed. In 1970, government health care expenditures accounted for 36.4 percent of total health care spending in the U.S. In 2002, they accounted for 44.9 percent. During this time, government spending for health care grew 11 percent faster than private sector health care spending.

Reasons for Growth in the Medicaid Program

Benefit expansion accounts for 75 percent of the growth of government health care spending in the United States, while the other 25 percent is due to the aging of the covered population. Benefit expansion occurs when program coverage increases, when programs are expanded to cover new populations, or when new programs like the Children’s Health Insurance Program (CHIP) are introduced.

In Texas, Medicaid and CHIP have effectively insured more Texans, but at a high price. In October 2005, one in eight Texans relied on Medicaid for health insurance or long-term care services. To care for these individuals, the Texas Legislature will appropriate $36.2 billion for the Medicaid program during the 2006-2007 biennium. Funding for the Health and Human Services Commission (which administers the program) accounted for a staggering 35 percent of all state funding at $48.2 billion. This represents a 10.2 percent increase from the previous biennial budget. By comparison, funding for public education increased only half as much as Health and Human Services funding during this period.

In Texas, most Medicaid dollars are spent on services for the aged, blind, and disabled. While these individuals make up only 21 percent of Medicaid recipients, they account for 59 percent of program expenditures. By contrast, non-disabled children account for 70 percent of the Medicaid population, but they claim a mere 30 percent of total expenditures. National figures reflect a similar pattern. As the population ages and the population requiring
nursing home services increases, the rate of growth in Medicaid spending is likely to increase more rapidly.

Cost-Containment Efforts

The state must slow the growth of Medicaid costs to avoid a budget crisis. There are several options: reducing Medicaid benefits, limiting or cutting eligibility, lowering payment rates to providers, or saving money by implementing more cost-effective health plans. While the Legislature should be cautious about expanding Medicaid eligibility, cutting benefits to current recipients would be a harsh remedy. Instead, the state should continue to expand proven cost-containment measures, such as Medicaid managed-care programs.

Seventy percent of Texas Medicaid recipients are now enrolled in Medicaid managed-care plans.35 The most popular program, State of Texas Access Reform (STAR), provides acute care services to pregnant women, children and healthy adults through contracts with a variety of private and public HMOs. Many studies indicate that capitation (per person) contracting with Medicaid health plans “achieves the most savings, provides the strongest array of outreach, education, and access initiatives, and creates the greatest opportunity to measure quality.”36 Older delivery systems, like fee-for-service (FFS) and primary care case management (PCCM), do not offer the cost-containment features that Medicaid managed care plans provide. For example, Medicaid recipients covered by an HMO are much likelier than FFS or PCCM patients to seek preventive care from their primary care physicians.37 These and other measures save money by promoting a healthy Medicaid population.

The STAR+PLUS system provides both acute- and long-term care to the aged, blind and disabled also through a managed care system. The STAR+PLUS pilot program was initiated in Harris County in 1998 to control costs for these populations, which account for nearly 60 percent of all Medicaid expenditures. Program participants are matched with a care coordinator – sometimes a specialist – who provides efficient, quality services with an emphasis on disease management and preventive care. These programs help participants avoid expensive emergency room visits and institutional care.

A 2003 study by the Institute for Child Health Policy and the External Quality Review Organization found that the STAR+PLUS program led to remarkable savings in Harris County:38

| Inpatient rates were 28 percent lower for STAR+PLUS beneficiaries than for a matched control group of Supplemental Security Income (SSI) voluntary participants in the STAR program. |
| Emergency room visits were 40 percent lower for STAR+PLUS beneficiaries than for a matched control group of SSI voluntary participants in the STAR program. |
| The overall annual health care expenditures were 279 percent higher for the SSI voluntary STAR control group members than STAR+PLUS members. |

In response to these savings, the 79th Legislature (2005) instructed the Health and Human Services Commission (HHSC) to “implement alternative managed-care models for people who are older, are blind or have other disabilities in eight service areas of the state.”39

In September 2005, HHSC announced that it will implement a new capitated STAR+PLUS model in the Bexar, El Paso, Harris, Lubbock, Nueces and Travis county service areas. However, this model will “carve” hospital payments out of the capitation rate, meaning that the state (and not the contracted HMO) will bear financial responsibility for Medicaid recipients’ hospital bills. If the state pays a public hospital the Medicaid rate for a procedure, the hospital receives a federal Upper Payment Limit (UPL) reimbursement. If the Medicaid HMO makes the same payment, however, the hospital does not qualify for the UPL. By requiring the state to cover Medicaid hospital bills, the STAR+PLUS carve-out ensures that public hospitals will receive millions of dollars in much-needed UPL payments. While considered necessary, the carve-out will adversely impact the managed-care model’s ability to control costs.

Instead of the STAR+PLUS model, the HHSC will implement the Integrated Care Management (ICM) program in the Dallas and Tarrant service areas. Like STAR+PLUS, the ICM model provides aged, blind, and disabled Medicaid recipients with care coordination for acute- and long-term care services. However, the ICM model is non-capitated. Instead of contracting with HMOs at a capitated rate, the state pays an Administrative Service Organization (ASO) to provide case management and reimburses providers on a fee-for-service basis. This model was originally proposed as an alternative to the early STAR+PLUS program. Proponents suggest that the ICM model will not interfere with UPL payments in the way that a pure capitated managed-care arrangement will. However, this model will not deliver the same level of sav-
ings as the STAR+PLUS system with hospital carve-out to permit UPL payments.

**Medicaid Payment System for Hospitals**

The Medicaid Payment System for Hospitals includes the STAR+PLUS system with hospital carve-out to permit UPL payments.

**Medicaid Payment System for Hospitals**

Since 1983, the federal Medicare Prospective Payment System, sometimes referred to as the “Diagnosis-Related Group” (DRG) System, has paid hospitals a flat fee per service, based on the average cost to all hospitals of serving Medicare patients with a given DRG. Payments are adjusted for geographic differences in costs and several other factors. Thus, any two hospitals in the same area are reimbursed at the same rate for a given DRG, regardless of the costs actually incurred by each hospital.

With the ICM and STAR+PLUS carve-out models, the state also pays hospitals on a fee-for-service basis. However, the Texas HHSC reimburses hospitals in the same city different amounts for the same services to Medicaid patients based on differences in their costs. This practice is harmful because it undermines the incentive that hospitals have to provide Medicaid patients with cost-effective, efficient care.

**Solutions**

By calling for the expansion of Medicaid managed care, the Texas Legislature has demonstrated its commitment to controlling the costs of Medicaid. However, not all managed-care models were created equal. Without a doubt, the fully capitated STAR+PLUS model has demonstrated a superior ability to provide high-quality, cost-effective care to aged, blind, and disabled Texans. Unfortunately, the Legislature has required HHSC to implement a “carved-out” version of this program in order to ensure that public hospitals are eligible to receive federal UPL reimbursements. TAB prefers another solution:

The State should file for a Section 1115 Waiver that allows for the implementation of the capitated STAR+PLUS program AND the preservation of UPL payments. Section 1115 waivers are granted by the Centers for Medicare and Medicaid Services (CMS) at the Federal Department of Health and Human Services. These waivers allow state governments to pursue innovative approaches to Medicaid cost-management by exempting them from certain federal guidelines. In recent years, the CMS has granted Section 1115 Waivers to several states, including California, Florida, and Massachusetts. The state should file for a Section 1115 Waiver that provides for a comprehensive capitated program (like STAR+PLUS) while preserving UPL payments to hospitals for Medicaid patients. If the waiver is secured, the Legislature should instruct the HHSC to implement the capitated version of STAR+PLUS – not the carved-out model – in the six service areas where expansion is to occur. This particular Medicaid managed-care model allows for the greatest savings.

The Texas Legislature should require HHSC to develop a Medicaid Prospective Payment System. As discussed above, HHSC currently pays hospitals a bill-adjusted Medicaid rate for each procedure. Consequently, two hospitals in the same area can be paid different amounts for performing the same procedure. This is not required by federal law, and no federal waiver would be needed for HHSC to standardize its payments. Thus, the state should develop a Medicaid Prospective Payment System for all inpatient and outpatient facility services, much like the federal Medicare Prospective Payment System. For inpatient services, HHSC will need to develop DRG classifications and weights that reflect the characteristics of the Medicaid population. For outpatient services, HHSC should utilize the Medicare Hospital Outpatient Prospective Payment System, adjusting payments to con-

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**Satisfaction Factor**

**Provider** 8.5 0-10  
**Specialist** 8.4 0-10  
**Overall Health Care** 8.1 0-10  
**Overall Health Plan** 7 0-10  
**Ability of Health Plan to Meet Needs** 7.5 0-10  
**Getting Care When Needed** 2.5 1-3  
**Getting Care Quickly** 3.4 1-4  
**Communications with Provider** 3.4 1-4  
**Overall satisfaction** 8.4 1-10  
**Satisfaction with Care Coordinator** 87% 0-100%  
**Satisfaction in Obtaining Assistance from Care Coordinator** 97% 0-100%

**Medicaid Payment System for Hospitals**

Surveys of STAR+PLUS members taken from 1999-2004 demonstrate satisfaction with the program.
form to overall funding levels. A standard payment rate by procedure will lower administrative costs and encourage hospitals to provide low-cost, efficient care to Medicaid patients.

**Conclusion**

Health care spending in the United States continues to grow at unsustainable rates, straining family budgets and overwhelming government programs. Worst of all, the soaring cost of private health insurance has led 46.6 million Americans into the ranks of the uninsured, where access to quality care is difficult to find.

Yet there is hope. Faced with an imminent crisis, experts and policymakers have begun to develop and implement innovative cost-containment measures. In the private sector, transparency initiatives are beginning to arm cost-conscious consumers with important information, enabling them to choose providers and treatments based on overall value. In the public sector, better models of health care delivery are beginning to spread, bringing with them higher quality care at a lower price. Although still in their early stages, these developments are already showing powerful potential.

Providers, insurers, employers, and consumers must work together to encourage these promising trends. As an organization that represents all employers, TAB will continue to push for long-term solutions.

We hope you join us.
Because of the growing uninsured population, hospitals are changing their approach to satisfying this legal obligation. Instead of treating non-emergency patients who arrive at the ER, more hospitals are screening patients and refusing to provide treatment not required by federal law if the patient cannot pay. The hospital refers such patients to physicians or clinics in the community. If this trend continues, some of those who are eligible for public and private insurance programs but have opted out may reconsider.


22 The URL for WI’s PricePoint is http://www.wipricепoint.org; the URL for CheckPoint is http://www.wicheckpoint.org.


24 For more information on Aetna’s program, and for a gateway to their price and quality data, visit http://www.aetna.com


33 Legislative Budget Board. Fiscal Size-Up 2006-07.


36 The Lewin Group, Medicaid Capitation Expansion’s Potential Cost Savings, April 2006, 1.
