TCCRI
Texas Conservative Coalition
Research Institute

# Health Care Reform: Charting a State Path

THE FINAL REPORT
OF THE TCCRI
HEALTH & HUMAN
SERVICES TASK FORCE

FEBRUARY 2011

The Texas Conservative Coalition Research Institute | txccri.org

# HEALTH & HUMAN SERVICES TASK FORCE
# FINAL REPORT

For more information about any of the recommendations contained in this document, please contact the Texas Conservative Coalition Research Institute:

Brent Connett, Task Force Director and Policy Analyst – brent@txccri.org

Tom Aldred, Director of Policy and Research – tom@txccri.org

Texas Conservative Coalition Research Institute

P.O. Box 2659, Austin, TX 78768

(512) 474-6042

www.txccri.org

The contents of this document do not represent an endorsement from any individual member of the Texas Conservative Coalition Research Institute Board of Directors or any individual participant of the Health and Human Services Task Force.

There may be some policy recommendations or statements of philosophy that individual members are unable to support. We recognize and respect their position and greatly appreciate the work of everyone involved in the organization.

# ABOUT TCCRI TASK FORCES

The Texas Conservative Coalition Research Institute's Task Forces are the backbone of the Institute's research and education efforts. Based on the conservative principles of limited government, individual liberties, free enterprise, and traditional values, the Institute's Task Forces develop legislative leaders and sound public policy ideas by bringing together legislators, experts, industry leaders, and stakeholders in a unique forum that fosters discussion and debate among public and private sector leaders. This approach has proven to be very successful.

## THE 2009-10 HEALTH AND HUMAN SERVICES TASK FORCE

Chaired by State Senator Jane Nelson (R-Lewisville) and State Representative John Davis (R-Houston), the TCCRI Health and Human Services Task Force met throughout the 2009-10 Interim. The Task Force was convened to develop policy proposals aimed at creating a more streamlined health and human services agency that provides better services to a limited group of well-defined beneficiaries through a modernized and more functional eligibility determination system.

The Task Force evaluated policy reforms for Medicaid and Children's Health Insurance Program, and reviewed the eligibility determination process that has been subject to much debate. The Task Force discussed efforts to tackle fraud and to improve quality of care to current beneficiaries.

With the passage of the Patient Protection and Affordable Care Act of 2010, the Task Force also evaluated the impact of federal health care reform on Texas and developed a state-level response to the challenges it poses to the state budget and to individual freedom.

# HEALTH CARE REFORM:

# CHARTING A STATE PATH

## FINAL REPORT OF THE TCCRI HEALTH & HUMAN SERVICES TASK FORCE

## CONTENTS

## 1. Federal Health Care Reform: More Costs, Less Choice for Texas

President Obama signed into law the Patient Protection and Affordable Health Care Act (PPACA) on March 23, 2010, setting into motion a major overhaul of the U.S. health care system and dramatically reshaping one-sixth of the American economy. These reforms have very significant implications for the state of Texas, including major new Medicaid costs and unprecedented levels of federal oversight in the state's authority to regulate private insurance. Never before has one piece of legislation presented such a direct challenge to the constitutional authority of the states. If implemented without significant revision by a future Congress, PPACA will effectively put states on a path to bankruptcy due to unsustainable Medicaid rolls.

There are hundreds of provisions contained within PPACA. In many instances, the extent of these changes cannot be assessed until the federal government establishes the rules and regulations—written by the U.S. Department of Health and Human Services (HHS)—that will determine the specifics of the reform. Some of the more complicated provisions may take years to regulate, while other provisions are likely to have rules governing their implementation within the year. To be sure, the impact of this reform will have significant implications for the state budget, doctors, health care facilities, and the state economy in general. The most significant impacts for Texas will be within the Medicaid program.

The principal goal of PPACA is to increase the number of Americans covered by health insurance. Texas has the nation's highest uninsured rate, with more than 6 million children and adults uninsured. Under the new reform, many of these uninsured will now become eligible for Medicaid. Starting in 2014, the legislation requires states to extend Medicaid eligibility to all individuals under age 65 with family incomes below 133 percent of the federal poverty level (FPL). Under current law, adults must have income at or below 23 percent FPL to qualify for Medicaid, so this increase will dramatically impact caseloads.

As a result of this eligibility expansion, the Texas Health and Human Services Commission (HHSC) estimates that caseloads for Medicaid and the Children's Health Insurance Program (CHIP) will increase by more than 1.8 million by 2014, and more than 2.1 million by 2019.[i] The cost of such massive increases in enrollment will be significant. The Texas Comptroller's Office estimates the cost of such a significant increase will require an additional $5.8 billion from the General Revenue Fund (GR) by 2019.[ii]

Beyond the extra Medicaid costs that states are certain to incur, there are some other state Medicaid cost increases that are very likely to occur. This includes payments to Disproportionate Share Hospitals (DSH), which consists of extra, lump-sum Medicaid payments to hospitals that treat a "disproportionate share" of Medicaid patients. Theoretically, DSH payments help defray those hospitals' costs of providing uncompensated care to the low-income uninsured, though most states have little real accounting control over how hospitals actually use the funds.

Under the new law, federal DSH funding will be reduced each year beginning in FY 2014 under the premise that as more of the uninsured gain coverage, hospital uncompensated care costs will decline. While this theory is logical, in practice, state lawmakers are likely to confront political pressure from DSH payment–dependent hospitals seeking to maintain their revenues. Nearly 200 facilities in Texas are designated at DSH-eligible hospitals.[iii]

Another central goal of PPACA is changing the way health insurance is arranged for working-age Americans and their families. For the first time, the federal government is going to impose a

requirement on citizens and legal residents to purchase a product in the private economy, namely government-approved health insurance. The government will also establish what constitutes an appropriate insurance policy, and heavily regulate the premiums that can be charged.

Beginning September 1, 2010, insurance plans are no longer allowed to set lifetime limits on benefits, deny coverage to children with pre-existing conditions, or rescind coverage once offered. Additional restrictions come into effect in 2014 with prohibitions against requiring waiting periods of more than 90 days, setting annual limits on benefits, or denying coverage to any individuals with pre-existing conditions. The result of these provisions is almost certain to be higher premiums. According to recent filings with state regulators, Aetna, some BlueCross BlueShield plans, and other smaller carriers have asked for premium increases of between 1% and 9% to pay for extra benefits required under PPACA. Coupled with already rising medical costs, premiums could rise as much as 20 percent. [iv] Health plans administered for state employees as well as the University of Texas and Texas A&M systems will all be affected by the changes to dependant coverage and limitation of waiting periods, resulting in costs well over $250 million to the state by 2019, according to the Comptroller's Office.[v]

States are expected to create new "exchanges" by 2014 through which individuals and employees in smaller firms of less than 100 employees would get their insurance. However larger employers could choose to let their workers get their insurance through the exchanges as well instead of through the employer. The federal government would subsidize the premiums of those with incomes between 133 and 400 percent of the federal poverty level. Employers with at least 50 employees would pay a tax penalty if any of their workers ended up in subsidized insurance through the exchanges. High-risk pools will be temporarily established to accommodate the uninsured more immediately, but Governor Perry has rightly declined to establish a high-risk pool for Texas, instead leaving its administration up to the federal government. The governor cited concerns with many unanswered questions relating to the implementation of the temporary high-risk pool program, such as the absence of rules and key contract terms to ensure financial solvency of the program. While Congress has committed $5 billion to operating these risk pools in all 50 states for at least four years, this amount is expected to be inadequate. In the coming years, state officials will most likely be forced to reduce health coverage, raise premiums or ask state taxpayers to pay for these high-risk pools once the federal funds run dry.

Finally, the provisions of PPACA that may have the most immediate effect on state budgets are the "maintenance of effort" (MOE) requirements in the law that are applied to Medicaid and CHIP. Under those provisions, state are prohibited from enacting more restrictive eligibility standards or processes than were in effect for Medicaid and CHIP at the time the new federal legislation was enacted. Without the ability to enforce tougher eligibility standards or processes, the state faces very limited options to help reduce the costs of Medicaid and CHIP.

In order to offset the significant costs of PPACA, Medicare payments will be cut by over $500 billion dollars over the next 10 years. A large portion of these reductions will come from the Medicare Advantage program, which allows seniors to enroll in private health insurance plans instead of traditional Medicare. These plans—which provide extra benefits with frequently no extra costs—are likely to be discontinued. Additionally, there are many new taxes on health care products and services, including drugs, medical devices and insurance policies. There are also new taxes unrelated to health care added to finance the massive new spending spree. There are new or increased income taxes, business taxes, even a tax on tanning salons.

## 1a. Life After Obamacare: What Can Texas Do?

In passing "Obamacare," Congress and the Administration have enacted a sweeping overhaul of one-sixth of the American economy and in doing so have dramatically expanded the reach and scope of federal power. This federal expansion is a direct challenge to the traditional authority of the states.

Since the passage of President Obama's unpopular PPACA, many states, including Texas, have pushed back against the federal government's intrusion into the nation's health care system. This includes challenging the constitutionality of the law's insurance mandate and calling for repeal and replacement of the law. Now Texas must confront a simple but crucial question: What should be done further while litigation and repeal efforts run their course?

There are now two clear paths for states: A proactive one, creating reform measures ahead of the PPACA deadlines to help preserve value and choice for consumers, or one where state officials simply wait for the federal Department of Health and Human Services to dictate how the state of Texas should operate its health care system. Proactive steps include pressuring the federal officials at HHS to explain the implications of the reforms for individual states, preferably in public hearings and appearing before the state legislature to answer questions. State lawmakers should also pressure HHS for rational and simplified regulations for the PPACA provisions, leaving as much flexibility for states as possible.

Additionally, Texas Attorney General Greg Abbott should continue his efforts to protect the state's authority to regulate health care for its own citizens. In response to the passage of federal health care reform, Attorney General Abbott joined with 25 other attorneys general in filing a lawsuit in opposition to the legislation. The lawsuit asserts that numerous aspects of the federal legislation are unconstitutional, noting especially that:

> The Constitution nowhere authorizes the United States to mandate, either directly or under threat of penalty, that all citizens and legal residents have qualifying healthcare coverage. By imposing such a mandate, the Act exceeds the powers of the United States under Article I of the Constitution and violates the Tenth Amendment to the Constitution.[vi]

Congress and advocates of the legislation contend that the federal government has the authority to mandate the purchase of personal health insurance under the Commerce Clause contained in Article I, Section 8 of the United States Constitution. The Commerce Clause states that "[The Congress shall have power] To regulate Commerce with foreign Nations, and among the several States, and with the Indian tribes."

The authors of the health care reform legislation (H.R. 3590, 111th Congress) even attempted to head off a constitutional challenge by asserting their powers under the Commerce Clause and including the following justification in the bill itself:

> SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.
>
> (a) Findings- Congress makes the following findings:
>
> (1) IN GENERAL- The individual responsibility requirement provided for in this section (in this subsection referred to as the 'requirement') is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

> (2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE- The effects described in this paragraph are the following:
>
> (A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.
>
> *[H.R. 3590, 111th Congress, Section 1501.]*

The attorneys general joined in voiding the law, however, counter that:

> The Act is directed to a lack of or failure to engage in activity that is driven by the choices of individual Americans. Such inactivity by its nature cannot be deemed to be in commerce or to have any substantial effect on commerce, whether interstate or otherwise.[vii]

The position adopted by the attorneys general is supported by a legal brief compiled by the Heritage Foundation in December 2009, which suggests that precedent is on the side of the attorneys general, noting that:

> Because the personal insurance mandate purports to reach the refusal to engage in economic activity—which is both inactivity and noneconomic—the Supreme Court could not uphold this exercise of power without admitting that the Commerce Clause has no limits, a proposition it rejected in *Lopez* and *Morrison*, and from which it did not retreat in *Raich.*[viii]

The Heritage Foundation goes on to argue that if the individual mandate were upheld by the Supreme Court:

> Congress would have the unlimited power to regulate, prohibit, or mandate any or all activities in the United States. Such a doctrine would abolish any limit on federal power and alter the fundamental relationship of the national government to the states and the people. For this reason it is highly doubtful that the Supreme Court will uphold this assertion of power.[ix]

Even the New Deal-era Supreme Court wrote that:

> The authority of the federal government may not be pushed to such an extreme as to destroy the distinction, which the commerce clause itself establishes, between commerce 'among the several states' and the internal concerns of a state.[x]

If the Supreme Court determines that the Commerce Clause does not give the federal government the power to compel individuals to purchase a specific product (health insurance), it would be a major victory for limited government and personal liberty.

In December 2010, a federal court in Virginia stuck down the portion of PPACA that requires a person to purchase health insurance or pay a penalty- often referred to as the "individual mandate."[xi] In January 2011, a Florida federal judge also ruled against the current administration and in favor of 26 states over the constitutionality of the PPACA.[xii]

The second opinion, however, differs from the first in that the second opinion found that the individual mandate of the PPACA is "not severable" from other portions of the health care act. As a result, the second court struck down not only the individual mandate, but the entire PPACA.

In the opinion, Judge Roger Vinson first rejected the states' argument that the PPACA exceeds the federal government's spending powers because it is coercive. The states argued that the PPACA left them in an impossible situation- either exit Medicaid and forfeit federal funds, or remain in Medicaid as modified by the PPACA. Either case, the states argued, would lead to state budget disasters. The court rejected this argument, citing precedent that state participation in Medicaid is voluntary, not coercive.

Turning to the individual mandate portion of the PPACA, the court found that it exceeded the scope of Congress's power under the Commerce Clause of the federal Constitution. While the Commerce Clause empowers Congress to regulate commercial activity, the court concluded that the decision by an individual to not purchase health insurance is inactivity, not activity. Therefore, Congress cannot compel a person to purchase health insurance.

After deciding that the individual mandate was unconstitutional, the court considered the question of whether it was "severable," from the PPACA- in short, whether the remaining parts of the statute could be salvaged. The court pointed out that the Obama administration itself had referred to the individual mandate as an "essential" part of the PPACA fourteen times in its briefs on the case. Moreover, Congress originally included a "severability clause" in a draft of the PPACA (which states that if a portion of a law is found unconstitutional, the rest of it should not be affected), but removed that clause before the statute was enacted, thus raising doubt about whether Congress intended for the PPACA to be implemented if the individual mandate was struck down.

Four federal courts have now split evenly over the constitutionality of PPACA. Given this split and the importance of the health care issue, the Supreme Court is likely to eventually decide the issue.

As litigation over the constitutionality of the PPACA continues, legislators in Texas must continue to work to protect health care freedom in Texas. Enacting "health care freedom" legislation similar to that which passed the Arizona Legislature in 2009 is a vital step in this process. Legislation such as House Joint Resolution 51 (82R) by Representative Christian is recommended. HJR 51 would amend the Texas Constitution to the effect that "each individual in this state has the right to choose or decline to choose health insurance coverage without penalty or sanction or threat of penalty or sanction."

The federal system of government relies on the notion that states are equally charged with protecting the rights of their citizens. Underscoring this point, former Supreme Court Justice William Brennan argued that "the legal revolution which has brought federal law to the fore must not be allowed to inhibit the independent protective force of state law — for without it, the full realization of our liberties cannot be guaranteed."[xiii]

***Recommendations***

- *Pass Health Care Freedom Legislation that protects Texas residents' right to participate or not in any health care system and prohibits the government from imposing fines or penalties on that person's decision.*

- *Pass Health Care Compact Legislation. Compacts are described in Article I, Section 10 of the United States Constitution. Interstate compacts between states exist in a wide variety of areas, covering issues such as transportation, taxation, criminal background checks, and the supervision of former prisoners. By entering into a health care compact with other states, Texas can regain control over its own health care policy because member states of the compact will be freed from federal regulation.*

  *The member states of the compact would work together to ratify the compact and to gain congressional approval. Once the compact is ratified and approved, each state is able to create a health care system in a way that meets the needs of its citizens. An interstate compact that attains the approval of Congress becomes federal law and would therefore supersede existing state and federal laws.*

  *The Health Care Compact returns the power to regulate health care to the states in the states which pass the Compact (the Member States). Each Member State will then be able to write its own health care laws, creating more effective and efficient health care policy for its citizens. Once the Member State creates its own health care policy, its citizens will no longer be subject to federal health care laws and regulations, including "Obamacare."*

## 1b. The Cost of Entitlement Programs

The Texas Legislature appropriated $45 billion for 2010-11 to administer the Medicaid program, serving almost 3 million Texans, of which 2 million are children. This represents almost one third (31 percent) of the state budget.[xiv] Never in the history of the program has spending declined from one year to the next. Children are accounting for a declining share of total Medicaid enrollment due to evolving demographics, most notable of which are aging "Baby Boomers" with significant long-term-care costs and the gradual expansion of the eligible population.

CHIP was appropriated $2.02 billion for 2010-11, serving over 500,000 children. Although CHIP is not an entitlement program and spending is theoretically capped, it has required supplemental appropriations to prevent budget shortfalls since its inception in 2000 and budgets have grown steadily since. The federal government provides a 72 percent match for CHIP funds, but with state-only resources, the program also covers children of legal immigrants, children of school employees who participate in the Teacher Retirement System, and through the State Kids Insurance Program (SKIP), it also provides coverage for children of state employees who meet income requirements.[xv]

Despite the growth and increased costs in CHIP and the Texas Medicaid program, the number of uninsured Texans has continued to increase, reaching six million today. Growth of entitlement programs has neither arrested nor reversed this number.

Federal micromanagement has created an incredibly complex and expensive entitlement program in Medicaid. Without reform, this unsustainable program will become significantly worse as the states' aging populations continue to drive-up the already high cost of long-term care, while the provisions of Obamacare will nearly triple the Medicaid caseloads.

With billions of dollars in new costs and unprecedented levels of federal control because of PPACA, Congress is recklessly encouraging states to exercise their sovereign authority and end their participation in the Medicaid program. Medicaid is an optional program, and any state is legally entitled to opt-out of the program, although to be sure, not without significant political and public controversy. While the Texas Medicaid program operates on a budget of $45 billion biannually, only around a third of this funding--$16 billion—is state funds. If Texas were to withdraw from participation in the Medicaid program , it is unlikely that the state would still receive the remaining federal allotment. But the $16 billion allocated by state funds could still be used in innovative and more cost-effective ways to serve millions of low-income Texans.

A recent Heritage Foundation analysis finds that Texas would save over $60 billion between 2013 and 2019 by withdrawing from Medicaid, even assuming they still spend the majority of their current spending on long-term care.[xvi] At a time when significant new costs and millions of new enrollees threaten to cripple the program to unsustainable levels, state lawmakers should prudently consider whether continued participation in Medicaid is in the best interest of Texas.

***Recommendation***

- *Using the Joint Report of the Health and Human Services Commission and the Texas Department of Insurance as starting-point, legislators should assess how Texas should continue to provide health care services to the indigent in the most effective way possible for both taxpayers and those served by the program. That report concluded that:*

*With a 9% annual rate of growth in Texas, the Medicaid program, according to the Congressional Budget Office, is unsustainable at the state and federal level…Texas has implemented initiatives to contain costs but has been limited by federal Medicaid policies that overly restrict the application of client cost sharing and do not reinforce individual responsibility in the health care decision making process.*

## 2. Fraud Control

Estimates of health care fraud within government programs ranges from 10 percent to 30 percent of health care spending.[xvii] Data collection within Medicaid is so poor that it is difficult to accurately measure the levels of fraud within the program. Even assuming the low end of the spectrum, fraud is costing the state of Texas $4.5 billion in 2010-11. Regardless of the exact number, there is emerging political consensus that any amount of fraud is unacceptable

Fraud within the Medicaid program can take many forms, including providers filing false claims, or a patient accessing Medicaid services fraudulently. Because of the distant relationship between the payers and the actual health care services in a third-party system, it is easy for patients and health care providers to be less than vigilant about dollars being spent and billed.

The Texas Legislature has enacted numerous bills over the past decade aimed at curbing Medicaid fraud. Seventeen bills with provisions addressing fraud have been signed into law since 2001, ranging from organizational reforms to improve fraud detection between state agencies, to the establishment of specific criminal offenses related to Medicaid fraud. Despite these efforts, Medicaid fraud remains a significant problem that the Legislature must continue to take seriously.

While the federal officials at HHS can do many things to reduce fraud and abuse, including better data sharing across Departments and increased technology solutions to fraud prevention, there are several steps that Texas must take to reduce fraud and abuse within Medicaid:

***Recommendations***

- *Add the phrase "under penalty of perjury" to applications used by people wanting to become providers or suppliers. This addition would give significant weight to prosecutors going after bad actors.*
- *Require Medicaid providers and suppliers to sign contracts stating that Texas has the right to terminate the provider or supplier at any time.*
- *Use private sector standards for establishing the number of providers or suppliers for a product or service in a defined area.*
- *Increase transparency of Medicaid providers by creating a website where payments to providers and suppliers are posted for public access.*
- *Study and carefully consider the role of the HHSC Office of Inspector General (OIG) and whether Medicaid fraud detection responsibilities could be better-handled by Medicaid Managed Care organizations (MCOs). Under this reform, MCOs would be responsible for reporting potentially fraudulent activity to HHSC, conducting investigations of identified providers, and collecting and retaining funds identified as part of fraudulent, wasteful, or abusive practices. Specifically, the following should be studied:*
    - *Permit MCOs to collect fraudulent overpayments: MCOs are currently hindered in their efforts to collect overpayments made to providers. Texas MCOs do not currently have the ability to collect overpayments because of OIG's restrictive policies.*

- *Permit MCOs to retain all collected fraudulent overpayments: MCOs are currently prevented from retaining the full amount of identified fraudulent overpayments made to providers. The state retains a percentage of the collected overpayments unless OIG returns a case back to an MCO. The MCOs have systems in place to identify fraud, waste, and abuse and because they also directly contract with the rendering providers, the MCOs are in the unique position to capture overpayments made to these providers and educate them on correct billing practices.*

- *Expand reporting requirements by permitting MCOs to report all fraud, waste, and abuse efforts to the state on a quarterly basis: MCOs are only required to report cases to OIG with no fraud, waste, or abuse implications. This practice runs counter to efforts to ensure that all efforts to mitigate fraud, waste, and abuse are utilized. Permitting MCOs to report all suspected cases to the state will encourage state involvement with fraud, waste, and abuse efforts, which may expedite recoveries.*

*A range of states, including Florida, Georgia, Maryland, New Mexico, Nevada, New Jersey, New York, Ohio, Tennessee, and Virginia, have enacted reforms similar to those outlined above in order to improve Medicaid fraud investigation and recovery.*

## 3. Medicaid Managed Care

Since 2001, the cost of the Texas Medicaid program has doubled, while enrollment has increased by more than 70 percent. Such increases demand that the state employ the most cost-effective method of Medicaid delivery on a statewide basis.

Currently, there are two major Medicaid delivery models being utilized in Texas: the Health Maintenance Organization (HMO) managed care model, which is a fully capitated, risk-based model; and the Primary Care Case Management (PCCM) model, which is a non-capitated, fee-for-service. A third model, Integrated Care Management (ICM) , was recently dismantled.

Under the HMO model, the state pays a specific amount per person to the HMO and the HMO assumes the financial risk of providing all medically necessary services. Under this arrangement, the state has a greater degree of budget certainty and the Medicaid enrollee receives a higher quality of care. The incentives are aligned for HMOs to redirect care away from unnecessary and costly over-utilization of emergency room care and hospitalization and to invest funds into prevention, disease management, and long-term care support services. The HMO managed care model is also less vulnerable to fraud than other methods of Medicaid delivery. Because the state contracts with HMOs on a flat monthly fee-per-client basis, there is no scope for the state to be fraudulently billed for health services.

Conversely, the PCCM model assigns a primary care physician to each client and uses an administrator to set up physician networks and liaise with providers. Under the PCCM model, providers are reimbursed on a fee-for-service basis and primary care physicians receive a monthly “case management” fee based on the number of clients in their care. Because the functions of financing and health care delivery are separate, there is greater potential for duplication of effort and the emergence of unnecessary costs.

Medicaid managed care represents a successful private sector solution for addressing costs and improving quality. The HMO model (State of Texas Access Reform (STAR) and STAR+PLUS) has proven to be a stronger approach to managed care than the PCCM models. Specifically, the HMO model is significantly more cost-effective for the state, provides a more comprehensive level of care to Medicaid clients, and is less vulnerable to fraud and abuse than other Medicaid delivery models. HHSC estimates suggest that expansion of the STAR and STAR+PLUS programs in South Texas could save the state $290 million in general revenue in 2012-13.

In order to contain the growing cost of the state’s Medicaid program, the HMO managed care model must be expanded statewide. Currently, statute prohibits expansion of STAR+PLUS into Cameron, Maverick and Hidalgo Counties, while state law allows significant scope for expansion into the Dallas, Tarrant, Lubbock, and El Paso service areas, with HHSC planning to roll out STAR+PLUS in the Dallas and Tarrant service areas in 2011.

***Recommendations***

- *Expand the STAR and STAR+PLUS Medicaid managed care models by ending county-specific exemptions. Expand STAR+PLUS into the El Paso and Lubbock service areas.*
- *In addition to expanding the service areas in which STAR+PLUS operates, the state can also improve Medicaid delivery by carving STAR+PLUS hospital, pharmaceutical, and nursing home*

*costs into managed care, and replacing Medicaid Primary Care Case Management (PCCM) service delivery with Exclusive Provider Organization (EPO) coverage where appropriate. Legislators should also study capitating Medicaid dental services into managed care.*

## 4. The Children's Health Insurance Program

Begun in 1997—established in 1999 in Texas—the State Children's Health Insurance Program (S-CHIP) was created to address the large number of uninsured children. Texas S-CHIP is limited to children under age 18, in families whose incomes fall below 200 percent of the Federal Poverty Level (FPL) and who are not eligible for Medicaid.[xviii] Unlike Medicaid, S-CHIP has not traditionally been an entitlement and states have been permitted to set eligibility standards and require monthly premiums from enrollees. In fact, the US Code states that "nothing in this subchapter shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan."[xix] However the passage of PPACA has changed that.

PPACA included provisions specific to S-SCHIP that severely limit states' ability to restrict eligibility or change coverage determinations. Section 2001 of PPACA requires that:

> States would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

The Texas Comptroller Confirms that:

> The Patient Protection and Affordable Care Act (PPACA) does not allow states to implement more restrictive eligibility standards, methodologies, or procedures than were in place before enactment of the bill. The American Recovery and Reinvestment Act of 2009 (ARRA) included the same restriction effective through December 31, 2010 (PPACA extends the restriction until January 1, 2014 for Medicaid adults and October 1, 2019, for Medicaid children and CHIP). In August 2009, CMS issued a letter to state Medicaid directors related to ARRA and indicated that states cannot increase the frequency of eligibility re-determinations (for example from 12 months to 6 months). It is expected that CMS will similarly interpret the PPACA restriction.[xx]

This change in federal law runs up against the Texas statute that created S-CHIP in 1999. Senate Bill 445 (76R), which established Texas S-CHIP contained the following provision:

> Sec. 62.003. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM. (a) This chapter does not establish an entitlement to assistance in obtaining health benefits for a child.

By prohibiting states from establishing more stringent eligibility levels, PPACA has effectively made S-CHIP an entitlement program and has drastically reduced the ability of states to run their own programs. Prohibiting a transition to six months continuous eligibility where eligibility is determined twice a year is particularly egregious because this would help to ensure that only eligible children are on the program.

Given the increased enrollment that is likely to result from PPACA, the inability of states to change or amend their programs in response to budget constraints is alarming. Without repeal of the law—or at

least the provisions prohibiting changes to eligibility or program determinations—states will be significantly handicapped in their ability to contain growing costs and rising enrollment in S-CHIP.

The PPACA provisions mean that Texas cannot lower income eligibility levels for S-CHIP. However, a range of other reforms may be possible. The reforms outlined below do not directly affect the income eligibility requirements for S-CHIP, although they may still fall under the type of reform that is prohibited by PPACA. Given the budget situation that the state is likely to face in 2012-13 and the cost of continuing S-CHIP under current program rules, it would be worthwhile to enact these reforms, even if a legal challenge results under the PPACA provisions:

***Recommendations***

- ***Limit Enrollment to Children:*** *CHIP is clearly intended to serve children. Section 62.101 of the Texas Health and Safety Code established that an individual must be under the age of 19 to receiver coverage under CHIP. However, the Government Accountability Office (GAO) identifies 14 states that have received federal waivers to expand CHIP coverage to adults. Texas should resist any efforts to cover adults under CHIP, since they can be served already through Medicaid.*

- ***Increase Individual Contributions to Coverage:*** *Section 62.153 of the Texas Health and Safety Code establishes a clear requirement for families receiving CHIP benefits to contribute co-payments, an enrollment fee, or part of the cost of the premium. Current program rules require co-pays ranging from $3-$20 for brand name drugs; $0-$5 for generic drugs; $3-$10 for doctor visits, and; $3-$50 for emergency room visits, in addition to an annual enrollment fee ranging from $0-$50.*

- ***Increase the contributions that families are expected to make toward their CHIP coverage, including, but not limited to a $20 monthly premium:*** *Requiring families to contribute to the cost of the health care coverage serves to underscore the notion that health care is a personal responsibility. The contributions should be raised so that the burden of paying for health care is borne less by taxpayers generally and supported more by the families who receive coverage under CHIP.*

- ***Eliminate the Immigrant Child Health Insurance Program, Perinatal Services, and the School Employee Children Insurance Program:*** *Texas operates these overlapping programs that duplicate service provided by S-CHIP and waste millions of Texas taxpayer dollars. The Immigrant Child Health Insurance program costs $34.4 million in 2010-11, Perinatal Services costs $577.5 million in 2010-11, and the School Employee Children Insurance Program costs $35.3 million in 2010-11. These are optional state programs and cover children who could be otherwise covered by S-CHIP or Medicaid.*

## 5. Improving Health Insurance and Coverage

The regulation of health insurance and particularly the mandated levels of coverage that the state requires are a driving force behind the high cost of health insurance. Every health condition for which an insurer is required to provide coverage increases the cost of that coverage, making it less affordable for individuals, families, and businesses. Consumers are forced to buy health benefits packaged together in "Cadillac" plans they would not otherwise choose, and others—especially small businesses—may no longer be able to afford any coverage at all.

There are currently 58 health insurance mandates in force within the state of Texas, ranking the state as one of the country's 5 most heavily regulated. According to the Council for Affordable Health Insurance (CAHI), insurance premiums in Texas increased 40 percent in five years, the third highest rate of increase in the nation. The number of mandates continues to rise, as each legislature adds new ones.

In 2003, Texas legislators enacted Senate Bill 541 (78R) which created "consumer choice" health insurance plans. The legislation permits insurers in Texas to offer policies that do not cover the full range of health benefits normally mandated by the state, provided that the enrollee is informed that the policy does not provide all state-mandated coverage. According to the Texas Department of Insurance (TDI), these mandate-free plans have provided insurance to more than 21,000 previously uninsured Texans since 2004.

***Recommendation***

- *Oppose new health insurance mandates and expand the availability and affordability of mandate-free health insurance plans.*

The lack of price transparency is a major factor contributing to the high—and rising—cost of health care. Because patients have little or no access to information about the estimated cost of various procedures or treatments, they are not able to make informed decisions about cost or relative quality regarding their health care, thus triggering over-utilization. It is not until after the patient has received a treatment or procedure that they are made aware of out-of-pocket costs. The health care sector is the only industry in our society where information on the cost and quality of services sought is not readily accessible to the consumers who seek it. Only by exposing consumers to the health care cost and quality options available to them will any genuine price or quality competition be achieved.

Within the health care market, cosmetic surgery stands out as a rare example of a form of health care for which prices are falling. Cosmetic surgery expenses are paid out-of-pocket by the patient, and are therefore subject to market forces in which the prices are transparent and services are paid for by the patient at the time of service.

By eliminating health insurance mandates, consumers would increasingly pay out-of-pocket for their health care which would foster a much higher level of transparency. By allowing them to judge health care providers on the quality of care they will provide, patients become true consumers who are better equipped to make informed and cost-effective decisions.

The 81st Legislature passed HB 2256 into law, which promotes transparency by requiring prior notification by the physician to the enrollee of the estimated cost of their out-of-pocket charges. Additionally, the bill requires hospitals to indicate the specific facility-based physicians who have exclusive privileges in that hospital and requires the hospitals to inform the enrollee of the possibility of receiving a bill with out-of-pocket charges. While HB 2256 addressed a fundamental lack of transparency, much work remains. The Legislature should require that hospitals, physicians, and health plans make cost and quality information available to the public.

***Recommendation***

- *Improve price and quality transparency among hospitals, physicians, and health care plans.*

Employer sponsored insurance is not usually portable. When an individual loses or changes jobs, they are likely to also lose their health insurance coverage. List billing could be expanded so that coverage afforded to employees is not tied to their current employer and can be easily transferred to another employer.

***Recommendation***

- *Improve employer-sponsored health insurance by increasing portability of and removing regulatory barriers to cost-effective solutions such as list billing.*

The Employees Retirement System of Texas (ERS) administers the insurance and retirement benefits of state employees across Texas. Serving more than half a million state employees, retirees, and their dependents, ERS has experienced significant cost increases since 2000. According to the Legislative Budget Board, providing health insurance to state employees will cost $4.1 billion—approximately 2.2 percent of the state's budget—in 2010-11. The increasing cost of health insurance is the primary driver of such dramatic growth in cost.

One way to generate cost savings would be to allow state employees and their dependents the opportunity to choose a Health Savings Account (HSA) instead of the standard benefits package. Created by Congress in 2003, HSAs combine a high-deductible health plan with a savings account used to pay for health care with pre-tax dollars. Tax-exempt contributions are made to the account by either the employer or by the individual. Employees meet their deductible by paying medical bills out-of-pocket with funds in the HSA and any money not used in their account rolls over to the next year with no penalty. Not only do employees have more control over their health care, the cost savings of high deductible health plans are significant.

At the state level, Indiana has had significant success implementing HSAs for state employees. 70 percent of Indiana's state employees are enrolled in high-deductible health plans coupled with HSAs, which are offered as part of the standard benefits package for state workers. As a result of this high take-up rate, these employees have a total of $30 million in their accounts ($2,000 per employee) and their health care costs have fallen. Indiana Governor Mitch Daniels (R-Indiana) pointed out that:

> Most important, we are seeing significant changes in behavior, and consequently lower total costs. Overall, participants in our new plan ran up only $65 in cost for every $100 incurred by their associates under the old coverage.[xxi]

In Texas, legislation similar to House Bill 1269 (80R) by Rep. Crownover is recommended. HB 1269 would have provided state employees the option to have a Health Savings Account rather than the standard state health benefit package. This approach will ensure that employees are given control over the kind of health care coverage they receive and that the state will be able to reduce its health care costs into the future as its employees choose the HSA option.

***Recommendation***

- *Introduce a voluntary Health Savings Account option for state employees and retirees.*

Improving health coverage means that legislators should also seek to improve the access that Texans have to timely medical care. Convenient care clinics, which are small healthcare facilities located in high-traffic retail outlets with pharmacies staffed by advanced practice nurses and physicians assistants, are an important development in this area. They provide affordable and accessible, non-emergency care to consumers who would otherwise wait for appointments with primary care physicians (PCPs). They also give individuals without health insurance the opportunity to obtain affordable health care without having to resort to the emergency room. Recent efforts to support convenient care clinics in HB 1096 (80R) by Representative Orr are important steps in facilitating their operation. By limiting the amount of time that a physician must be at location supervising the work of advanced practices nurses or physician assistants, the clinic can more easily and quickly service patients.

***Recommendation***

- *Study solutions to physician shortages at convenient care clinics in order to better facilitate effective operation of such clinics.*

## 6. Reforming Human Services

The Texas Health and Human Services Commission (HHSC) administers several important human services programs serving low-income Texas families. With the recent economic downturn, many of the human service programs in Texas have seen rising enrollments and increased pressure on the budgets to serve more people. Given these dynamics, it is important to ensure these programs operate as efficiently and cost-effectively as possible.

The Temporary Assistance for Needy Families (TANF) program in Texas has been one of the most successful in the nation at moving recipients from dependence into self-sufficiency. Overhauled as part of the 1996 welfare reform effort, the TANF program is a block grant that provides assistance and work opportunities to low-income families. TANF requires participants to be engaged in meaningful work or job-training activities while also limiting the amount of time that assistance is available. Since the 1996 reform, state caseloads have dropped dramatically and millions of TANF recipients have entered the workforce.

Federal work requirements mandate that at least 50 percent of all families and 90 percent of those in two-parent families enrolled in TANF must be involved in a work activity. Approved activities include job-training, subsidized or unsubsidized employment, community service, and up to six weeks of job-searching annually. However, there are large groups of people exempt from these work requirements, often making it difficult for states to meet the federal participation rate targets. Allowable exemptions include recipients aged 18 or younger, aged 60 or older, those unable to work because of a disability, a single parent caring for a baby under 1 year of age, a caretaker of a family member with a disability or illness, or a single grandparent aged 50 or older caring for a child younger than 3.

The percentage of Texas TANF recipients exempted from the work-activity requirement is increasing. In 2003, only 20 percent of TANF recipients were exempt from work-activity requirements; today 39 percent are exempt.[xxii] If this trend continues, the shrinking pool of TANF recipients not exempted from work requirements will barely enable Texas to meet its 50- and-90 percent work requirement targets. In fact, the Texas Workforce Commission projects that by July 2011, 45 percent of TANF recipients will be exempt.[xxiii] Failure to meet the work participation requirements will result in a reduction to the state's TANF block grant.

***Recommendation***

- *Strictly enforce the exemptions to the TANF work requirements to ensure that the state can fully engage recipients in meaningful work activities and prepare them for self-sufficiency.*

One of the reasons for the successful reduction of the TANF caseloads since the mid-1990's is the strict sanctions for non-compliance that were enacted by the 78th Legislature. Texas utilizes a full family sanction model in which the entire family's cash grant is terminated when the adult recipient is not in compliance with the requirements for receiving TANF. The state will also terminate Medicaid benefits for non-compliant adults. These stronger sanctions have encouraged responsible behavior and incentivized compliance with all requirements in order to receive the maximum TANF benefit. Many other states that utilize reductions in TANF benefits rather than a full sanction have not seen the dramatic declines in caseloads that Texas has experienced. The number of families in Texas receiving

TANF fell over 70 percent between 1996 and 2006, compared to a 56 percent decline nationally during that same time period.[xxiv]

***Recommendation***

- *Maintain the full family sanction and Medicaid sanction for TANF recipients who are not compliant with work requirements.*

The Supplemental Nutrition Assistance Program (SNAP)—also known as Food Stamps—serves over 3 million Texans with electronic nutrition assistance benefits that can be used to purchase food at most grocery stores. The current recession that has driven up unemployment in Texas, combined with three major hurricanes in recent years, has caused the SNAP caseloads throughout the state to swell. The rising number of applicants has created a large backlog of applications that remain pending within the state of Texas, in violation of federal law which requires food stamp applications to be processed in fewer than 30 days. Additionally, many local SNAP eligibility offices continue to rely on outdated and inefficient methods to process SNAP applications, compounding the backlog while also increasing the number of errors made in eligibility determinations.

Improving technology is a crucial way for the SNAP program to minimize delays in processing applications and avoiding errors. Approximately 80 percent of SNAP cases are still maintained as paper files, which are more prone to errors, while also being labor-intensive to maintain. Texas had previously appealed to the Federal Nutrition Service (FNS) at the US Department of Agriculture (USDA) to allow for online, fax, and phone applications for food stamps, but was denied. The application process for SNAP benefits is notoriously cumbersome, by requiring in-person interviews for eligibility determination and the submission of paperwork often over numerous visits to local offices. Increased technological capacity would allow for SNAP officials to more effectively communicate with applicants over the internet, and also allow applicants to check the status of their application online.

***Recommendation***

- *The SNAP program should use scanning equipment to create electronic files. The state should continue to pressure FNS for the ability to allow electronic submission of applications. The internet should be increasingly used as a resource to communicate with applicants regarding the status of their eligibility determinations.*

ENDNOTES

[i] Texas Comptroller of Public Accounts, "Diagnosis: Cost—An Initial Look at the Federal Health Care Legislation's Impact on Texas," June 4, 2010.
[ii] Texas Comptroller of Public Accounts, "Diagnosis: Cost—An Initial Look at the Federal Health Care Legislation's Impact on Texas," June 4, 2010.
[iii] http://www.dshs.state.tx.us/chs/hosp/Forms/hsprep.pdf.
[iv] Wall Street Journal, "Health Insurers Plan Hikes," September 7, 2010.
[v] Texas Comptroller of Public Accounts, "Diagnosis: Cost—An Initial Look at the Federal Health Care Legislation's Impact on Texas," June 4, 2010.
[vi] Lawsuit filed by 13 attorneys general in the United States District Court, Northern District of Florida, March 22, 2010; http://www.oag.state.tx.us/newspubs/releases/2010/032310healthcarelawsuit.pdf.
[vii] Ibid.
[viii] "Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional," The Heritage Foundation, December 9, 2009; http://www.heritage.org/Research/Reports/2009/12/Why-the-Personal-Mandate-to-Buy-Health-Insurance-Is-Unprecedented-and-Unconstitutional.
[ix] Ibid.
[x] N.L.R.B. v. Jones & Laughlin Steel Corp., 301 U.S. 1, 30 (1937).
[xi] http://online.wsj.com/article/SB10001424052748703727804576017552229615230.html.
[xii] http://online.wsj.com/article/SB10001424052748703439504576116090813454296.html.
[xiii] William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 491 (1977).
[xiv] Legislative Budget Board, "Fiscal Size Up: 2010-2011," December 2009.
[xv] See information on the SKIP program at http://www.ers.state.tx.us/insurance/skip/default.aspx.
[xvi] The Heritage Foundation *Web Memo*, "Medicaid Meltdown: Dropping Medicaid could Save States $1 Trillion," by Dennis G. Smith and Edmund F. Haislmaier, December 1, 2009.
[xvii] Testimony to the House of Represenatives Committee on the Judicary, Subcommitee on Crime, Terrorism, and Homeland Security, "The Enforcement of Criminal laws Against Medicare and Medicaid Fraud," by James Frogue, Vice President, Center for Health Transformation, March 4, 2010.
[xviii] See information on the State CHIP (S-CHIP) at http://www.chipmedicaid.org/english/index.htm
[xix] 42 USC § 1397bb(b)(4).
[xx] Texas Comptroller letter to TCCRI Task Force on the State Budget, 2010.
[xxi] "Hoosiers and Health Savings Accounts," Editorial in the *Wall Street Journal,* March 10, 2010.
[xxii] Texas Workforce Commission, Caseload Forecasts, January 2010.
[xxiii] Ibid.
[xxiv] TANF 8th Annual Report to Congress, Table A, http://www.acf.hhs.gov/programs/ofa/data-reports/annualreport8/chapter01/chap01.htm.