TEXAS HEALTH POLICY TASK FORCE

TEXAS HEALTH CARE ★ NEW DIRECTIONS

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TEXAS HEALTH CARE NEW DIRECTIONS

HE WHO HAS HEALTH

HAS HOPE

AND HE WHO HAS HOPE

HAS EVERYTHING

AN ANCIENT PROVERB

TEXAS HEALTH POLICY TASK FORCE

November, 1992

The Honorable Ann W. Richards
Governor of Texas
The Honorable Bob Bullock
Lieutenant Governor of Texas
The Honorable Gibson D. "Gib" Lewis
Speaker, Texas House of Representatives
Members of the 73rd Texas Legislature

The Texas Health Policy Task Force is pleased to submit to you our report, **TEXAS HEALTH ★ NEW DIRECTIONS.**

In response to the Governor's proclamation of November 13, 1991, our twenty-nine member Task Force engaged in study and discussions to address the charge of "ensuring that all Texans have access to appropriate and affordable health services". We benefited greatly from the many individuals and agency representatives who provided us with information, and from the hundreds of citizens who presented testimony at public hearings at eight sites throughout Texas.

We were guided in our work by Executive Director James W. Fields who provided counsel, structure and organization for our work. Highly qualified policy analysts and technical assistants engaged in research, data collection and writing on our behalf.

Speaking personally, I extend special thanks to the Task Force members who regularly attended meetings and reviewed extensive materials related to health care. Each brought expertise and a particular perspective to our deliberations. I have enjoyed working with an excellent group of dedicated and knowledgeable Task Force members and staff.

The enclosed report presents the Task Force's recommendations for health care reform in Texas. We believe that health care reform is one of the major issues facing the nation and the state today. Thank you for your thoughtful consideration of our report, **TEXAS HEALTH ★ NEW DIRECTIONS.**

Sincerely,

Shirley S. Chater

Shirley S. Chater, Ph.D., Chair
Texas Health Policy Task Force

SSC: cbb

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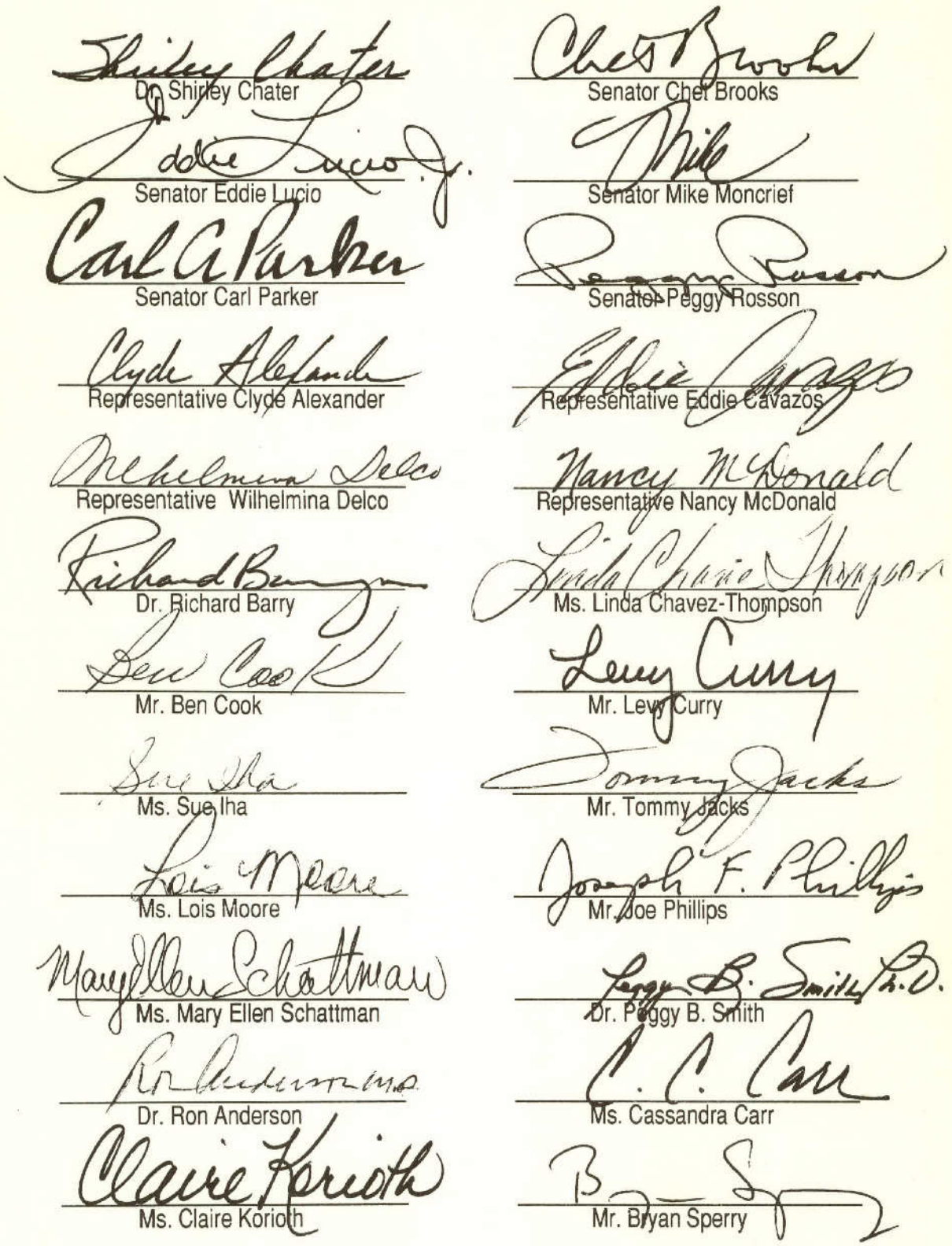
The following Task Force Members supported the recommendations for the *Texas Children's Health Plan, Reforms to the Current System* and the *Texas Health Plan*:



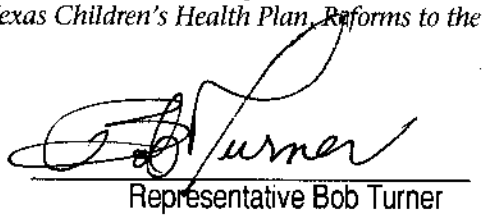
The following Task Force Members opposed the recommendations for the *Texas Children's Health Plan, Reforms to the Current System* and the *Texas Health Plan*:


Representative Jim Tallas

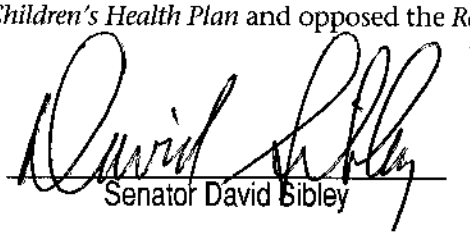

Mr. Bill Daves


Mr. Larry Milner

The following Task Force Member supported the recommendations for the *Texas Children's Health Plan, Reforms to the Current System* and opposed the *Texas Health Plan*:


Representative Bob Turner

The following Task Force Member supported the recommendation for the *Texas Children's Health Plan* and opposed the *Reforms to the Current System* and the *Texas Health Plan*:


Senator David Sibley

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TEXAS DEPARTMENT OF INSURANCE
TEXAS DEPARTMENT OF PUBLIC HEALTH
TEXAS DEPARTMENT OF HUMAN SERVICES
OFFICE OF THE STATE COMPTROLLER
TEXAS RAILROAD COMMISSION
TEXAS SENATE MEDIA SERVICES

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Carolyn Henson

The Task Force gratefully acknowledges all of the persons who worked to set up site visits and public hearings in Tyler, Lubbock, Abilene, Dallas, McAllen, Houston, El Paso and San Antonio.

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TEXAS HEALTH CARE ★ NEW DIRECTIONS

THE PROBLEMS

	PAGE
INTRODUCTION	pp. 10-12
BACKGROUND	pp. 13-15
HEALTH CARE PROBLEMS FACING TEXAS	pp. 18
Problem Area #1	
Access To Coverage	pp. 19-31
▪ Unmet Health Care Needs of Children and Pregnant Women	pp. 19-21
▪ Failure to Utilize Available Medicaid Funding	p. 22
▪ Problems With Private Health Care Coverage	pp. 23-31
Problem Area #2	
Providers	pp. 32-43
▪ Inadequate Supply and Distribution of Providers	pp. 32-40
▪ Lack of Medicare and Medicaid Acceptance	p. 41
▪ Needed Improvements in State Board Licensing Regulations	p. 42
▪ Conflicts of Interest Regarding Self-Referral	p. 43
Problem Area #3	
Infrastructure	pp. 44-58
▪ Barriers Hindering Delivery of Primary and Preventive Care	pp. 44-47
▪ Lack of Infrastructure in Selected Populations	pp. 48-50
▪ Inadequate Charity Care Delivery by Tax-Exempt Hospitals	p. 51
▪ Deficiencies in Trauma Care Delivery	pp. 52-54
▪ Lack of Available Transportation to Health Care Services	p. 55
▪ Underutilization of Medical Telecommunication Systems	p. 56
▪ Lack of Comprehensive Planning/Evaluation	pp. 57-58
Problem Area #4	
Cost Containment	pp. 59-67
▪ An Overview of Issues Associated With Controlling Costs	pp. 59-60
▪ Rapidly Escalating Pharmaceutical Inflation	p. 61
▪ Questions Regarding Administrative Costs of Health Plans	p. 62
▪ Problems Limiting Consumer Participation	p. 63
▪ Needed Reforms in Medical Malpractice	pp. 64-67
CONCLUSION	p. 68

THE RECOMMENDATIONS

	PAGE
INTRODUCTION	pp. 70-72
Recommendation Area #1	
The Texas Children's Health Plan	pp. 73-80
▪ An Introduction to TCHP	pp. 73-75
▪ Financing the TCHP Plan	pp. 76-77
▪ Delivery of TCHP Services	p. 78
▪ TCHP Cost Containment Measures	pp. 79-80
Recommendation Area #2	
Reforms to the Current System	pp. 81-126
▪ An Introduction to the Reforms	p. 81
▪ Reforms in Access to Coverage	pp. 82-89
▪ Reforms in Provider Services	pp. 90-100
▪ Reforms in Infrastructure	pp. 101-114
▪ Reforms in Cost Containment	pp. 115-126
Recommendation Area #3	
Directions for the Future: The Texas Health Plan	pp. 127-133
▪ An Introduction to the Plan	pp. 127-130
▪ The Benefits to Texans	pp. 131-133
CONCLUDING STATEMENT	PP. 134-136
APPENDIX	
1 - The Texas Children's Health Plan	p. 137
2 - Small Group Benefits Package	p. 138
3 - Primary Health Care Program Expansion	p. 139
4 - School-Based Health Care Expansion	p. 140
5 - The Texas Health Plan	p. 141
REFERENCES	
Cross Reference Guide to the Recommendations	pp. 142-146
Endnotes	pp. 147-149
Chart and Graph Sources	p. 150
Photo Credits	p. 150
Acronyms	p. 150
Task Force Members Biographies	p. 151-152

INTRODUCTION

Over the past decade, access to affordable health care has become a critical problem for the people of Texas. Our state faces a crisis so great that before the turn of the century, our entire health care delivery system could collapse.

The major problem is that our current system fails to deliver basic health care for *millions* of our people.

THE CRISIS

While a great many Texans have access to medical technology that is the most sophisticated in the world, millions of others cannot afford even the most basic ***preventive*** and ***primary care***. In addition, large numbers of Texans with health insurance benefits often become targets of unfair cost-shifting by health care providers. Millions more are either underinsured or uninsured because of out-of-reach premium costs.[1]

The people of Texas are also experiencing skyrocketing health care costs. In the past five years total health care costs in Texas have soared from approximately $30 billion in 1988[2] to some $44 billion in 1992.[3] The health care expenditure in Texas for 1993 is expected to approach and possibly exceed $49 billion.[4]

While health care costs are escalating, access to health care coverage is plunging. Health care coverage is becoming progressively more expensive, more difficult to obtain and less predictable in its benefits.

In 1989 approximately 120,000 small businesses in Texas either changed health care coverage or completely stopped providing health care benefits.[5] According to a 1990 estimate, approximately 40% of Texans lack adequate health care coverage. Over 3 million (17.6%) are uninsured. An additional 3-4 million (17.6-23.5%) are underinsured.[6]

The health care crisis in Texas reflects a national crisis. In 1980, Americans spent an average of $1,063 per person, per year for health care. In 1990 this figure rose to $2,566. By the year 2000, it is expected that Texans will spend an average of $5,712 per person per year for health care.[7]

PRIMARY CARE

The first level of care a patient receives from a primary care provider for a particular health need.

PREVENTIVE CARE

Providing patients with access to (1) routine, periodic examinations, immunizations and screening tests, (2) risk-reduction counseling, and (3) information and resources that can help them achieve and maintain good health.

While the problems Texans face are being experienced throughout the nation, our state is particularly hard-hit. The reason? Texans are both *younger* and *poorer*[8] than the population of the nation as a whole. The greatest number of underinsured or uninsured come from these two groups.

The severity of our problem — and the urgency to create a solution — is felt by Texans from every segment of the population. *In a recent poll, 7 out of 10 Texans indicated they are disillusioned with the current system of health care coverage and are ready for a new approach.*[9] Individuals, families and businesses are now seeking the government's leadership in solving the health care dilemma.

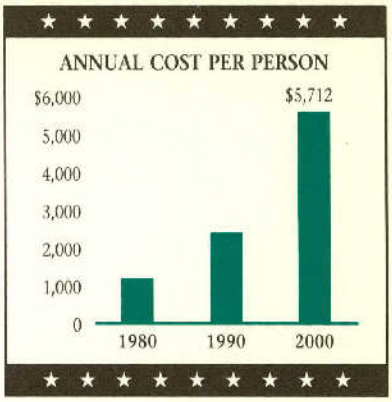
Hundreds of bills designed to help alleviate the crisis have been filed in the Texas Legislature, as well as in the United States Congress. And yet, no comprehensive plan has emerged at either the state or national level.

As the crisis intensifies, it is becoming increasingly clear that states must bear a large part of the responsibility for both developing — and implementing — new systems of delivery. Federal initiatives may indeed eventually be approved by Congress. But in the meantime, Texas simply *cannot afford to wait.*

THE CHARGE

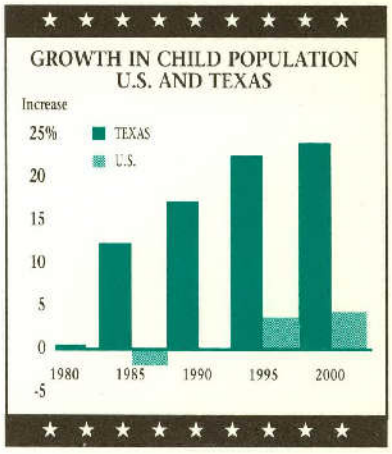
Governor Ann Richards and the leaders of the Texas Senate and House of Representatives — recognizing that a fragmented, "hit-or-miss" approach will not solve the problem — asked for a comprehensive, well-documented study that would result in specific recommendations. *The goal: to assure all Texans access to affordable health care.*

On November 13 1991, the Governor created by proclamation the *Texas Health Policy Task Force.* Twenty nine members were appointed, including six Senators appointed by Lt. Governor Bob Bullock, six Representatives appointed by Speaker of the House Gib Lewis, 13 public members appointed by the



COSTS SKYROCKETING

In 1980, Americans spent an average of $1,063 per person, per year for health care. In 1990 this figure rose to $2,566. By the year 2000, it is expected that Texans will spend an average of $5,712 per person per year for health care.



YOUNGER *AND* POORER

While the problems Texans face are being experienced throughout the nation, our state is particularly hard-hit. The reason? Texans are both younger *and* poorer *than the population of the nation as a whole. The greatest number of underinsured or uninsured come from these two groups.*

"Our state faces a crisis so great that before the turn of the century, our entire health care delivery system could collapse ."

Governor and an additional four ex-officio members, all heads of state agencies.

In her proclamation, Governor Richards asked the members of the Task Force to direct their attention to these six extensive tasks:

- Define a *basic health care service package* for Texans that emphasizes both primary and preventive care.
- Propose a *basic health insurance benefits package* or other health care financing mechanism for Texans — not necessarily tied to place of employment — that includes recommendations for state regulation of health insurance or other financing plans.
- Provide *a range of options for small businesses* to assist with health care benefits for their employees.
- Recommend *cost containment and financing options* for health services.
- Recommend *a coordinated health care delivery system*, with special emphasis on rural health services and trauma care.
- *Define the responsibilities and commitments* of consumers, providers, insurers, employers and government at the local, state and federal levels to ensure the delivery of high quality, affordable health care to the citizens of Texas.

BACKGROUND

The Task Force began meeting in December of 1991. During the early meetings in December and January, Task Force members heard from experts who shared information about:

- ★ Health policy task forces in other states,
- ★ Specific health issues in Texas, and
- ★ Models from other nations and states that had been proposed or were already in effect.

The Task Force initiated panel discussions with representatives from organizations who were affected by the current health care structure. These discussions included delegates from employer, provider, consumer and insurer groups. In addition to a discussion of the problems with health care in Texas, each representative was asked to share suggestions for solutions to the health care crisis.

THE PROCESS

At the early meetings, work plans and schedules were developed so that a final report could be presented to the Governor and Legislature by November 1, 1992. The Task Force work schedule was divided into two main functions —
(1) exploration of specific topics by subcommittees, and
(2) public hearings and on-site visits to selected areas throughout Texas.

Task Force membership was organized into four subcommittees:

- ★ Essential Services,
- ★ Cost Containment,
- ★ Finance, and
- ★ Access/Availability.

Testimony Gathered From Experts

Subcommittees met concurrently, usually for two days at a time from February through June. Each subcommittee heard from state, national and international experts on their particular subtopic, as well as from other interested parties who were encouraged to participate in the process.

TASK FORCE MEMBER

"Our early meetings focused on educating ourselves about issues and investigating what others had tried.

We talked with all sorts of experts who had struggled with health care delivery problems.

This helped us get a better grasp on the complexity of the problems facing our state and our nation."

ON-SITE VISITS & PUBLIC HEARINGS

Part of the data collection process for the Task Force involved on-site visits to over 20 locations around the state plus public hearings held in eight Texas cities — Tyler, Lubbock, Abilene, Dallas, McAllen, Houston, El Paso and San Antonio. Hearings began at 5:00 PM and often lasted until well past midnight.

The second part of the data collection process involved on-site visits and public hearings. During the same period of time, from February through May, the full Task Force travelled throughout the State to conduct public hearings and make on-site visits. Public hearings were held in eight Texas cities — Tyler, Lubbock, Abilene, Dallas, McAllen, Houston, El Paso and San Antonio.

On-Site Visits

The Task Force visited more than 20 locations where actual health care was provided either through traditional or alternative methods. Visits were made to a variety of clinics, hospitals, health professional schools, birthing centers, home health care units, school based clinics, ***colonias***, insurance claim operations, as well as to many other sites. These on-site visits focused on the problems and difficulties facing populations in different areas of the State.

Testimony Gathered At Public Hearings

Public hearings were scheduled following each afternoon site visit. The hearings began at 5:00 p.m. and often lasted until well past midnight. At almost every public hearing, more than 200 people filled the auditoriums. In total, the Task Force heard from more than 500 citizens, each of whom shared not only their concerns regarding health care, but their ideas for solutions.

Each subcommittee's recommendations were presented to the full Task Force on June 26. The full Task Force discussed each recommendation in depth. Whenever necessary, various experts were called upon to clarify questions. When the public hearings, site visit and subcommittee meetings were completed, deliberations began to meet the Governor's charge.

In total, Task Force members:

- ★ Heard more than 320 hours of public testimony,
- ★ Invested more than 40 days of our time,
- ★ Read thousands of pages of reports and articles, and
- ★ Listened to testimony from more than 150 state and national experts.

COLONIAS

Settlements along the Texas-Mexico border without amenities, such as running water, sewer systems, etc.

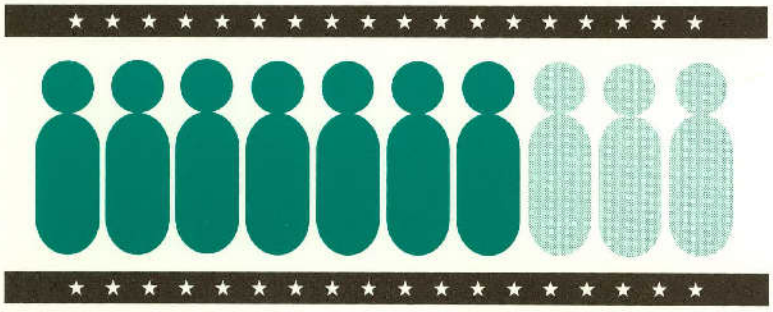
THE OUTCOMES

From the outset, Task Force members were asked to be bold and innovative in our recommendations. There was a general consensus among us that Texas cannot afford to rely on the federal government to address the growing health care crisis in Texas — or the nation.

There was also general consensus that:

- ★ Texas must move ahead in our effort to increase access and contain cost.
- ★ We cannot afford to delay or ignore our health care dilemma.
- ★ We must deal with the health care issue boldly and compassionately.
- ★ The problem affects all Texans; it requires each of us to work together toward fair and equitable solutions.
- ★ Texas must prepare now to meet the problem.

The Task Force understands that many of our recommendations could take several years for the State to implement. Despite these constraints, we believe this report and the recommended reforms contained in the report move the State of Texas closer to achieving the goal of the Governor's Executive Order, *"to propose a comprehensive health plan to ensure that all Texans have access to appropriate and affordable health services."*



SEVEN OUT OF TEN TEXANS ARE READY FOR A NEW APPROACH.

TASK FORCE MEMBER

"In Austin we dealt with the academic, theoretical side of health care.

At site meetings we listened to powerful testimonies about the enormous gaps in our health care system.

The testimonies were so moving that we had lumps in our throats. Some of us wiped away tears as we listened to the dilemmas people face."

THE HEALTH

OF THE PEOPLE

IS REALLY THE

FOUNDATION UPON WHICH

ALL THEIR HAPPINESS

AND ALL THEIR POWERS

AS A STATE DEPEND.

Benjamin Disraeli,
Earl of Baconfield
1877

THE PROBLEMS

HEALTH CARE PROBLEMS FACING TEXAS

Many of the issues with which the four subcommittees dealt overlapped. Working as a full Task Force, the major health care issues facing Texas were categorized into four major areas:

ACCESS TO COVERAGE

- Unmet health care needs of children and pregnant women
- Failure to utilize available Medicaid funding
- Problems with private health care coverage

PROVIDERS

- Inadequate supply and distribution of providers
- Lack of Medicare and Medicaid acceptance
- Needed improvements in State Licensing Board Regulations
- Conflicts of interest regarding self-referral

INFRASTRUCTURE

- Barriers hindering delivery of primary and preventive care
- Lack of infrastructure: effects on selected populations
- Inadequate charity care delivery by tax-exempt hospitals
- Deficiencies in trauma care delivery
- Lack of available transportation to health care services
- Underutilization of medical telecommunication systems
- Lack of comprehensive planning/evaluation

COST CONTAINMENT

- An overview of issues associated with controlling costs
- Rapidly escalating pharmaceutical inflation
- Questions regarding administrative costs of health plans
- Problems limiting consumer participation
- Needed reforms in medical malpractice

Health

"Physical and mental well-being."

The Dictionary

PROBLEM AREA # 1

ACCESS TO COVERAGE

Unmet Health Care Needs of Children and Pregnant Women

The unmet health care needs of Texas citizens seriously jeopardize our state's future welfare. Our most vulnerable citizens are our children, teenagers and pregnant women. Although Medicare ensures health care access for the vast majority of our elderly population, no such guarantee protects our children.

Access to health care in Texas — and the rest of the United States — is generally achieved through some kind of insurance mechanism. Health care coverage is extended to people through programs such as traditional health insurance, self-insured programs, health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other systems.

1. Access Issues Related to Childrens' Health

According to the 1990 census, the population of Texas is 16,987,000[10] – or roughly 17 million. Overall figures indicate that 3-4 million[11] Texans are currently uninsured. This figure translates into *over 1 million uninsured children*[12] in Texas alone.

Children — ages 0 through 18 — make up 35% - 40% of the uninsured population in Texas. This figure is significantly higher than in the U.S. as a whole.[13]

In addition, *many more Texans of all ages are considered* ***under-insured.*** That is, although they have some kind of health coverage, their coverage has such high deductibles and co-payments — or such low caps on benefits — that the individual or family could be dealt a crippling financial blow should a major health problem occur.[14]

Contrary to popular belief, the majority of the uninsured do not come from the stereotypical "poor family." *More and more of the* ***uninsured*** *population are coming from employed single- and two-parent families who live above the poverty level.*[15]

It is the children of these families who often fall into the cracks. With limited incomes and little or no insurance, their parents are unable to pay for needed health care.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

"The United States and South Africa are the only developed nations that do not offer basic health care insurance for children."

David Smith, M.D.
Texas State Health Commissioner

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

EQUAL PROTECTION UNDER THE LAW

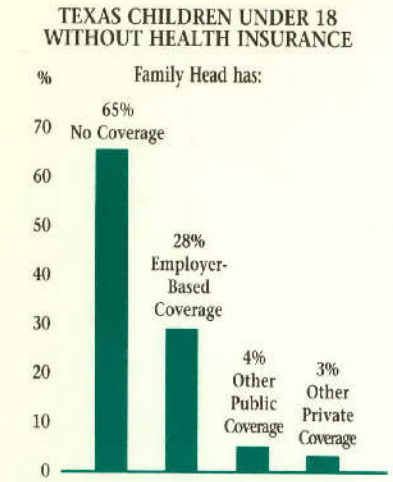
Although Medicare ensures health care access for the vast majority of our elderly population, no such guarantee protects our children.

THE UNINSURED

People without health care coverage of any kind.

THE UNDERINSURED

People who have health care coverage but are unable to pay a substantial portion of their health care expenses. That is, they have such high deductibles and co-payments — or such low caps on benefits — that they forgo care.



"It's not a question of whether Texas spends money on children's services — it's a question of how."

LOW-BIRTH-WEIGHT BABIES

Babies born with low weights — often resulting from the lack of prenatal care — who are at risk for complications. These complications frequently require costly medical care at birth, during childhood or throughout their lives. Low-birth-weight babies are sometimes referred to as premature babies or preemies.

UNCOMPENSATED CARE

Care for which the provider is not paid.

The cost to society which results from lack of health care is extensive. Each child born — or who grows up — lacking adequate health care is at risk of:

- ★ Becoming dependent on society,
- ★ Needing special public assistance, and/or
- ★ Ending up in prison.[16]

The health care problem in Texas which created the greatest concern to the Task Force was lack of comprehensive health care for children and pregnant women. In spite of our state's increased emphasis on maternal and child health within recent years, Texas continues to lack a systematic approach to the problems of health care delivery for *all* children and pregnant woman. Priority was given to this problem because of the large cost savings that can result from a comprehensive health care program for children and pregnant women.

It's not a question of whether Texas spends money on children's services — it's a question of how. We have dealt with the problems in the system by building one system on top of the other. The problem is — one becomes exhausted trying to access the system.

2. Access Issues Related To Prenatal Care

In Texas, 1 in 4 pregnant women currently has no form of health insurance.[17] One-third of Texas women (31.6% in 1990) receive no prenatal care during the first three months of pregnancy. And, almost 4% receive no prenatal care at all.[18]

Failure to receive adequate — and timely — prenatal care contributes to low birth weight and infant mortality.[19] According to the Texas Department of Public Health, the percentage of ***low-birth-weight babies*** born during the 1980s has remained constant. This statistic indicates that Texas has failed to reduce the number of low-birth-weight babies — 7 out of every 100 babies — born during the last 10 years.[20]

Low-birth-weight babies come into the world with a heavy load of both emotional and financial difficulty. Low-birth-weight babies consume 60% of all dollars spent on newborn intensive care,[21] a very costly form of newborn care. A recent Wall Street Journal article states that "U.S. companies and their employees pay about $5.6 billion/year to care for babies born prematurely or with other complications to mothers covered by insurance plans."[22]

The Journal article goes on to add that these companies will pay an additional $4.0 billion in 1992 due to costs "built into" hospital fees (costs added to other hospital patients' fees) to make up for ***uncompensated care*** given to premature infants.[23]

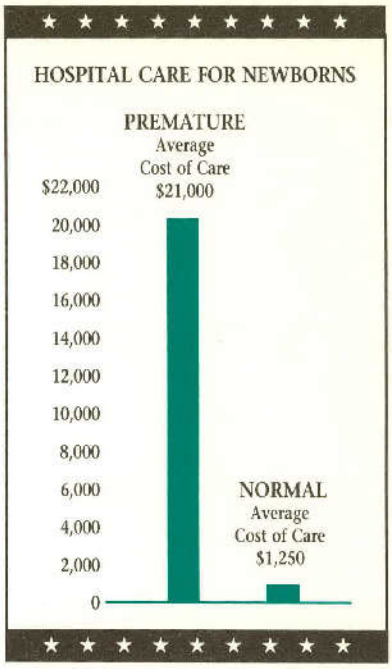
Health care costs for a single premature infant average $21,000 and can exceed $1 million in extreme cases.[24] Contrast this figure with the average cost for a "normal" newborn — $1,250 — which includes prenatal care, delivery and hospital care until the mother and child are discharged.[25] When you look at these figures, the case for targeting prenatal care becomes clear.

Beginning prenatal care in the first trimester and continuing care throughout pregnancy significantly reduces the numbers and the costs of high-risk pregnancies and low-birth-weight babies. The total average cost for providing adequate prenatal care for a pregnant woman is about $600.[26] The average cost for a premature baby for *just one day* is $2,500.[27]

From a purely financial perspective, every $1 spent on prenatal care saves approximately $3 in newborn intensive care costs.[28]

Providing prenatal care and counseling to pregnant women also helps prevent the tragedy of low-birth-weight babies as well as infants born with conditions such as fetal alcohol syndrome, cocaine addiction or the damaging effects of brain hemorrhage or respiratory distress.[29]

The financial burden associated with these problems — which is enormous — is often borne by taxpayers. In addition, problems associated with low birth weight and prematurity frequently result in future problems for the child, such as learning disabilities and developmental delay.[30]



COST OF CARE

Lack of prenatal care often results in low birth weight babies, sometimes called preemies.

- *The **average cost** of care for a premature baby is almost **$20,000 more** than the cost of care for a normal baby.*
- *In addition, problems associated with low birth weight and prematurity frequently result in **future problems** for the child, such as learning disabilities and developmental delay.*

Failure To Utilize Available Medicaid Funding

Texas ranks 47th among the states in getting back federal tax dollars through Medicaid.[31] In addition, our state ranks 43rd in the percentage of the poverty population that is covered by Medicaid.[32] *In other words, only three states have a worse record in getting Medicaid benefits, and only seven have a higher percentage of their poor* ***not covered*** *by Medicaid.*

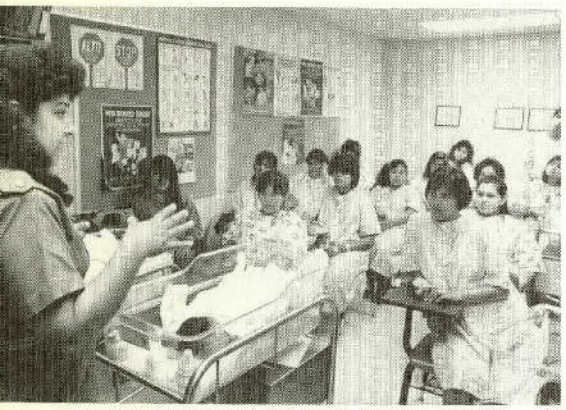
The Task Force determined that failure to aggressively pursue increased federal Medicaid funding will result in further deterioration of the Medicaid program in Texas.

Medicaid is funded jointly by state and federal governments. Federal regulations determine what states may — or may not do — in their Medicaid programs.

In Texas, roughly 65¢ of every Medicaid dollar comes from the federal government. This amount represents the amount of federal income tax dollars coming back to the state.

In the past, Federal Medicaid regulations allowed states to use this money to cover only those children who were eligible for cash assistance. However, beginning in the mid-1980s, federal and state policies have made children's health and maternity care a top priority. These reforms made more children and pregnant women — nationally and in Texas — eligible for the Medicaid program.

Today the citizens of Texas may be as generous in covering children and maternity care as they choose to be.



NEW FEDERAL REGULATIONS MAKE MORE WOMEN AND CHILDREN ELIGIBLE FOR MEDICAID

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• However, beginning in the mid-1980s, federal and state policies have made children's health and maternity care a top priority.

• These reforms made more children and pregnant women — nationally and in Texas — eligible for the Medicaid program.

DEPENDENT COVERAGE

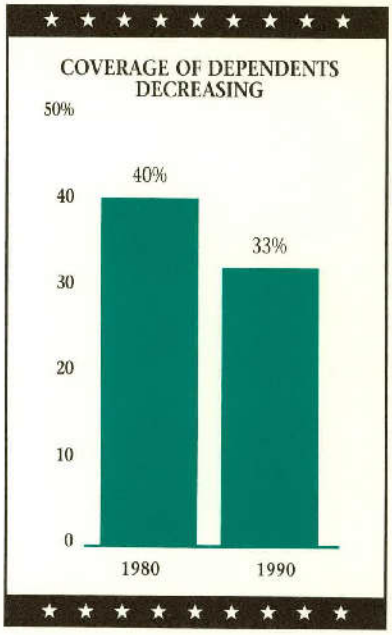
Individuals — usually a spouse or minor child — who are covered on another's health care policy.

Problems With Private Health Care Coverage

Each adult who lives with little — or no — health care runs the risk of developing serious and costly health problems. Many of these problems can be prevented. These problems which could be drastically reduced — or even eliminated — cost us all. The loss of human potential, as well as the economic cost to society, cannot be measured.

The Task Force categorized problems with private health care coverage that contribute to decreased access in these 13 categories:

- ★ Declining dependent coverage
- ★ Limited preventive coverage
- ★ Costs related to mandated benefits
- ★ Financial instability of some health plans
- ★ Problems unique to small businesses
- ★ Access problems for government and public school employees
- ★ Access problems for migrant workers
- ★ Lack of Medigap coverage for the elderly
- ★ Employee coverage/Medicare time gaps for early retirees
- ★ Access problems for students
- ★ Access problems for other populations
- ★ Insurance practices limiting access
- ★ Excessive administrative costs for health care coverage



COVERAGE OF DEPENDENTS NO LONGER AFFORDABLE

Due to the rising cost of health coverage, more and more employers find they must drop coverage for employee benefit packages.

1. Declining Dependent Coverage

Studies point out that ***dependent coverage*** is increasingly expensive. According to the same studies, dependent coverage is declining even more rapidly than employer-sponsored health coverage in general.[33] *Escalating health insurance costs have led hard-pressed employers to shift more and more dependent coverage costs to employees — a shift that appears to signal a new national trend.*

In 1980, 40% of employers paid the full cost of dependent coverage. By 1990, the number of employers paying the full cost of dependent coverage fell to 33%.[34]

Further evidence of declining dependent coverage is contained in studies which indicate that nearly 23% of uninsured children live in families with insured parents.[35]

★ ★ ★ ★ ★ ★ ★ ★ ★

ECONOMICS

★ ★ ★ ★ ★ ★ ★ ★ ★

HOW OUR CURRENT SYSTEM COSTS US MONEY

Traditional health insurance has encouraged us to spend ***little or nothing on preventive services*** *by not covering these services.*

2. Limited Preventive Coverage

Contrary to what might be expected, many people insured through private plans receive a level of benefits lower than that which low-income individuals receive through Medicaid plans.

For instance, traditionally private health coverage plans do not cover many routine health care services. They are not covered precisely because they are routine and predictable in nature. Insurance coverage was designed to cover only the unpredictable — and often more expensive — needs.

Many problems with private health coverage arise because the usual principles that guide insurance, such as property and casualty insurance, are often directly at odds with sound public health goals.

For example, people with "poor experience" — those who wreck cars frequently or repeatedly burn down houses and who file more insurance claims — should have to pay more for their coverage than those with "good experience" — who file fewer claims. There is reason to believe that in most cases individuals have it within their power to drive more carefully and to protect their property.

But health care is different. Traditional health insurance has encouraged us to spend little or nothing on preventive services by not covering these services. But avoiding the cost of prevention may lead to the far greater costs of serious illnesses. It is precisely the preventive services that society wishes to promote — childhood check-ups and immunizations, pap tests, colorectal screenings, mammograms, etc.

From a private sector insurance perspective, it makes no sense to cover people for an event, such as a check-up, that almost everyone is going to experience. From a societal perspective, it makes all the sense in the world.

MANDATED BENEFITS

Benefits - governed by state law - that are required ("mandated") to be included in health coverage plans.

SELF-INSURED PLAN

A procedure by which a company sets aside money to pay health care costs directly rather than purchasing coverage from an insurance company.

ERISA

Employee Retirement Income Security Act of 1974 — Federal law which governs self-insured plans and exempts them from state law.

Though the benefits of early detection and treatment are obvious, primary and preventive services are rarely covered in private insurance plans. Examples of such services include well-baby/well-child check-ups and routine dental care. As a result, costs for primary and preventive care often strain the family budget. These "preventive health care luxuries" compete with basic needs — such as food, clothing and shelter. As a result, they are often the first items cut from a strained family budget.

On the other hand, preventive services are covered in Medicaid's Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), a program of regular check-ups for children and teens.

Taking into consideration the special needs of children, Medicaid provides these preventive services as well as transportation, home health services, comprehensive dental care and eyeglasses — services commonly excluded, or limited, in private health care plans.[36]

3. Costs Related to Mandated Benefits

The Task Force heard a large amount of testimony about the high cost of ***mandated benefits***. It was clear that each mandated benefit included in any health plan adds something to the average cost per participant. For this reason, *there was Task Force support for the concept that mandated benefits may contribute to currently unaffordable health insurance premiums paid by small business.*[37]

Federal law currently exempts any employer which ***self-insures*** (called ERISA plans) from state laws regarding what benefits the group health plans must provide. *Since the majority of large employers now self-insure, mandated benefit laws place an inequitable burden on small employers who cannot afford to self-insure.*

However, in spite of repeated inquiries to various insurance groups, no clear evidence was uncovered by the Task Force on the actual cost of mandates. Furthermore, it is unclear what costs are associated with the failure to provide mandated coverages to individuals, businesses, and/or society as a whole.

The Task Force reviewed studies conducted in states where laws have been passed exempting small employer groups from some

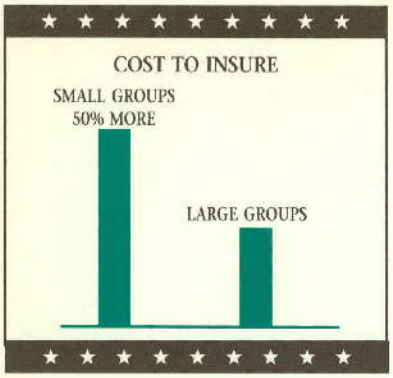
TASK FORCE TESTIMONY

"I put off taking my children to the doctor for check-ups and immunizations.

I put off going to the doctor myself, and my husband never goes.

I know that check-ups are important, but our insurance doesn't cover them. We just can't afford routine medical care."

Correspondence to the Task Force from an East Texas Citizen



SMALL BUSINESSES PAY MORE

The collection of health history information itself is a substantial administrative cost to small groups. As a result, even small groups with healthy employees typically pay premiums that are 50% higher than the national average for large employers.

or all mandated benefits. These studies demonstrate that most premium reductions in these ***"bare bones" plans*** come from

- ★ higher deductibles and co-payments,
- ★ limits on days of hospitalization covered, and
- ★ limits on covered doctors visits per year —

rather than from elimination of a mandate, such as coverage of mental health or chemical dependency treatment, two items which are often targeted in mandated benefit discussions.[38]

Finally, the Task Force learned that group plans marketed under ***small-group mandate exemption laws*** have been unsuccessful in enrolling small businesses.[39]

Surveys of small employers currently not providing health benefits indicate that large reductions in health plan costs — 50% or more — are required to induce small employers to voluntarily pick up a portion of the cost of a health plan. *Even programs providing partially subsidized coverage are still considered too expensive by most small businesses.*

4. Financial Instability of Some Health Plans

Some health care plans have left people without coverage and with unpaid bills. A Texas Department of Insurance (TDI) expert noted that a number of insolvencies occurred when life insurance companies shifted their emphasis to health care coverage.[40] That is, these companies were unable to pay the claims of their policy holders.

One part of the problem related to insolvent health coverage plans stems from the exemption of self-insured health plans from ***state solvency regulations***.

In theory, self-insured plans are regulated by the United States Department of Labor (DOL). Unfortunately, the DOL has never exercised any real supervision over the solvency of these plans.

Associations of small employers who self-insure — called ***Multiple Employer Welfare Arrangements, or MEWAs*** — receive very little DOL scrutiny. This is true, in spite of the fact that a number have failed, leaving enrolled members liable for unpaid health bills. *The Task Force noted a well-defined need for either active federal oversight of MEWAs or state authority to oversee their solvency.*

"BARE BONES" PLANS

Insurance plans that do not include mandated benefits.

SMALL GROUP MANDATE EXEMPTION LAWS

State laws that give small groups the same or similar exemptions from mandated coverages that large self-insured groups enjoy.

STATE SOLVENCY REGULATIONS

Rules designed to ensure that plans or companies remain financially sound and able to pay claims.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS)

Groups of small employers who form a group large enough to self-insure.

INDIVIDUAL UNDERWRITING

The practice of using health status or history upon which to base insurance rates or to exclude an individual from coverage.

5. Problems Unique to Small Business

The Task Force listened to a large amount of testimony regarding the unique problems faced by small business in providing health care coverage for employees. Small businesses pay more per capita than large firms for identical coverage.

Individual underwriting is the norm for groups of 25 or fewer employees but not for larger groups. In underwriting, the costs of one unhealthy person working for a large corporation are simply averaged out over hundreds or thousands of employees and dependents.

The same is not true for small businesses. For example, in a small business, one sick employee might be the reason for:

- ★ Drastically higher premiums,
- ★ Denial of coverage, or
- ★ Cancellation of policy.

Another significant problem for small businesses has to do with administrative costs. Many of the costs of administering a health plan are fixed. Therefore, since small groups have fewer people over which to spread costs, as much as **40% of a small group premium** may be due to administrative costs.[41]

For example, the collection of health history information itself, is a substantial administrative cost to small groups. As a result, even small groups with healthy employees typically pay premiums that are 50% higher than the national average for large employers.

This information led the Task Force to conclude that large groups clearly have an economic advantage over small groups in purchasing health care.

6. Access Problems for Government and Independent School District Employees

Access to health care coverage is often a problem for municipal employees and other public sector workers. The Task Force found that lack of coverage for government and independent school district employees often results in higher costs both to employees and to public systems where they are forced to seek care.

TASK FORCE TESTIMONY

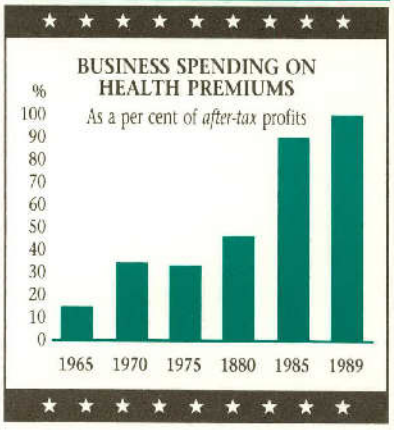
"As a small business owner with 9 employees, I paid full health premiums until 1980.

Over the next 10 years we had to change plans four times because of high premiums.

By 1990, the cost exceeded monthly profit after expenses. Finally, we had to cancel insurance - not only for our employees - but for my family.

That's the most painful announcement I've ever had to make."

Testimony
to the Task Force from a
Central Texas Citizen



100% OF AFTER-TAX PROFITS

In 1989, business spending on health care coverage equaled after tax profits.

Pre-existing condition exclusions and waiting periods can effectively prevent individuals from changing jobs due to the fear that they may lose their health care coverage, either entirely or temporarily.

7. Access Problems for Migrant Workers

Another segment of the population that has great difficulty getting private health coverage is migrant workers. The Task Force noted that this group has three major problems accessing coverage:

- They do not stay in an area long enough to qualify for existing federal programs,
- They do not make enough money to purchase health care coverage from the private market, and
- They typically receive no employer subsidies in purchasing coverage.

8. Lack of Affordable Medigap Coverage for the Elderly

In spite of the variety of private options available to supplement Medicare coverage, the reality for many elderly Texans on fixed incomes is that they are unable to afford supplementary health care coverage. Because of their inability to afford Medigap supplementary coverage, the elderly often suffer needlessly.

9. Employee Coverage/Medicare Time Gaps for Early Retirees

Additionally, there are profound health care coverage problems for people who are placed on — or choose — early retirement. Early retirees frequently find themselves without insurance coverage because of a time gap between cessation of employee insurance and age eligibility for Medicare.

10. Access Problems For Students

Due to age and other reasons, students are often ineligible for coverage under their parent's health care plans. As a result, students with limited resources are often unable to afford individual coverage.

11. Access Problems for Other Populations

Other populations, including the self-employed, may also face problems in obtaining health care coverage. Ineligible for large group coverage or other ***economies of scale,*** they are often unable to afford individual coverage.

MEDIGAP INSURANCE

Insurance designed to pick up health expenses that exceed Medicare limits.

ECONOMIES OF SCALE

A situation in which unit costs are lower because certain fixed costs are averaged over a larger number of units.

MEDICAL UNDERWRITING

The practice of assessing the health risk of an applicant or group so that policy issuance may be modified.

CHERRY PICKING

The practice of offering health care coverage plans only to the healthiest.

PRE-EXISTING CONDITIONS

Health conditions that exist prior to the beginning date of a health coverage policy.

WAITING PERIOD

A period of time — such as 6 weeks — after a policy is issued before coverage becomes effective.

12. Insurance Practices Limiting Access

Through ***medical underwriting*** a single group member (or members of a group) is rated as a substandard risk. In these situations, the health care carriers may either —

- ★ Decline to cover the group, or
- ★ Issue a rider limiting coverage for the conditions, or
- ★ Eliminate the high-risk individual(s) from the group.

Serious illness can result in the loss of health care coverage, either due to exhaustion of maximum benefits, or cancellation of coverage. Insurers may ***cherry pick,*** choosing to issue health coverage policies only to the healthiest applicants. Individuals are sometimes denied coverage because of a past condition, even though that condition may have been cured.

Pre-existing condition exclusions and ***waiting periods*** often prevent individuals from changing jobs due to the fear that they may lose their health care coverage, either entirely or temporarily.

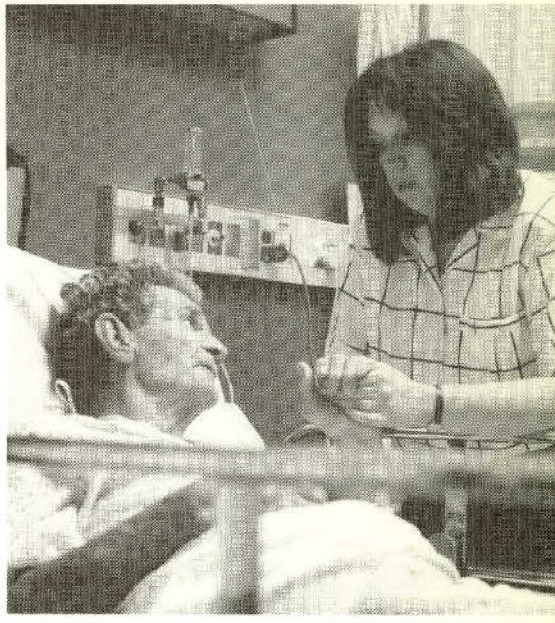
People with pre-existing conditions are frequently excluded from purchasing private health care coverage. Many examples could be cited. Two conditions which were frequently presented to the Task Force by excluded citizens are:

- ***Example 1 - HIV/AIDS***

AIDS is the fastest growing cause of death in Texas and the U.S. The HIV/AIDS virus is spreading throughout the nation, affecting increasing numbers of infants, children, teenagers, females and minorities. Persons infected with the HIV/AIDS virus frequently may lose whatever health coverage they have or be unable to obtain coverage. This leaves the public health system as their only source of health care.

- ***Example 2 - Persons With Disabilities***

Because of accidents, illnesses or conditions present at birth, many people are left with physical or mental disabilities. Due to pre-existing condition exclusions, these people are severely limited in accessing private health care coverage. Since health care coverage for this group is inadequate, these people often face an unnecessary worsening of their conditions, which results in higher costs through loss of job and/or schooling, premature institutionalization, complicated health problems, etc.



ELDERLY TEXANS ON FIXED INCOMES

In spite of the variety of private options available to supplement Medicare coverage, the reality for many elderly Texans on fixed incomes is that they are unable to afford supplemental health care coverage.

DUBIOUS HONOR

*Task Force members noted that among industrialized countries, the United States is unique in its exclusion of those who **most** need care from the health coverage system.*

At the heart of the deterioration of access to health coverage has been the movement away from a ***community rating*** approach toward an ***experience-rating*** approach.

Under an experience rating approach, a health coverage plan adjusts rates up or down according to the health status and experience of the group and/or its individual members. For example, if a small group – or an individual in the group – has had large medical bills, those bills may be reflected in an increase in the premiums of the small group and/or the individual.

Experience rating permits relatively healthy individuals and groups — the young, physically fit, and employees of businesses and industries with low claims for accidents or illness — to buy less expensive coverage. At the same time, it increases premiums for older or less healthy individuals and groups.

The move to experience rating was perfectly rational from a competitive standpoint, because it gave health coverage plans some basis for competition other than good, efficient service. On the other hand, the inevitable consequence of whittling away at the degree to which risk is spread across a large population moves the highest-risk individuals and groups closer to paying full direct costs for their own care. *This is precisely the opposite of what "insurance" means to most Texans.*

Experience rating has also had the effect of creating a growing group of people who cannot buy health coverage at any price. These people have two choices. They can depend on overburdened public health programs or go without health care. If the latter option is chosen, their health problems may become far advanced and much more costly to remedy.

*Task Force members noted that excluding those who **most** need care from the health coverage system is unique to the United States among industrialized countries.*

COMMUNITY RATING

The practice of setting rates based on average health care costs for the population of an area rather than for a particular group.

EXPERIENCE RATING

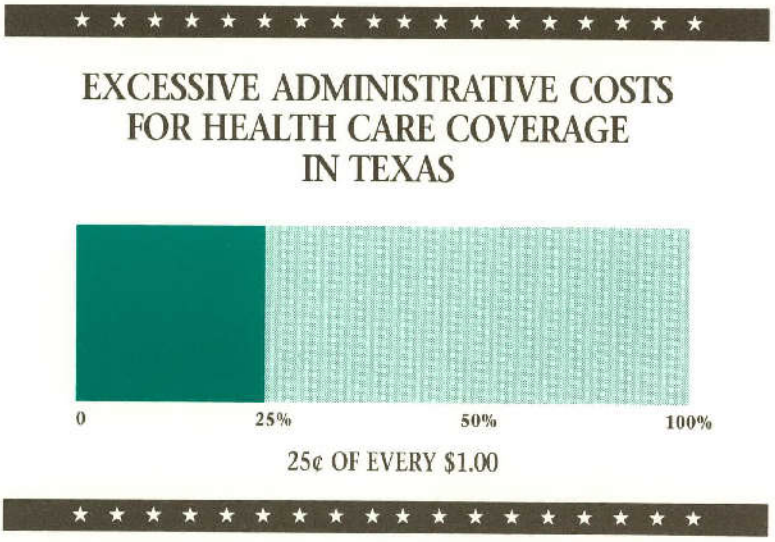
The practice of adjusting rates up or down according to the health status of the group and/or its individual members.

Consumers testifying before the Task Force related experiences of drastic increases in health care coverage premiums following serious illnesses. These increases sometimes occurred at short intervals, varying from periods of once a month to every six months. This made their health care coverage so expensive that it quickly became unaffordable. Others reported that their premiums grew at double-digit rates even though they had made few or no claims.

13. Excessive Administrative Costs for Health Care Coverage

The administrative costs of the present health care coverage system have been the target of criticism. Nearly 25¢ of every $1 spent on health care coverage in Texas is spent on marketing, commissions, billing, collections and other administrative expenses.[42] The bulk of administrative costs are related to:

- ★ The sheer number of players providing and paying for health care, and
- ★ The nearly complete lack of standardization regarding: (1) benefits covered and prices charged, and (2) claims and billing forms.



ADMINISTRATIVE EXPENSE

Nearly 25¢ of every $1 spent on health care coverage in Texas is spent on marketing, commissions, billing, collections and other administrative expenses.

TASK FORCE TESTIMONY

" My wife has been a diabetic for 30 years.

She's in good health and takes exceptionally good care of herself.

Even without hospitalization, our insurance has increased three times.

Last January premiums shot up 81%. I'm trying to raise the deductible to $5,000 just to afford coverage.

They say I can't do this without cancelling my present policy and writing a new one.

The catch? The new policy would no longer cover my wife's diabetes."

Testimony
to the Task Force from a
Texas Panhandle Citizen

PROBLEM AREA # 2

PROVIDERS

Inadequate Supply and Distribution of Providers

The population, size and geographic diversity of Texas present special challenges in the delivery of health care. The state of Texas has 17 million people spread across 254 counties covering 266,807 square miles.

Each of our 254 counties differs widely in population density. For instance, 95 counties have a population of less than 10,000. These counties contain only 2.8% of the state's total population.[43] Among these 95 counties 60% are classified as ***frontier***.[44]

In contrast to these frontier counties are counties with dense populations. For example, six Texas counties contain a total of 48.2% of the state's population.

The supply and distribution of health care providers throughout diversely-populated Texas counties is inadequate to meet the needs of our people. There is a growing need for:

- ★ More ***primary care providers***, and
- ★ Better access to health care in underserved areas and populations.

Consider these statistics:

- ★ 18 Texas counties have *no* physician, and
- ★ 20 counties have *only one* physician.[45]
- ★ 34 counties (28 of them "frontier" have *no* hospital, *two or fewer* physicians and *no* ***nurse practitioners*** or ***physicians assistants.***[46]
- ★ 57 counties have *no* hospital, and
- ★ 62 counties have hospitals with *50 or fewer beds.*[47]

Small hospitals may have difficulty surviving hard economic times.

"FRONTIER" COUNTIES

Counties with less than 7 residents per square mile.

PRIMARY CARE PROVIDERS

Health professionals — such as physicians, dentists, nurses, physician assistants, health educators, dietitians, pharmacists, therapists and others — who give primary care as the first line of care (rather than specialized care) to children and adults.

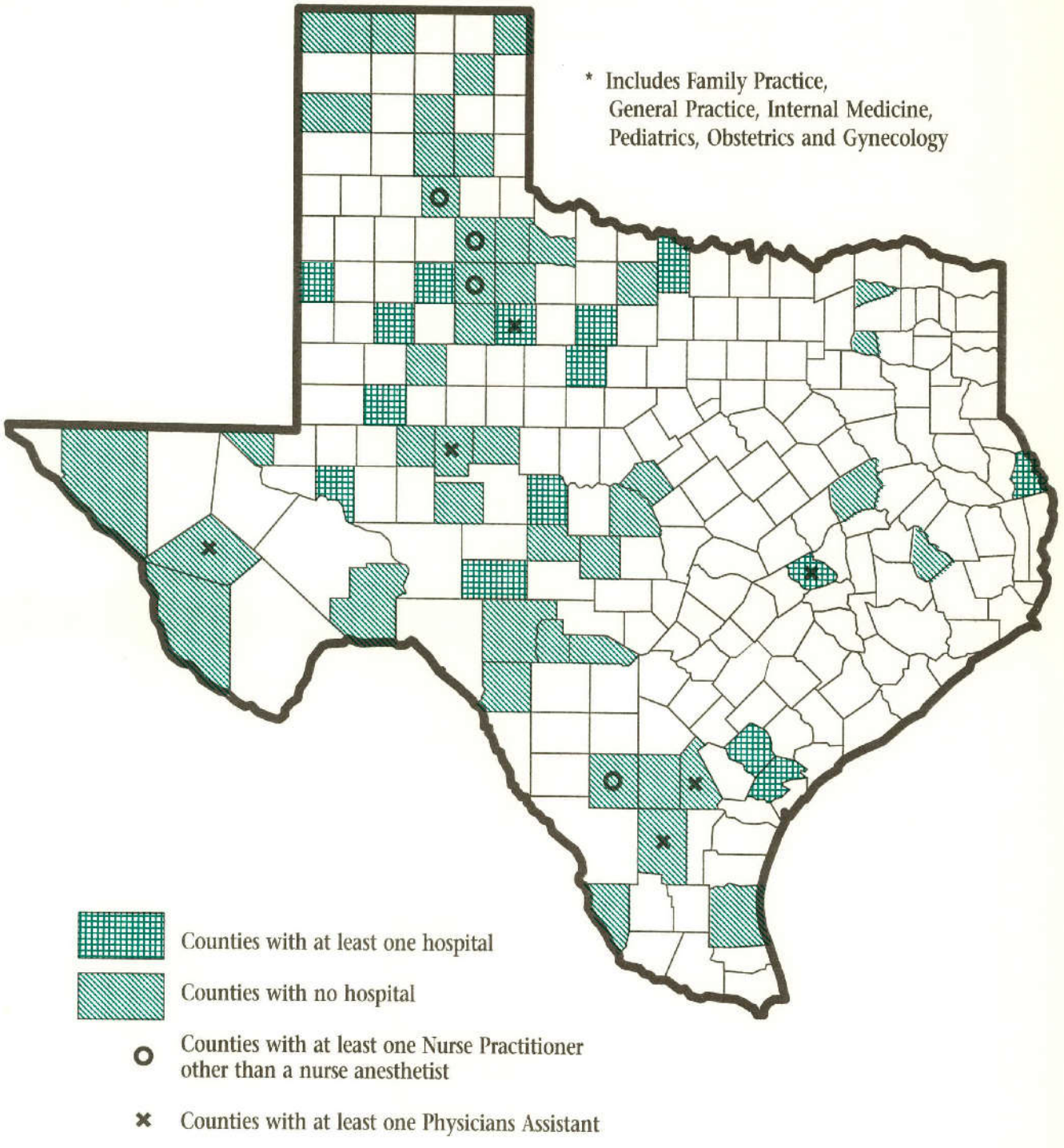
ADVANCED NURSE PRACTITIONERS - ANPs

Registered Nurses who are educated, certified and licensed to provide primary care to specialized populations. ANPs specialize in a variety of areas, including family, pediatric, obstetric and geriatric care.

PHYSICIAN ASSISTANTS - PAs

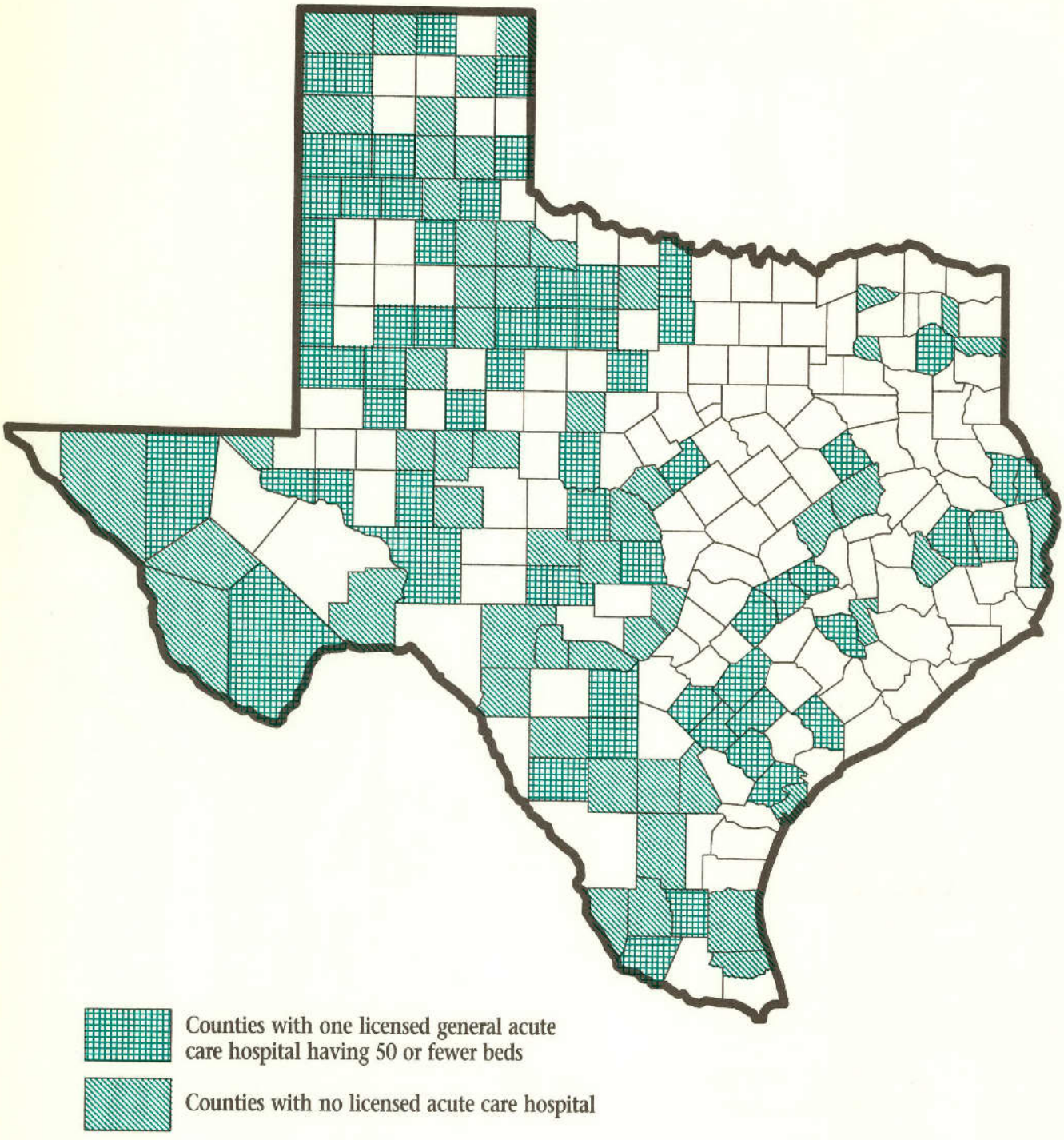
Allied health professionals who are educated to perform designated procedures and assist physicians in delivering care.

COUNTIES WITH TWO OR LESS PRIMARY CARE PHYSICIANS*



Source: Information provided by Texas Department of Public Health, Bureau of State Health. Data and Policy Analysis 5/18/92.

COUNTIES WITH FIFTY OR LESS HOSPITAL BEDS



Source: Texas Department of Public Health, Bureau of Licensing and Certification, September, 1992.

The Task Force noted an extreme need for *primary and family practice providers* throughout the state of Texas.[48] Rural and other medically underserved areas suffer particularly acute shortages. These shortages are due, in part, to economic conditions in these areas which make it far more difficult for health providers to establish and maintain financially viable health care practices.

Much of the underserved population consists of rural, border, or poor inner-city residents — many of whom are minorities.[49] *These groups are under-represented within health care professions.* That is, people from these groups rarely enter health care occupations. Female providers are also severely under-represented among certain provider populations.

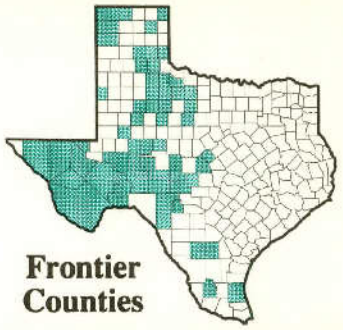
In addition, almost no effort is made to recruit people from these populations into health care occupations. And, when people from underserved areas do become health providers, there is minimal to non-existent encouragement for them to return to their original underserved area or to serve in other underserved locations throughout the state.[50]

1. Lack of Preparation in Primary and Secondary Education

The Task Force learned that public education may not adequately promote classroom work and skills required for entrance into primary health professions, especially for minorities and those from underserved areas.

In recent years, math and science aptitude scores have undergone a national decline. Some schools — particularly those in rural and underserved areas — may not provide the math and science classes required for admission to the colleges and universities which educate the bulk of medical students.

Without aggressive efforts to acquaint students with health professionals who might serve as mentors, most students lack health care role models. *Since childhood experiences often influence life choices, early deficits in classroom opportunities may create significant barriers for many young people. This is especially true for minorities and those living in underserved areas.*[51]



PROBLEMS WITH DELIVERY OF CARE

The population, size and geographic diversity of Texas present special challenges in the delivery of health care. The supply and distribution of health care providers throughout diversely-populated Texas counties is inadequate to meet the needs of our people.

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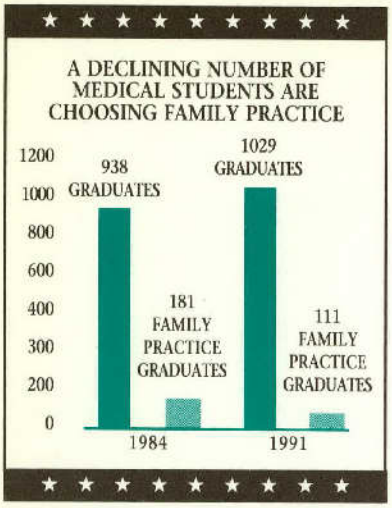
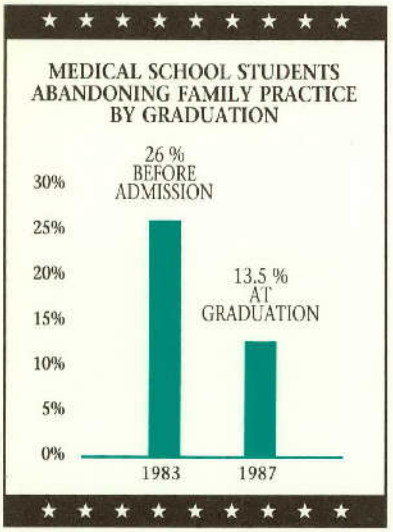


THE NUMBER OF FAMILY DOCTORS IS GOING DOWN



STUDENTS ARE OPTING OUT OF FAMILY PRACTICE DURING MEDICAL SCHOOL

Despite studies showing that health professionals who were raised in rural communities are the most likely to return to work in these areas, efforts to recruit rural residents into health care professions have been limited. The Texas Rural Scholars' Program has provided fiscal incentives to encourage rural residents to enter health professions. However, only about 15 counties can participate due to funding constraints. Also lacking are programs designed to recruit persons from other underserved groups or areas, such as the border and inner cities.[52]

2. Lack of a Primary Care Emphasis in Physician Education

The number of medical students interested in primary care is shrinking. That is, there are not enough medical students entering primary care specialties.

In 1984, 181 medical school graduates entered Family Practice Residency Programs in Texas. But by 1991, that number had dropped to 111 — a 38.7% decline over an eight year period.

Twenty-seven percent of all Texas physicians are 55 years of age or older. As such, they are nearing retirement. Included in this 55+ age group are 36.4% of the family physicians and 41% of the rural family physicians in Texas.[53] *Even with an aggressive program promoting primary care specialization, it will be difficult at best to assure an adequate supply of primary care doctors in Texas.*

Interest in primary care fields — including general/family practice, internal medicine, pediatric, obstetrics, geriatrics and emergency medicine — seems not to be a priority in admissions decisions. Neither is the likelihood that applicants might eventually choose to practice in underserved areas considered in admissions decisions. Primary care faculty are generally underrepresented on admissions committees, which adds to the tendency to overlook applicants who might eventually practice primary care.

Current evidence suggests that the process of medical school education may actually discourage students from entering primary care fields. Research indicates that the preference of U.S. medical students for family practice medicine dropped from 26% before admission in 1983 to 13.5% at graduation in 1987.[54]

Lower incomes for primary care physicians and the relatively low prestige of the primary care field within the medical community are probable factors in the decrease. Testimonies before the Task Force noted that the amount of time devoted to primary care and the length of the family practice clerkship is short, and that third-year clerkships are not fully funded.[55]

The makeup of medical school faculty also has an impact on specialization choices. Primary care providers have low representation on promotion and tenure committees within medical schools. Primary care is not emphasized in clinical practice and teaching. The Task Force heard testimony suggesting that in primary care disciplines, no system is in place to encourage faculty development, such as:

- ★ A reserve of research monies,
- ★ A well-understood career ladder leading to tenure, or
- ★ A well-established prestige/reward ladder associated with clinically-based teaching and/or service.[56]

The Task Force noted that the taxpayers of Texas make a significant investment in the education of medical students — nearly $69,000 per student/per year.[57] In-state students now pay a tuition of $5,463 per year while out-of-state students pay a tuition of $21,852.

Given this level of subsidy, the need for preventive and primary care providers could be better addressed. *The shortage of primary care specialists has a profound effect upon the cost of health care delivery. In countries where there are sufficient primary care providers, it is they, rather than far more expensive specialists, who are the point of first contact within the health care system.*

3. The Need for Education Improvements and Expanded Utilization of Other Health Care Professionals

The Task Force also heard testimony about major barriers that prevent the full utilization of "other licensed health care providers." Examples of other licensed providers include:

- ★ Dentists
- ★ Registered Nurses,
- ★ Advanced Nurse Practitioners,
- ★ Certified Nurse Midwives,
- ★ Certified Registered Nurse Anesthetists,
- ★ Therapists

Physician assistants are also an example of other health care professionals who could be better utilized.

The barriers preventing utilization of licensed health care providers and physician assistants include reimbursement from federal programs and private health care coverage that is either inadequate or nonexistent for these providers. ***Inadequate autonomy*** and limited ***prescriptive authority*** restrict the ability of some providers to participate to the fullest extent of their education.[58]

In addition, the Task Force was advised that in Texas there is:

- ★ A shortage of licensed health care providers and physician assistants,
- ★ A lack of appropriate postgraduate residency programs for these providers.

There is also a shortage of ***health care support personnel***, such as aides and volunteers. Existing support personnel also appear to be underutilized.[59]

Advanced nurse practitioners (ANPs) contend that current reimbursement by ***private*** or ***public payers*** cannot support a nursing practice.[60] Under federal Medicare policy, ANPs are reimbursed at *85% of the rate at which physicians are reimbursed.* The difference in reimbursement is based on the "type of service provided, the overhead expenses, and the cost of malpractice insurance."

REGISTERED NURSES - RNs

Nurses who complete a course of study, pass a state board examination and are licensed to deliver patient care.

CERTIFIED NURSE MIDWIVES - CNMs

Registered nurses who are educated, certified and licensed to provide prenatal care and deliver babies.

CERTIFIED REGISTERED NURSE ANESTHETISTS - CRNAs

Registered nurses who are educated, certified and licensed to administer anesthesia.

INADEQUATE AUTONOMY

Restrictions limiting licensed providers and physicians assistants from providing levels of care for which they are trained.

PRESCRIPTIVE AUTHORITY

Laws allowing providers, who are qualified to do so, to prescribe medications in some circumstances.

HEALTH CARE SUPPORT PERSONNEL

Non-credentialed personnel who assist in patient care, such as aides, volunteers, etc.

PUBLIC PAYERS

Programs such as Medicare and Medicaid that reimburse providers for services.

PRIVATE PAYERS

Health care or insurance plans that reimburse providers for services.

However, Texas Medicaid reimburses certified registered nurse anesthetists, family nurse practitioners, and pediatric nurse practitioners at *70% of the physician rate*, while certified nurse midwives receive *65%* of the obstetrician rate. The state has no mandate for the reimbursement of other licensed health care providers and physician assistants by private insurers. Furthermore, the state has no restrictions on reimbursement for such providers.

Laws and rules concerning the practice of licensed health care providers and physician assistants are complex and differ among the various types of providers. Rules regarding prescriptive privileges for registered nurses, physician assistants and advanced nurse practitioners have been characterized as too restrictive, thus limiting the potential impact of licensed health care providers and physician assistants.

Two subproblems were noted by the Task Force that impact the utilization of other licensed providers. The first is a state-wide shortage of nurses. The second is underutilization of school registered nurses.

A Shortage of Nurses

The nursing shortage in Texas — and the entire country — is well documented. Though there has been improvement in the State of Texas, there was still a 9.8% shortage of staff registered nurses and a 12.5% shortage of critical care registered nurses in January of 1992.

Under shortage conditions, the private sector has a distinct advantage in attracting nurses because they are able to pay the highest salaries. For this reason, the nursing shortage is particularly disastrous in state agencies. This results in decreased services to those in need of care. During 1991, unfilled nursing positions in state agencies grew as high as 25% statewide — and as high as 50-70% in facilities operated in geographical areas that are traditionally understaffed.[61]

OTHER HEALTH CARE PROVIDERS

The Task Force also heard testimony about major barriers that prevent the full utilization of "other licensed health care providers" and physician assistants. Examples of other licensed providers include: dentists, registered nurses, advanced nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, therapists, etc.

"Contrary to what one might think, the nursing shortage is due to a lack of enrollment slots created by a deficiency in nursing education faculty rather than a lack of qualified applicants."

Contrary to what one might think, the nursing shortage is due to a lack of enrollment slots created by a deficiency in nursing education faculty rather than a lack of qualified applicants.

It is difficult for nursing programs to expand enrollment when faculties are unavailable. Faculty recruitment efforts in Texas are hurt by the same salary disadvantages noted above. In the 1991-92 academic year, there was a waiting list of 2,950 qualified applicants for Texas nursing programs.

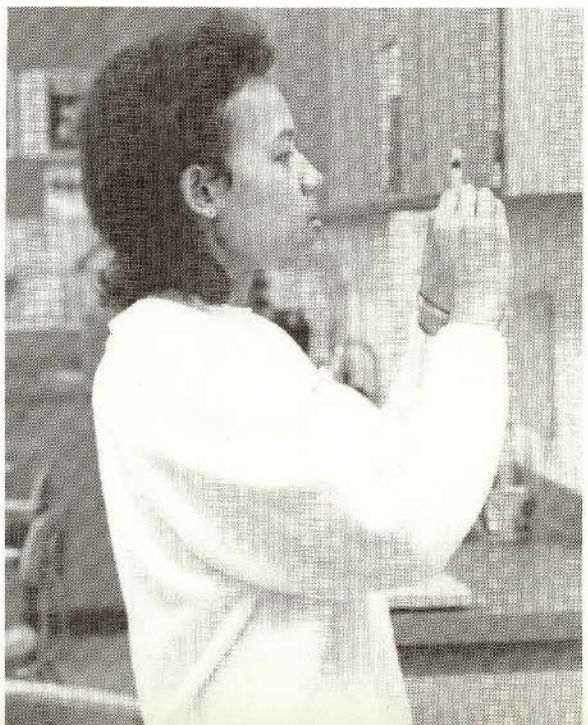
A 1990 study notes that for the year 2000 only "one-third the required number of nurses needed will be available at the master's and doctoral levels."[62] If this proves to be accurate, Texas faces an even greater deficiency in qualified nursing faculty in the future.

Under-Utilization of School Nurses

Another problem brought before the Task Force concerned the under-utilization of registered nurses that practice in schools.

One example of an important public health service which could be administered by school nurses is immunization. Current law permits RNs to administer immunizations only under standing physician orders. Reportedly, it is very difficult for school districts to find physicians who are willing to take responsibility for such orders. This requirement hinders the administration of immunizations in the school environment.

Recent measles outbreaks in Texas, for example, suggest a gap in immunization efforts.



IMMUNIZATIONS IN THE SCHOOLS

One example of an important public health service which could be administered by registered nurses practicing in schools is immunization.

Lack of Medicare and Medicaid Acceptance

Analysis by the Texas Department of Human Services (TDHS) points out that *20-28% of Texas' primary care physicians, depending on their specialty, do not accept Medicaid patients at all. And, according to the same data, just 32-41% see a high volume of Medicaid patients.*[63]

In addition, only 52-62% of Texas doctors who filed Medicaid claims in one quarter of 1991 saw any new Medicaid patients. Significant changes in Texas Medicaid regulations and increased primary care payment levels were implemented in April 1992 to help correct these deficiencies. The Task Force notes that it is too early to determine what effect they will have.

A second factor in Medicaid acceptance deficiencies is that a smaller — but growing — proportion of physicians refuses to accept Medicare patients largely due to fears about new federal Medicare reimbursement policies.

Providers reported to the Task Force that reimbursement rates below the cost of service along with administrative hassles associated with both Medicaid and Medicare discourage them from treating patients covered by these programs.

Providers reported to the Task Force that reimbursement rates below the cost of service — along with administrative hassles associated with both Medicaid and Medicare — discourage them from treating patients covered by these programs.

Needed Improvements in State Board Licensing Regulations

LACK OF STAFF DELAYS JUSTICE

• Lack of adequate staff delays the review process and the building of an appropriate legal case against incompetent and/or impaired physicians.
• Equally important, staff shortages reduce the TSBME's ability to quickly clear the records of physicians who may be wrongly accused.

The Texas State Board of Medical Examiners (TSBME) is charged with monitoring and disciplining substandard and/or impaired physicians. The Task Force received information regarding needed improvements in operations of the TSBME.

Research has illustrated that there is very little peer pressure encouraging physicians to report a colleague suspected of being substandard and/or impaired.[64] In reality, the potential for civil action and professional ostracism against a reporting physician is strong.[65] Physicians' concerns that they may be sued for defamation of character or interference with the right to earn a livelihood as a result of their good faith reporting severely decreases reporting.

The TSBME is a 15-member body, with only 3 public members. The Task Force heard testimony suggesting that a higher level of non-physician representation is needed to correct a perceived reluctance of physicians to discipline other physicians. Task Force members expressed an interest in increasing consumer representation on other such licensing boards.

The Task Force learned that the TSBME has difficulty attracting and retaining adequate numbers of experienced, competent investigative and legal staff. This lack of adequate staff delays the review process and the building of an appropriate legal case against incompetent and/or impaired physicians. Equally important, staff shortages reduce the TSBME's ability to quickly clear the records of physicians who may be wrongly accused.

PRACTICE STANDARDS

Guidelines which would promote the use of the most effective treatments.

Problems arise in the removal of incompetent physicians because of a lack of consistent, appropriately defined ***practice standards*** *for physicians.* Some limited treatment standards do exist for specified procedures such as prenatal care.[66] However, these standards have not been officially adopted by an appropriate state body that would permit their use in judging physician performance.

Conflicts of Interest Regarding Self-Referral

Concerns regarding conflicts of interest in the form of doctors' — or other health professionals' — referrals to services and facilities in which they have an investment interest *and* the fact that these self-referrals cause significant cost increases were brought before the Task Force.[67]

Texas currently has no registration, disclosure requirement or public record noting provider ownership or compensation from joint ventures, rentals, or leases of medical equipment, facilities, or services.

State efforts to control referrals were strengthened with the passage of House Bill 7 by the 1991 Texas Legislature.[68] As a result, current law prohibits direct kickbacks tied explicitly to referrals, such as a fee per referral. One remaining problem, however, is that nothing currently prohibits a physician investor from collecting profits from an investment facility to which he or she may routinely refer large numbers of patients.

Safe harbor regulations which identify acceptable referral patterns were mandated by Congress in the Medicare and Medicaid Patient and Program Protection Act of 1987 and finally put into law in 1991.[69] However, these federal rules technically restrict only referrals of Medicare and Medicaid patients.

Recent studies suggest that as many as 1/5 of all physicians refer patients to facilities in which they have financial interest.

In one study comparing physician-owned labs with independent labs, data revealed that at physician-owned labs:

- ★ Self-referring physicians ordered 34-96% more tests,
- ★ Prices were 2 - 38% higher, and
- ★ Total bills were 26-125% higher.[70]

An additional Florida study found that at least 40% of Florida physicians had invested in clinics and other health-care businesses and that 93% of diagnostic imaging centers were owned by doctors.[71] In response to these findings, Florida's legislature passed a broad prohibition against referrals to facilities in which providers have a financial interest.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

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MEDIA AWARENESS

"I watched as my one month old son coughed until he turned red and then blue.

I rushed him to the emergency room. The doctors said it was whooping cough. He spent two weeks in intensive care ..."

The problem is ... low immunization rates allow infants too young to receive their full pertussis vaccine series to be exposed to the whooping cough bacteria.

The Dallas Morning News
September 24, 1992

RUBELLA

The medical term for German measles. When a pregnant woman — as a result of lack of immunization or never having had the disease — develops rubella early in her pregnancy, birth defects can result.

PERTUSSIS

The medical term for whooping cough, an acute and severe infectious disease producing extreme coughing attacks. Both rubella and pertussis are preventable with immunization.

ADULT-ONSET DIABETES

A non-insulin dependent form of diabetes occurring in adulthood; often controllable with diet, loss of excess weight, and/or medication.

PROBLEM AREA # 3

INFRASTRUCTURE

Barriers Hindering Delivery of Primary and Preventive Care

The Task Force heard compelling testimony concerning a wide variety of problems regarding providing and accessing both primary and preventive care throughout the state. Primary care is defined as "first-line" health care dealing with common health problems, health maintenance, overall coordination of an individual's health needs and preventive care. A primary care provider may be a physician, nurse practitioner, physician's assistant, health educator, dietitian, pharmacist, etc.

Primary care accounts for more than 90% of the health services people receive. Typically, however, private health care coverage pays only 17-20% of such costs.

The effects of poor access to primary and preventive care can be devastating. When health care is delayed, health conditions that might have been prevented — or at least managed —are often left untreated until serious complications arise.

Early intervention and treatment can delay — or even prevent — the onset of acute conditions. Management of a chronic condition at an early stage often prevents the "worsening" of the condition. Early care not only saves large amounts of money for both the individual and the state, it eliminates unnecessary pain and suffering.[72]

*The promotion of primary health care can create profound economic savings. Consider this comparison: The cost of one dose of measles/mumps/**rubella** vaccine is $20. On the other hand, the total cost for one hospital day for an inpatient with measles, pneumonia or encephalitis is $3,000.*[73] *When you add the patient's average hospitalization stay of seven days to the bill, the costs become significantly higher.* According to vaccine cost/benefit studies, every $1 spent on ***pertussis*** vaccines saves over $11 in potential illness care.[74]

In spite of these well-documented savings, childhood immunizations have declined. The recent measles outbreak is a direct result of this decline. In 1988 there were fewer than 300 cases of measles. By 1989 the number of measles cases had risen to over 3,000.[75] Between 1989-1990, half of the counties in Texas experienced measles outbreaks. Large Texas cities — Houston, Dallas, Laredo, El Paso and Austin had measles epidemics. Corpus Christi continues to feel the effects of a recent measles epidemic.[76]

In addition, statistics show an increase in pertussis for all ages in 1989.[77] The most significant increase of pertussis, *an increase of over 100%,* was noted in children below the age of one.[78]

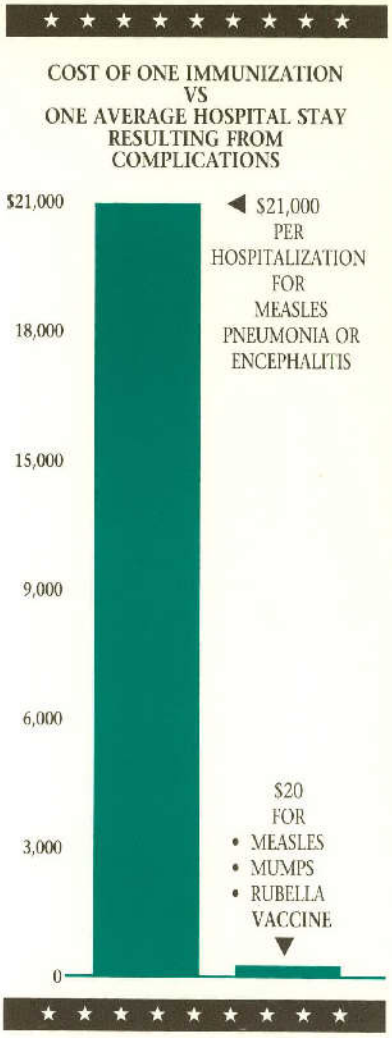
Adult-onset diabetes is another example of the efficiency of preventive care. In the overall population, conservative estimates indicate that 830,000 Texans suffer from diabetes. Of this number, about 90% have adult-onset diabetes. With early treatment, most of these patients' problems can be controlled with simple measures, such as weight reduction, exercise and diet.

A Baylor College of Medicine study illustrates the potential cost benefits of early diabetes intervention. The study findings indicate that diabetes intervention activities focused at prevention of complications showed a cost/benefit ratio of $2.59 for each $1.00 of cost per person.[79]

This example emphasizes the cost and personal benefits of prevention. Using 1990 data, the Texas Department of Public Health (TDPH) indicates that:

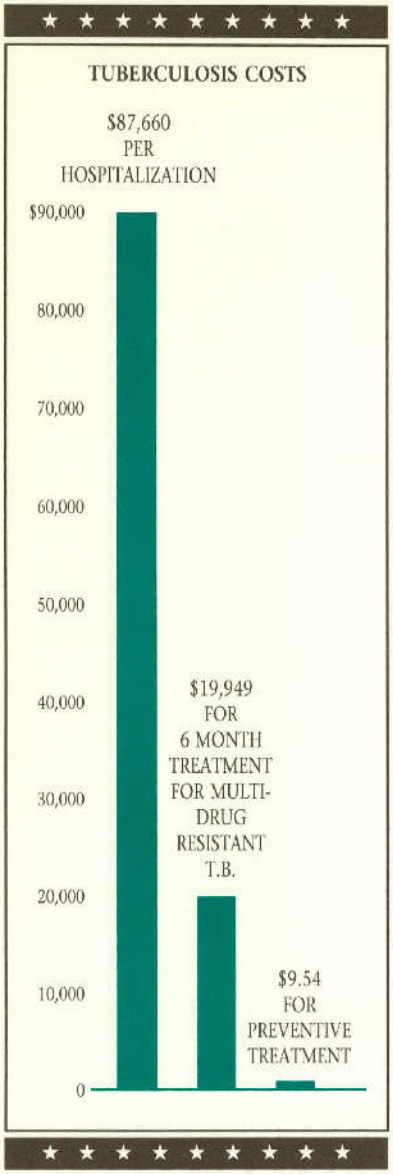
- ★ 860 new cases of diabetes-related blindness were reported.
- ★ Of these 860 cases, at least 50-60% were preventable with proper care.
- ★ 2,400 diabetes-related amputations were reported.
- ★ Of these 2,400 cases, at least 50% were preventable.

In addition, says the TDPH, the practice of individual diabetes-management techniques can reduce hospitalizations from diabetes-related conditions up to 70%.[80]



$20 PER DOSE OR $3000 PER DAY

When health care is delayed, health conditions that might have been prevented — or at least managed — are often left untreated until serious complications arise.



ACCESS TO BASIC HEALTH CARE SAVES MONEY

Recent reports reflect a dramatic increase in the incidence of tuberculosis. Lack of access to basic care has been cited as a major contributing factor.

The old adage, "an ounce of prevention is worth a pound of cure," continues to hold true.

The recent resurgence of tuberculosis is another costly example of deficits in the health care system. Recent reports reflect a dramatic increase in the incidence of tuberculosis. Lack of access to basic care has been cited as a major contributing factor. The old adage, "an ounce of prevention is worth a pound of cure," continues to hold true.

Compare the following costs:

- ★ Preventive treatment for tuberculosis costs $9.54 per person.
- ★ The medication costs for treating a standard tuberculosis case for six months is $631 per person.
- ★ The medication cost of treating a case of multi-drug resistant tuberculosis for six months is $19,949.
- ★ The cost of treating a hospitalized standard tuberculosis case for six months is $87,660.[81]

Five barriers hindering delivery of primary and preventive care were noted by the Task Force. *They include lack of coordination, cultural barriers, limited private coverage for preventive care, a growing demand for public services, and limited hours.*

1. Coordination Needed

Lack of coordination interferes with efforts to develop a system of health care based on primary and preventive services. One reason for the immunization crisis and other deficiencies discussed previously, is a lack of coordination between federal, state and local health care agencies and organizations.

Texas benefits from a variety of primary care delivery sites. These include:

- ★ Federally-funded Community Health Centers and Migrant Health Centers,
- ★ State-supported programs such as the Primary Health Care Services Program of TDPH, and
- ★ Local programs supported through hospital districts, and city/county governments.

Lack of coordination between these groups results in overlap of services in some areas and gaps in delivery of services in other areas. Testimony before the Task Force points out that active planning to eliminate gaps and overlapping of services is lacking.

2. Cultural Barriers

One of our state's greatest strengths is our multicultural population. *However, one problem brought to the attention of the Task Force is that the composition of the provider population does not adequately reflect our state's cultural diversity.*

3. Limited Private Coverage for Preventive Care

As previously noted, primary and preventive care have historically not been emphasized in health coverage plans. Both pediatric and adult preventive care are often excluded from private health care coverage. The exclusion is made because long-term cost savings from preventive care may not directly benefit the health care coverage provider. For persons with chronic health conditions, special services and medical supplies are often subject to increased cost sharing (higher deductibles or co-insurance) or at the least, extensive prior authorization is required by insurers for inclusion in the coverage.[82]

4. A Growing Demand for Public Services

The 1985 Task Force on Indigent Health Care reported that medically indigent Texans experience a critical lack of access to preventive and primary health care.[83] Since that report was issued in 1985, the adult portion of the medically indigent population has continued to grow. *In fiscal 1991, approximately 820,000 Texans (over 21) were at or below 150% of poverty without adequate access to public or private health care.*[84]

5. Limited Hours

Clinics are usually open only during working hours, such as 8:00 a.m. - 5:00 a.m., Monday-Friday. As a result, the people they serve must choose between receiving needed medical care for themselves or their children or earning a full day's pay.

TASK FORCE MEMBER

"Our state and our people are in such desperate need.

My heart went out to a woman in the Valley who told us that she and her friends got up as early as 3 a.m. on the days of their prenatal visits at the clinic so they could walk to the clinic and arrive by 4 a.m.

If they were any later, they would be too far back in line and clinic hours - 9 til noon - would be over before they could be seen.

It was a very shocking and powerful image."

ACCESSIBILITY — TIME IS MONEY

Clinics are usually open only during working hours, such as 8:00 a.m. - 5:00 p.m., Monday-Friday. As a result, the people they serve must choose between receiving needed medical care for themselves or their children — or earning a full day's pay.

Lack of Infrastructure: Effects on Selected Populations

The Task Force found three Texas populations especially vulnerable to the lack of primary and preventive care. They include minorities, children and teenagers.

1. Minorities

Minority populations in Texas are particularly at risk of serious health problems because of their inadequate access to primary and preventive care. In 1989, 19.9% of the African-American population and 35% of the Hispanic population — 3% higher than the national average — had no health care coverage.[85]

According to testimony presented by the Texas Department of Public Health, minorities have a far higher rate of sickness and death in all the diseases that are ***preventable***. These include conditions such as heart disease, diabetes, high blood pressure, strokes and certain types of cancer.

PREVENTABLE DISEASES

Diseases that can either be delayed, reduced in severity or totally prevented through early detection — or through a reduction in risk factors that contribute to disease, such as smoking, poor eating habits, excess weight, lack of exercise, and failure to receive routine care and screening tests.

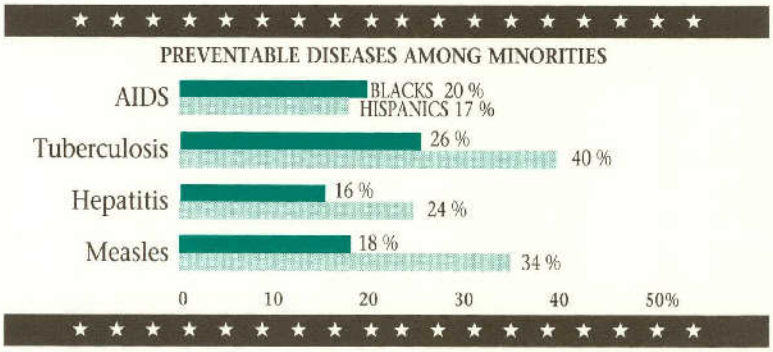
To understand the impact of preventable diseases on minority populations, return to our previous example of diabetes. Approximately 5% of Texans will develop diabetes during their lifetime. The statistics are particularly devastating for minority groups. In these groups the rate of diabetes is:

- ★ Native Americans = 1 of 5
- ★ Mexican-Americans = 1 of 8
- ★ African-Americans = 1 of 10.[86]

Many of the complications of uncontrolled diabetes — blindness, kidney failure, amputations, heart disease, strokes, birth defects and premature death — can be prevented through early detection and treatment.

MINORITIES AND PREVENTABLE DISEASES

According to testimony presented by the Texas Department of Health, minorities have a far higher rate of sickness and death in all the diseases that are ***preventable.***



2. Children

Many infants and children in Texas have no regular source of primary care.[87] Lack of a primary care provider prevents children from receiving consistent care, as well as treatment, for routine illnesses and injuries. A seemingly "mild" illness, if left untreated, may leave a child with permanent complications, such as hearing loss from recurring ear infections.[88]

Early diagnosis and treatment, on the other hand, prevents costly trips to the emergency room as well as reductions in hospitalizations.

One of the problems emphasized in Task Force testimony is the "childrens' access to immunization crisis." Statistics presented to the Task Force indicate that many children are not receiving all of the recommended battery of immunizations. *Studies reviewing the immunization records of urban kindergartners point out that only 10% of surveyed children in Houston, 30% in Dallas, and 40% in El Paso had received the recommended number of doses of basic vaccines by the time they were two years old.*[89]

3. Teens

The Task Force received a great deal of information regarding the special health problems facing Texas adolescents. *Numerous health problems are associated with the teenage years. These include such things as pregnancy, suicide, substance abuse, and HIV/AIDS. The problems underscore an urgent need to re-evaluate health care delivery to this segment of our population.*

According to sources at the Texas Department of Public Health, Texas ranks as one of the top five states leading the nation in the number of pre-teen and teen pregnancies.[90]

In 1990, there were approximately 4,678 pregnancies in the 10-15 year old age group, with a disproportionately high percentage of low-birth-weight babies. A staggering 36,575 pregnancies have been reported in the 16 to 18 year old age group.[91]

"We can no longer afford not to invest in prevention.

Medical care alone will not eliminate the devastating impact of chronic diseases on the disadvantaged, nor will it reduce the rate of infant mortality or the burden of homicide and violence or any of the other 'health' problems borne by our society."

Preface To
Healthy Texans 2000 Partnership
Texas Department of Health

PREMATURE PREGNANCY

Texas ranks as one of the top five states leading the nation in the number of pre-teen and teen pregnancies.

Complicating teenage access to existing health care services is the fact that aside from a few demonstration projects, school-based care is quite limited in Texas. Some school-based or school-linked programs are in existence, but funding for these programs is a constant concern.

Countless problems are related to early pregnancy. Early motherhood causes financial as well as emotional hardships for pre-teens, teenagers and their families. As a result of pregnancy, many young people drop out of high school. Lack of education makes it difficult for them to maximize their potential or even to compete in the job market. Early pregnancy is often the beginning — or the continuation of a ***cycle of poverty*** that is difficult, at best, to break.

Many young mothers in this group must depend on state assistance in the form of Aid to Families with Dependent Children (AFDC).[92] In 1990 alone, the state spent approximately $26 million in AFDC payments to teen mothers and their children.[93] In the same year, the state spent approximately $75 million on newborn care for infants born to teens.[94]

Barriers that limit teen access to health care complicate teenage health issues, such as early pregnancy. Delivery systems must be created to break down these barriers. Adolescent barriers that make teens unable or reluctant to access existing services include:

- ★ Concern for confidentiality,
- ★ Lack of transportation,
- ★ Inconvenient appointment hours,
- ★ Costs,
- ★ Lack of insurance coverage,
- ★ General apprehension, and
- ★ Disinterest among adolescents about health care in general.[95]

Complicating teenage access to existing health care services is the fact that aside from a few demonstration projects, school-based care is quite limited in Texas. Some school-based or school-linked programs are in existence, but funding for these programs is a constant concern.

In addition, a recent survey of school-based clinics determined that approximately 1/3 of the students served were eligible for Medicaid. *However, in many cases, these school-based clinics — which could be designed to serve all ages — have failed to pursue Medicaid payment.*

CYCLE OF POVERTY

A socio-economic condition that is perpetuated when generation after generation continues to be locked into poverty due to situations that hinder their ability to break the cycle.

CONTRACTUAL ALLOWANCES

Differences between what providers charge and what Medicare or Medicaid pay.

Inadequate Charity Care Delivery by Tax-Exempt Hospitals

Exemptions from federal, state and local taxation for non-profit facilities were initially granted to off-set costs of providing charity care. *Two factors have heightened interest in the amount of charity care being provided by tax-exempt hospitals. They are:*

- ★ An increase in the number of people needing charity care, and
- ★ A decrease in the ability to shift the costs of charity care to paying patients.[96]

Non-profit hospitals receive benefits, including exemptions from (1) property tax, (2) franchise taxes on net assets of the corporation when part of a religious, charitable, or educational institution, and (3) exemptions from certain sales taxes. Although some private non-profit hospitals provide an exceptional amount of charity care, it is reported that many provide very little. *In a study of five states, the U.S. Government Accounting Office (GAO) notes that in 1990 most private, non-profit hospitals were not providing enough charity care to justify their tax exemptions.*[97]

To address the reporting of charity care and other issues in Texas non-profit hospitals, the Special Task Force To Study Not-For-Profit Hospitals presented a definition for charity care in 1989.[98] However, *reporting charity care and bad debt in varying formats makes it difficult to determine the exact amount of charity care provided.* Community service, bad debt, and Medicare/Medicaid ***contractual allowances*** are reported by some hospitals as charity care figures.

Furthermore, individual hospital financial data, required by law to be reported to the Texas Department of Public Health, cannot be released without a hospital administration's express permission.[99] These data include detailed reporting of charity care and bad debt; however, hospitals often use different definitions on comparable issues — particularly on the question of where charity care ends and bad debt begins. The confidentiality requirement — making it difficult for a community to identify how much charity care a specific hospital provides — adds to this problem.[100]

★ ★ ★ ★ ★ ★ ★ ★ ★

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Deficiencies in Trauma Care Delivery

Trauma is the leading cause of death for Texans between the ages of 1-44. In Texas, an average of 30 people a day die from injury. Death is not the only consideration. For every trauma victim who dies, at least six are seriously injured.

In the last decade, annual patient loads in emergency rooms (ERs) have increased dramatically in the urban centers of Texas. The percentages below reflect the increase in the average annual ER visits per hospital in three Texas cities between 1980 and 1990:

- ★ Houston = 25.9% increase
- ★ Dallas = 31.6% increase
- ★ San Antonio = 47.7% increase[101]

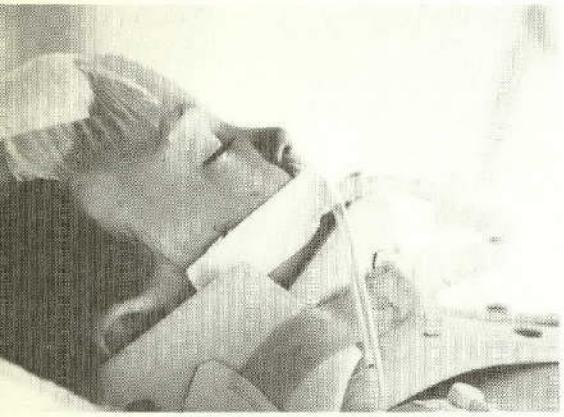
The incidence of true trauma is growing. In recent years, Dallas and Houston have seen a 25-30% increase in serious penetrating wounds related to drug and gang-related violence.[102]

In addition, many trauma patients do not receive rehabilitation because they cannot pay for such care.

The effect is an increased likelihood that these patients, as well as those with injuries too extensive for rehabilitation, will become dependent on federal, state, and local assistance programs.

To receive the appropriate level of care, critical trauma victims must reach expert care within a short period of time. This is often called ***the golden hour***. To insure that this occurs, a set of resources must not only be in place, but immediately accessible. These resources include informed citizens, communication systems, pre-hospital care providers, and multi-disciplinary emergency department trauma teams.

Deficiencies in trauma care provision exist in many parts of the state. Many rural areas do not have the full system of resources described above. For this reason, preventable death rates due to trauma in these areas may be as high as 85%.



FOR EVERY TRAUMA VICTIM WHO DIES — AT LEAST SIX ARE SERIOUSLY INJURED

Many trauma patients do not receive rehabilitation because they cannot pay for such care. • The effect is an increased likelihood that these patients, as well as those with injuries too extensive for rehabilitation, will become dependent on federal, state, and local assistance programs.

THE GOLDEN HOUR

The critical one hour period between an accident or medical event and appropriate care administered by a ***qualified*** *provider.*

Trauma care in inner-cities is also in crisis. Although trauma coalitions exist among hospitals, their future is uncertain because non-profit hospitals are urgently waiting for funding to assist with the care of indigent trauma patients.[103] This funding is needed to create trauma systems to support already large public teaching hospitals serving as the principal trauma safety net for urban areas.

Texas, like many other states, has been struggling in recent years to develop state-wide coordinated trauma care systems. These include:

- ★ 911 service,
- ★ The emergency medical service (EMS),
- ★ Transportation networks,
- ★ Hospital-based trauma services, and
- ★ Statewide trauma-prevention education programs.

The state recognized the need for both improved and better coordinated trauma care with the passage of House Bill 18 in 1989. As a result of this legislation, the Bureau of Emergency Management within the Texas Department of Public Health (TDPH) was reorganized to promote the development of a trauma system and to set up an EMS/trauma registry.

Several of the objectives of House Bill 18, including the planning of a state-wide trauma system, have been met; *however, no funding has been made available for the implementation of the plan.*[104]

Additional factors affect the quality of trauma services. One of these is the 911 system. In 1987, House Bill 911 called for the planning, financing and implementation of enhanced 911 emergency telephone services for residents throughout the state. Enhanced 911 service automatically routes emergency calls to the nearest emergency personnel. Features of the enhanced system include the ability to display the telephone number and the address of the number from which 911 was dialed.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Texas has passed legislation for a state-wide trauma system, including trauma prevention; however, we have not funded its implementation.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

"It is expected that by the end of 1992, over 97% of Texas communities will have some type of emergency phone service.

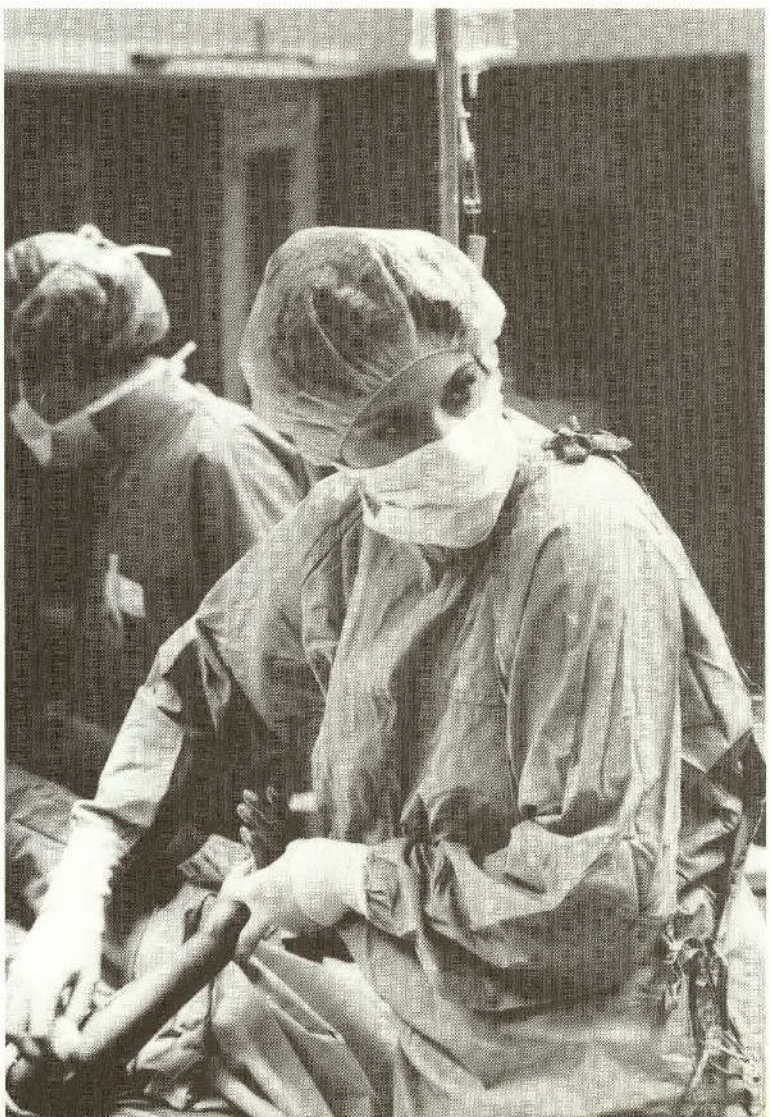
However, enhanced 911 services will still be lacking in many areas.

Without enhanced 911 service in every area, the system is not complete."

It is expected that by the end of 1992, over 97% of Texas communities will have some type of emergency phone service. However, enhanced 911 services will still be lacking in many areas. Without enhanced 911 service in every area, the system is not complete.[105]

There is also difficulty in maintaining up-to-date equipment and training for emergency personnel, especially in the hospitals of rural and frontier areas. Because of the small number of personnel working in a facility in such an area, there may be no one to substitute for them when they are away for training. As a result, it is difficult to keep their training up-to-date.

Rural emergency transportation services often struggle to remain financially viable, and find it difficult to acquire and maintain high-quality equipment.[106] National studies have found that Medicaid ambulance payments typically fail to cover the actual costs of providing services. As such, Medicaid may actually be undermining critical and financially vulnerable rural trauma providers.



TRAUMA CARE IN RURAL AND FRONTIER AREAS

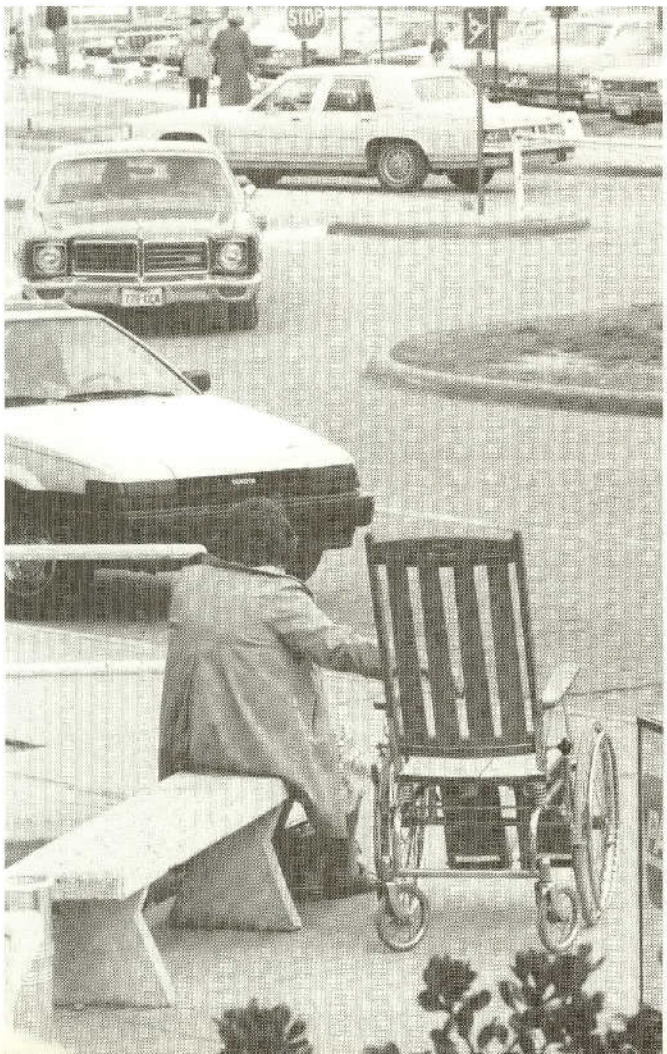
There is difficulty in maintaining up-to-date equipment and training for emergency personnel, especially in the hospitals of rural and frontier areas. Because of the small number of personnel working in a facility in such an area, there may be no one to substitute for them when they are away for training. As a result, it is difficult to keep their training up-to-date.

Lack of Available Transportation to Health Care Services

Several organizations have expressed concerns that their clients lack transportation to health care services. The Texas Medical Association lists transportation as the third most important barrier preventing patients from getting the medical care they need. Transportation was the number one need cited in a Texas Department on Aging assessment conducted in 1990. Twenty-six percent of all Texas counties currently have no scheduled public transport system, and 30% of urbanized areas are without scheduled public transport.[107]

There has been a consensus among state agencies and interested organizations that some type of coordination is needed to provide better transportation to both public health and human services.

An effort to address this need was made through the passage of House Bill 7, which mandated the creation of the Office of Health and Human Services Transportation Planning.[108]



TRANSPORTATION

*The Texas Medical Association lists transportation as the **third** most important barrier preventing patients from getting the medical care they need.*

Underutilization of Medical Telecommunication Systems

TASK FORCE MEMBER

"Task Force members were treated to a very uncomfortable, but enlightening view of an actual medical operation broadcast over MEDNET.

While one doctor in a hospital operating room in Alpine conducted an amputation, a specialist at the medical school assisted by providing expert knowledge transmitted via interactive television."

Telecommunications systems, if fully developed, can reduce the need for health-related transportation services in rural Texas. The full extent of the possibilities of telecommunication usage within the health industry are just now being realized.

The Task Force reviewed three Texas projects which serve as national models for the application of existing telecommunications technologies to health care services. They include:

1. The InfoMed Project

The InfoMed Project of Tarrant County Hospital District is a medical information hotline staffed by nurses.[109]

2. MEDNET

MEDNET is a demonstration project which links services provided by the Texas Tech Health Science Center with rural health care providers. It allows rural providers audio-video links with consulting specialists and transference of diagnostic and treatment data, as well as access to continuing medical education services.[110]

3. The Texas Telemedicine Project

The Texas Telemedicine Project in Giddings provides interactive telemedicine to a rural community, with applications through a hospital, mental health clinic, private dialysis clinic, and state youth corrections facility.

Such programs can help the state address its difficulties in accessing transportation for health care services and in linking health care providers. In addition, the possibilities for using telecommunications in education are enormous. These possibilities range from formally structured classes to the on-going transfer of medical information.[111]

Lack of Comprehensive Planning/Evaluation

As numerous studies of health care in Texas have noted, the absence of comprehensive planning and action within the health care system creates a health care delivery situation that cannot be described as a system at all. Health care delivery in Texas is filled with holes, gaps, uncertain jurisdictional boundaries, waste and fragmentation.

The lack of a state registry is a major problem. There is a great need to develop an extensive disease reporting system so that all health resources will have valuable targeting information available to them. It is impossible to develop data-driven policy without statistics on such items as:

- ★ Trauma,
- ★ Birth defects,
- ★ Poison control, and
- ★ Cancer incidence.

As yet, there has been no evaluation of need throughout the entire public health infrastructure to assess what data is needed to build and maintain an adequate health care system. When a needs evaluation is conducted, human resources should be considered a critical component of the infrastructure.

★ ★ ★ ★ ★ ★ ★ ★

As yet, there has been no evaluation of need throughout the entire public health infrastructure to assess what data is needed to develop data-driven policy for an adequate health care system.

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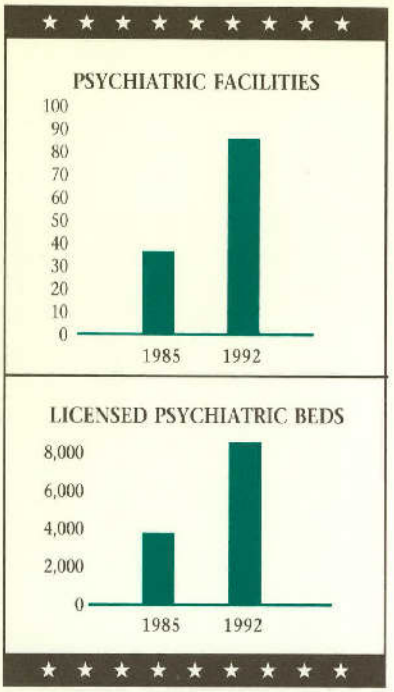
In Texas, health care resource planning — with regulatory constraints, such as a certificate of need (CON), a regulation that limited the number of hospital and nursing beds in certain regions or areas — no longer exists. Factors that have contributed in some respect to a health care cost inflation that exceeds 10% per year include:

- ★ Rapid expansion of Texas facilities, particularly psychiatric and rehabilitation facilities, and
- ★ Proliferation of equipment and high tech services.

From 1975-1985, the Texas Health Facilities Commission (THFC) was responsible for limiting hospital and nursing bed supply, high technology equipment and the creation of new services.[112] Although the Texas Sunset Review Commission recommended continuation of the agency, the Texas Legislature overrode this recommendation.



GROWTH IN PSYCHIATRIC SERVICES

The number of licensed psychiatric beds almost doubled between 1985 and 1992, increasing from 3,880 to 8,374.

Reasons cited for the rejection of this recommendation included (1) reports of excessive costs to providers, (2) the adversarial nature of the process, and (3) inequities in not covering all high technology equipment.[113] *Since the demise of the THFC, Texas has experienced a decline in the number of hospitals but an increase in total numbers of hospital beds.*[114]

The growth in private psychiatric facilities between 1985 and 1992 was more dramatic. The number of psychiatric facilities jumped from 37 facilities in 1985 to 85 facilities in 1992. The number of licensed psychiatric beds almost doubled in the same time period, increasing from 3,880 to 8,374.[115]

Excessive investment extends beyond facilities to high technology equipment. Ease of access to technology is an important component of a comprehensive health care delivery system. But excess equipment sometimes "creates a demand" for those services because investors need to recover the costs of purchase and operation. This increased utilization clearly results in greater costs.[116]

A national resurgence of interest in health planning and regulation of the supply of medical facilities and equipment appears to be underway. Programs are being created, reinstated, or expanded in states such as Colorado, Wisconsin, Virginia, and Georgia. One important national trend is the extension of planning programs to include free-standing facilities and expensive equipment in physician's offices.[117]

The Task Force notes the critical problems involved in identifying resources needed for cost-effective local and regional systems of health facilities, services and equipment.

TASK FORCE TESTIMONY

A national resurgence of interest in health planning and regulation of the supply of medical facilities and equipment appears to be underway.

COST SHIFTING

Increases in the rates health care providers charge to private payers, which are designed to make up for inadequate payment from other sources.

PROBLEM AREA # 4

COST CONTAINMENT

An Overview of Issues Associated with Controlling Costs

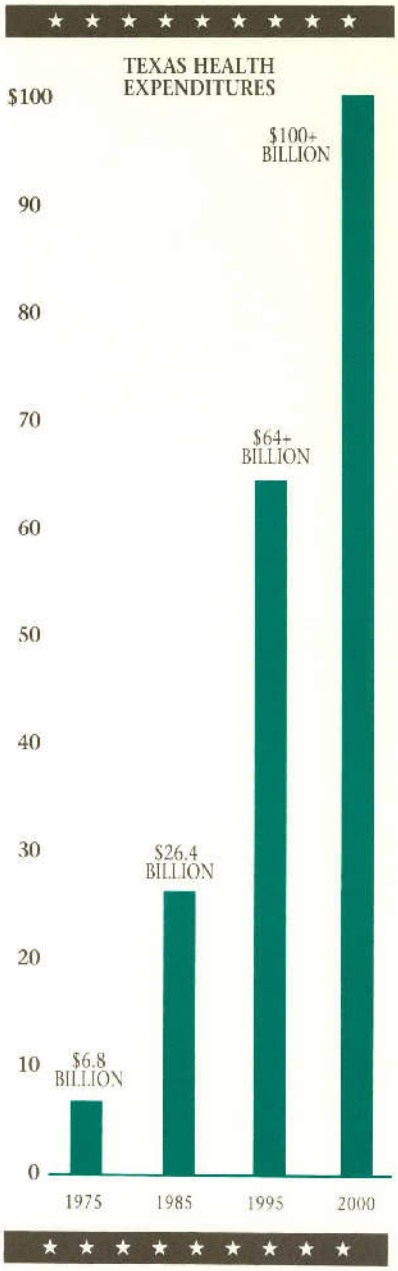
According to the Health Care Financing Administration of the U.S. Department of Health and Human Services, *total health spending per Texan increased from $1,063 in 1980 to $2,566 in 1990. If current growth rates continue, the per capita cost will increase to $5,700 in the year 2000.*[118]

If not brought under control, health care costs clearly have the potential to bankrupt not only individuals and businesses, but all levels of government.

The Task Force found that current mechanisms which were designed and have been implemented to help control health care costs have been unsuccessful. The overall, long-term trend of rising health care costs continues. A second problem with current control mechanisms is that they often result in limiting quality of health care rather than cost.

The Task Force heard repeatedly about the practice of ***cost-shifting*** in the health care market. Cost-shifting occurs when health care providers are not fully — or profitably — reimbursed for providing health care. In these situations, losses are made up by increasing charges to those who pay. *Cost-shifting is usually related to the provision of health care to the medically indigent or individually covered by public insurance programs. It is also increasingly being applied to the steeply discounted rates negotiated by some large health coverage plans.*[119]

As long as providers can charge essentially whatever the market will bear, health care costs will continue to spiral upward. Since the health care market does not respond predicably to conventional free-market forces, mechanisms for controlling costs that work in other markets are ineffective when applied to health care.



SPIRALING COSTS

If not brought under control, health care costs clearly have the potential to bankrupt not only individuals and businesses, but all levels of government.

The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not.

Mark Twain

Health care providers are currently struggling to negotiate with numerous independent insurers, employers and managed care organizations. Exceptional amounts of the provider's time and expense are necessary to determine eligibility requirements and provide appropriate documentation to each entity.

1. Inadequate Data Collection

The Task Force found that inadequate data made it very difficult to study health care costs. Furthermore, data that do exist are often too old to be used — with confidence — in an area as technologically and fiscally volatile as health care. This lack of data collection limits the ability of purchasers to determine the costs of procedures in advance.

2. Lack of Provider Participation in Rate Setting

The Task Force heard concern from the provider community that health care rates, such as Medicaid and Medicare, are set without input from providers. These providers believe that rates are not set at fair and equitable levels. Provider involvement in seeking solutions to this problem is critical.

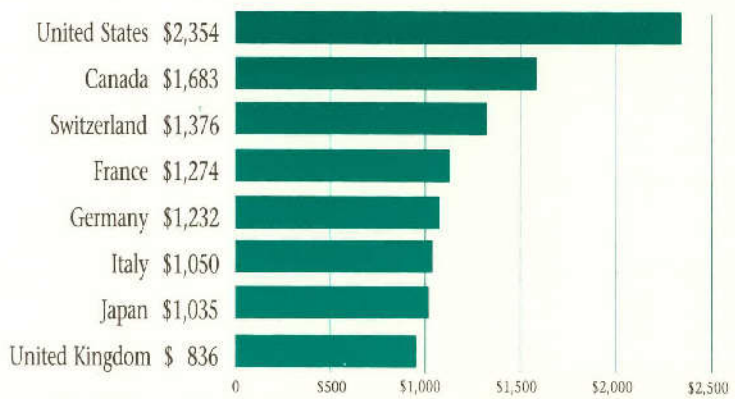
3. Exclusion of Expenditure Limits

In Texas, health care rates have been on an inflationary course for many years. In addition, most estimates point toward uncontrolled escalation in the future. *Currently, there are no state controls in place limiting this escalation.* The Task Force noted that other countries such as Germany, Canada, and France set budget targets and enforcement guidelines to hold down costs.[120]

CONTROLLING COSTS

Currently, there are no state controls in place limiting the escalation of health care costs. The Task Force noted that other countries such as Germany, Canada, and France set budget targets and enforcement guidelines to hold down costs.

PER CAPITA SPENDING IN OTHER DEVELOPED COUNTRIES



Rapidly Escalating Pharmaceutical Inflation

Pharmaceuticals are among the fastest growing cost drivers in health care. *During the 1980s while general inflation rose 57%, the prescription drug inflation rate increased a staggering 152 percent.*[121]

Medicare recipients, the elderly and the uninsured sick often pay more for medications than for food and other basic living expenses. *Most of our elderly population do not have the benefit of out-patient prescription drug coverage. As a result, for 3 out of 4 persons categorized as elderly, drug prices represent their highest out-of-pocket medical expense.*[122]

A second problem is that consumers find it difficult to make informed decisions about where to purchase pharmaceuticals. That is, they have difficulty knowing how and where to find the best value for their dollar. It was clear to the Task Force that on the whole, Americans pay higher prices for prescriptions than are charged in many other countries.[123]

The economic efficiency and improved quality of life that can result from appropriate drug therapy is not in dispute. The problem lies in the fact that if costs for medications exceed the individual's ability to purchase them, more expensive forms of treatment may have to be undertaken as the health problem worsens.

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TASK FORCE TESTIMONY

"My parents were small business owners in the Panhandle.

They believed their savings and Social Security would provide enough for their retirement.

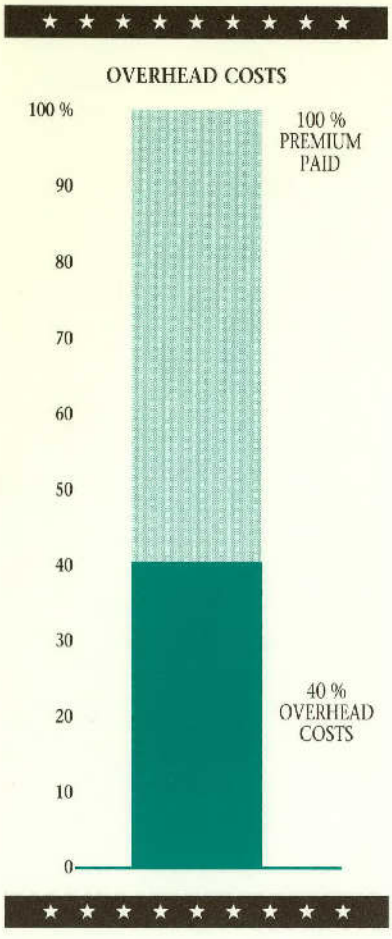
Their income is $1200/month.

Out of that, $600 goes to a live-in caretaker and $500 pays for medications.

I drive to three pharmacies to get the lowest prices possible.

Without my help, their medications would have cost $800/month at their local pharmacy."

Written Testimony
to the
Texas Health Policy
Task Force



40% OVERHEAD

In the small business and individual coverage markets, overhead costs may exceed 40% of premiums paid.

UTILIZATION REVIEW

A procedure whereby outside parties review health care practices for the purpose of controlling costs.

Questions Regarding Administrative Costs of Health Plans

An overwhelming amount of paperwork flows through the Texas Department of Insurance. For example, in the year 1991 more than 1,000 carriers generated over 30,000 different insurance plans for review and approval.[124]

Several problems exist regarding insurance paperwork. Obscure language makes it difficult to compare policies for the best benefits and price. In addition, the fact that numerous forms must be completed creates both extra cost and confusion for providers. *To stay current with changes, payment procedures, referrals and documentation, providers often find it necessary to employ additional staff.*

The Task Force learned that, in many cases, a large percentage of dollars spent on health care coverage premiums are used for administrative, marketing and other overhead costs — rather than purchase of health care services. For example, in the small business and individual coverage markets, overhead costs may exceed 40% of premiums paid.[125] *No data are available to consumers regarding how much of their premium dollars actually went toward the purchase of their health care services. There is also lack of data regarding how much of their premium dollars go toward administrative overhead and profits.*

1. Utilization Review Issues

Utilization review is defined as the "evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay and discharge practices".[126] In theory, this mechanism should hold down health care costs. However because individual hospitals may now deal with 50 to 250 different review organizations, additional personnel requirements — from physicians, nurses and other personnel — create new costs.[127] This reduces the net benefit of utilization review. The result is that quality is often sacrificed to cost effectiveness. *In looking at utilization review it is necessary to look at outcome as well as quality, costs and value. There must be a balance between cost appropriateness and cost effectiveness.*

Problems Limiting Consumer Participation

The Task Force learned that *all too frequently* health care bills which contain mistakes are presented to payers. Health benefit plan personnel may be unable to identify billing errors that the consumer could readily spot.

Although consumers could help remedy this problem, there is currently no trend toward consumer involvement in correcting health care billing errors. The reason is that few incentives exist which encourage consumers to examine their bills and pursue corrections.

A second factor in consumer participation noted by the Task Force was that consumers presently have no effective means of comparison shopping for their health care needs. Testimony before the Task Force stressed the need for ready access to information on the costs of office visits, procedures, treatments, tests, etc. in order to compare services.

The Task Force found that consumers also lack outcome information that can help them make choices about providers and facilities. *Outcome information — such as the quality and proficiency of health care providers — is currently unavailable to Texas consumers.*

The Task Force learned that all too frequently health care bills which contain mistakes are presented to payers. Health benefit plan personnel may be unable to identify billing errors that the consumer could readily spot.

Needed Reforms in Medical Malpractice

The Task Force received extensive testimony concerning medical malpractice. Problems related to medical malpractice are complex. They involve medical, legal and insurance issues.

Medical malpractice is not a new area of controversy for Texas or the nation. The issues surrounding this controversy include:

- ★ Medical negligence and malpractice,
- ★ Increasing costs of professional medical liability insurance,
- ★ Fair allocation and payment for fault, and
- ★ Consumer protection

These issues have been in the news for many years. However, relatively little research using reliable data has been conducted on them.

In a cooperative effort intended to supply reliable, Texas-based data, the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association jointly funded a study of the impact of medical malpractice costs on overall health care costs. The results of this study were presented to the Task Force by Larry Tonn in a full-day session and were the subject of testimony before the Cost Containment Subcommittee.

The Tonn Report discussed the medical, legal and insurance aspects of the medical malpractice issue. Some of the major findings of the Tonn Report are summarized below:

1. Medical Aspects of the Medical Malpractice Issue

Medical and hospital professional liability in Texas accounts for less than 1% of overall health care costs. For this reason, changing the liability system will likely have minimal impact on overall health care expenditures.[128]

DEFENSIVE MEDICINE

The use of medical procedures and treatments to initiate protection against malpractice suits and claims of negligence.

However, many physicians report that they must practice ***defensive medicine.*** This practice involves ordering more diagnostic services, or choosing courses of treatment that minimize the risk of a negative outcome, even if that possibility is remote.

The Tonn Report's findings indicate that reducing defensive practice is more complex than tort reform. As such, it will require more consensus on practice standards and peer review initiatives.[129]

This finding is consistent with the following conclusion of a highly regarded study recently completed by researchers at Harvard University's School of Medicine:

> *Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO) and state and hospital requirements, or a combination of factors.*[130]

According to the Tonn Report, even if it is assumed that 15% of the total cost of all physicians' services represent purely defensive medicine, medical malpractice still would account for no more than 3.6% of Texas' overall health care spending.[131] *Because there is no agreement about what constitutes "defensive medicine" and because no reliable data exist upon which to base any estimate of how much it costs, this area requires further study.*

Finally, claims are sometimes filed as the result of poor communication between the physician and patient following an adverse event that may or may not involve negligence.[132]

TASK FORCE TESTIMONY

"It was unclear whether defensive medicine resulted from the malpractice environment or from other factors, such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization and state and hospital requirements, or a combination of factors."

Harvard
Medical Malpractice Study
Cited In The Tonn Report

While the impact of an individual malpractice suit on the overall health care system may be minimal, it may be very significant to the patient and health care provider who are affected.

INDEMNITY PAYMENTS

Payments made by an insurance company on behalf of its policy holders.

STATUTE OF LIMITATIONS

A law which establishes a period of time beyond which one cannot be held responsible for certain acts.

CLAIMS CLOSED WITHOUT INDEMNITY

A case in which a process is begun which might lead to a claim or a lawsuit, but which is closed without any payment by the insurance company.

NON-ADMITTED CARRIERS

Insurance carriers who are not licensed or chartered to underwrite business in the state where the coverage will be issued.

INDEMNIFICATION

An agreement between the state and health care providers designed to protect them against large malpractice settlements in return for service in indigent or government health care.

2. Legal Aspects of the Medical Malpractice Issue

While the impact of an individual malpractice suit on the overall health care system may be minimal, it may be *very* significant to the patient and health care provider who are affected.

When actual ***indemnity payments*** on behalf of physicians are seen in 1980 constant dollars, data indicate that average payments have leveled off in Texas since the mid-1980s. At the same time, the frequency and average amount of payments on behalf of hospitals have continued to increase.[133] The definition of medical malpractice "claims" for reporting purposes also continues to be a problem.

Frequently, because of the ***statute of limitations***, a malpractice suit names several providers related to a case until the discovery process can determine the parties who are actually responsible. *This practice distorts data collected on claims filed and can cause unnecessary costs to the system.*

Additionally, some ***claims closed without indemnity*** represent nothing more than an attorney requesting records and subsequently advising the patient not to pursue litigation. Since no suit is filed, no indemnity is paid. *Reporting procedures are needed that distinguish legitimate inquiries from cases that are truly "frivolous."*[134]

3. Insurance Aspects of the Medical Malpractice Issue

The insurance issue includes questions about the cost and availability of professional medical liability insurance.

Malpractice insurance premiums for Texas physicians in most specialties compare favorably with those paid by their counterparts in other states. There is both an increase in availability of liability insurance for physicians and a growth in competition among insurance companies.[135]

It is difficult to analyze the availability of hospital professional liability because of differences in coverage limits, self-insuring mechanisms and the use of unlicensed or ***non-admitted carriers.***[136]

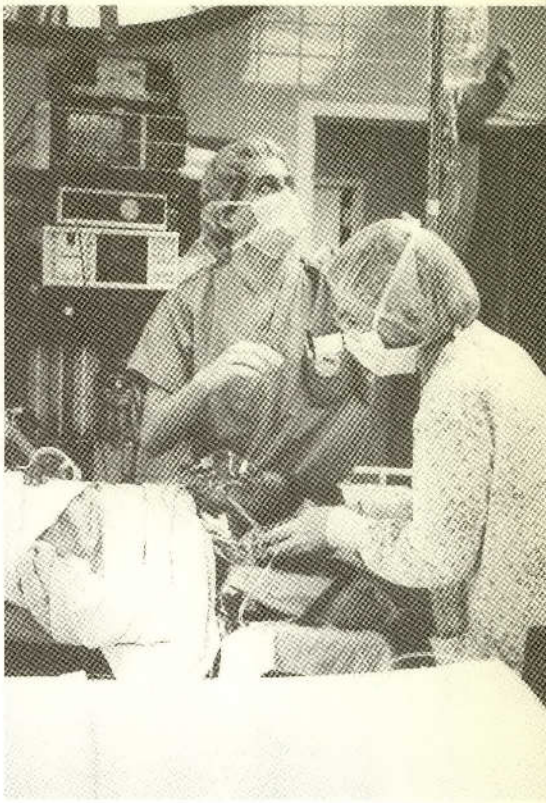
Several hospital representatives testified about difficulties in enlisting physicians to serve in emergency rooms because of a perception of increased liability exposure. This is due, in part, to their concerns that Medicaid patients are more prone to sue than other patients. However, numerous studies agree Medicaid patients do not file a disproportionate number of malpractice suits.[137] The Texas Legislature has attempted to address this misperception with the ***indemnification*** program established in 1989 under House Bill 18.

Under this program, the state pays a portion of medical liability claims for health care professionals

- ★ $100,000 for physicians who provide obstetrical care and who devote at least 10% of their annual practice to indigent health care
- ★ $25,000 to other physicians who devote at least 10% of their annual practice to indigent health care,
- ★ $25,000 to federally qualified health centers.

There is a need to consider whether this program should be extended to include payment of some portion of claims against hospitals.

The Task Force also received reports that providers are encountering difficulty in collecting indemnification payments from the state. The indemnification program is currently administered by the Attorney General's office. This collection delay creates additional headaches for providers that the program intends to benefit.



DIFFICULTIES IN ENLISTING PHYSICIANS TO SERVE IN EMERGENCY ROOMS

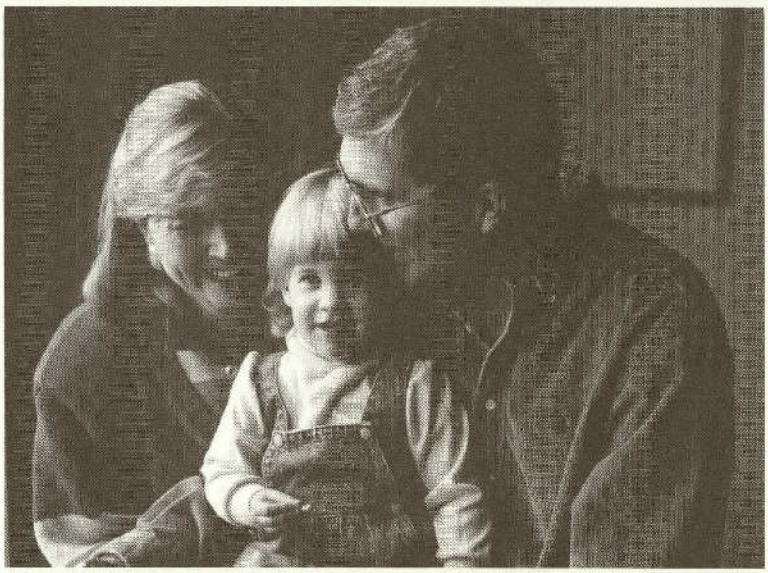
Several hospital representatives testified about difficulties in enlisting physicians to serve in emergency rooms because of a perception of increased liability exposure.

CONCLUSION

The Task Force is fully aware that there are no simple answers to the problems we have identified. The solutions which follow are complex.

It is clear that they will require sacrifice by all facets of the health care industry if accessible, affordable health care for all Texans is ever to be realized.

TEXAS RESOURCES



"It's Our Money. It's Our Choice."

THE RECOMMENDATIONS

INTRODUCTION

Responding to public demand for reform in health care, the Task Force listened diligently to extensive testimony, sifted through large quantities of written material and debated at length about possible solutions.

In the search for answers, several points became clear:

- ★ The existing health care system is broken.
- ★ The people of Texas are insisting on major changes targeted at controlling health care costs and improving access.
- ★ Many small or limited approaches to the problem have been tried. All of these approaches have failed to produce any major improvements in cost control or access.

The Task Force concludes that the goals set forth in this report can only be reached through fundamental and comprehensive change in the health care system.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

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★ ★ ★ ★ ★ ★ ★ ★ ★ ★

We point out that the best and most efficient way to make this kind of major change is at the national level, because states have no control in areas regulated by federal law, federally-funded health care programs, employer-provided health benefit plans, or federal tax policy.

In spite of this limitation, it is clear to the Task Force that Texas cannot wait for the federal government to take action. We must begin the process NOW.

Without such action, our future economic stability is at great risk.

Each year that more than a million of our children go without health care places Texas one step closer toward a decline in productivity and competitiveness.

Every child born to a mother who receives little or no prenatal care is at risk of requiring a lifetime of public support rather than contributing to our state's future.

As a Task Force, we believe one of the most important components of comprehensive reform must be a dramatic shift from our current system.

We must move away from our present focus on expensive treatments, high-technological procedures and specialty care. We must move toward a system built on

- ★ Preventing illness, and
- ★ Meeting the basic primary health care needs of *all* of our people.

This new direction will not happen quickly. It will require careful and thoughtful planning. It will require coordination at all levels of health care delivery. And, it will require the cooperation of all of us.

This report contains specific recommendations for short-term action — discussed in the sections titled "The Texas Children's Health Plan" and "Reforms to the Current System." It also includes a discussion of an optimal long-range direction for future health care in Texas — discussed in the section titled "A Direction for the Future."

Children — and pregnant women — have been given first priority in our recommendations because they *are* our future.

The Task Force, therefore, has divided this section into three areas of focus.

- ★ **The Texas Children's Health Plan**
- ★ **Reforms To The Current System**
- ★ **A Direction For The Future: The Texas Health Plan**

TASK FORCE MEMBER

"I didn't expect to see and hear the things that were presented to us.

One physician told us that many providers don't want Medicaid patients in waiting rooms because their presence disturbs other folks.

In other instances, we saw elderly Texans and even middle income people that can't afford basic health care.

It was disturbing to find such a dual level system in our state."

THE RECOMMENDATIONS

THE TEXAS CHILDREN'S HEALTH PLAN

- An Introduction To The TCHP
- Financing The TCHP
- Delivery Of TCHP Services
- TCHP Cost-Containment Mechanisms

REFORMS TO THE CURRENT SYSTEM

- An Introduction To The Reforms
- Reforms In Access To Coverage
    1. Medicaid Reforms
    2. Private Health Care Coverage Reforms
- Reforms In Provider Services
    1. Supply And Distribution Of Providers
    2. Medicare And Medicaid Acceptance
    3. Texas State Board Of Medical Examiners
    4. Self-Referral
- Reforms In Infrastructure
    1. Preventive And Primary Care
    2. School-Based Health Care Services
    3. Tax-Exempt Hospitals
    4. Trauma Care Delivery
    5. Transportation
    6. Technology
    7. Health Care Planning
- Reforms In Cost Containment
    1. Negotiated Rate Regulations
    2. Pharmaceutical Cost Containment
    3. Standardization And Streamlining
    4. Competitive Market Improvements
    5. Medical Malpractice Issues

A DIRECTION FOR THE FUTURE: THE TEXAS HEALTH PLAN

- An Introduction To The THP
- Benefits To Texans
    1. Guaranteed Universal Access And Coverage
    2. Greater Utilization Of Health Care Providers
    3. A Coordinated Infrastructure
    4. Control of Cost Escalation
    5. A Responsible System of Finance

THE TEXAS CHILDREN'S HEALTH PLAN

An Introduction To The TCHP

The children of this state are our greatest treasure. As such, they deserve not only our greatest resources, but our very best efforts. Throughout its deliberations, the Task Force has been reminded over and over that our children *must* be our top priority.

THE TCHP RECOMMENDATION

The Task Force recommends that Texas establish a statewide system for financing and ensuring access to high quality, comprehensive health care for all children — from birth through age 18 — and for all pregnant women. This plan would be known as the ***Texas Children's Health Plan (TCHP)****. The plan includes both children and pregnant women with disabilities. Voluntary participation — for children and pregnant women — is recommended.*

THE GOAL

Our goal in recommending the provision of ***preventive*** and ***primary care*** to children and pregnant women is the reduction of long-term health care costs.

While more than a million Texas children have limited access to health care because they are ***uninsured***, many more lack basic health care because they are ***underinsured***. That is, their parents simply cannot afford to pay co-payments and deductibles.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Our goal in recommending the provision of preventive and primary care to children and pregnant women is the reduction of long-term health care costs.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

PRIMARY CARE

The first level of care a patient receives from a primary care provider for a particular health need.

PREVENTIVE CARE

Providing patients with access to (1) routine, periodic examinations, immunizations and screening tests, (2) risk-reduction counseling, and (3) information and resources that can help them achieve and maintain good health.

THE UNINSURED

People without health care coverage of any kind.

THE UNDERINSURED

People who have health care coverage but are unable to pay a substantial portion of their health care expenses. That is, they have such high deductibles and co-payments — or such low caps on benefits — that they forgo care.

THE BENEFITS

Four major benefits will result from coverage of comprehensive health services for children and pregnant women:

- ★ Families will no longer need private insurance for children or maternity services,
- ★ Health care providers' uncompensated care will be reduced,
- ★ Employers' costs for providing health care coverage will be reduced, and
- ★ Parents who are motivated to file medical malpractice claims on behalf of their children — based on concerns that expensive medical care is unavailable — will be assured of the availability of comprehensive medical care for their children during their first 18 years of life.
- ★ For a full list of the package patient coverage, see Appendix 1.

To develop and implement this statewide system, the Task Force makes recommendations in three specific areas:

- ★ **Financing the TCHP Plan**
- ★ **Delivery of TCHP Services**
- ★ **TCHP Cost Containment Mechanisms.**

THE TEXAS CHILDREN'S HEALTH PLAN BENEFITS PACKAGE *

FOR ALL TEXAS CHILDREN

PREVENTIVE PACKAGE

- ★ Child Preventive Care, including:
  - Routine Office Visits,
  - Routine Immunizations,
  - Routine Laboratory Tests, and
  - Preventive Dental Care
- ★ Care of Newborn Infants and Attendance at High-Risk Pregnancies
- ★ Comprehensive Reproductive Health Care, including:
  - Prenatal,
  - Postnatal, and
  - Family Planning Services

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physician Services
- ★ Pediatric and Family Practice Advanced Nurse Practitioner Services
- ★ Hospital Services
- ★ Emergency Services
- ★ Diagnostic Services
- ★ Outpatient Hospital Services
- ★ Ambulatory Surgical Center Services
- ★ Maternity Center Services
- ★ Home Health Services
- ★ Ambulance Services
- ★ Medical Transportation Services
- ★ Acute Dental Care
- ★ Corrective Eyeglasses or Lenses
- ★ Hearing Aids
- ★ Prescription Drugs

EXTENDED MAJOR MEDICAL PACKAGE

- ★ Case Management Services, includes
  - Chronically Ill, and
  - Other At-Risk Children
- ★ Treatment of Developmental and Learning Disabilities *(may be educational rather than medical, depending on the diagnosis and type of service)*
- ★ Mental Health Services
- ★ Substance Abuse Services
- ★ Speech Therapy
- ★ Occupational Therapy
- ★ Physical Therapy
- ★ Home Health: In-Home Care
- ★ In-Home Intravenous Therapy
- ★ In-Home Respiratory Therapy
- ★ Hospice Care
- ★ Nutritional Assessment and Counseling
- ★ Orthodontics *(other than cosmetic)*
- ★ Rehabilitation Services, including:
  - Medical Supplies, and
  - Durable Medical Equipment

  (paid for under the Comprehensive Care Program -CCP, which in Texas is available only for people under age 21)

FOR ALL PREGNANT WOMEN

- ★ Pregnancy-Related Care, including
  - Family Planning Services
  - Prenatal, Delivery and Postnatal Care

  (delivered either by a Physician, or Pediatric Advanced Nurse Practitioner, or Family Practice Advanced Nurse Practitioner)
- ★ Specialized Care for High-Risk Women
- ★ Ambulance Services and Medical Transportation Services
- ★ Home Health: In-Home Care

All of the services on the above list are currently covered by the Texas Medicaid program.

ALL INCOME LEVELS

Recent changes in federal law now make it possible for states to create health programs for children and pregnant women ***at all income levels.***

UNCOMPENSATED CARE

Care for which the provider is not paid.

COST SHIFTING

Increases in the rates health care providers charge to private payers which are designed to make up for inadequate payment from other sources.

Financing The TCHP Plan

As a foundation for recommendations regarding financing the TCHP plan, the Task Force reiterates the following points discussed in the PROBLEM section of this report:

- ★ Recent changes in federal law now make it possible for states to create health programs for children and pregnant women at all income levels.
- ★ These programs qualify for matching federal funds.
- ★ Texas has a long history of failing to take advantage of available federal dollars.
- ★ Texans send more than $1 to Washington for every $1 returned to the state in federal aid, while other states send less and get more.
- ★ Under current matching rates, approximately 65¢ out of every $1 spent in the *Texas Children's Health Plan* (TCHP) could be paid with federal funds.
- ★ We cannot afford to ignore this opportunity to maximize generous federal funding to meet the needs of our most valuable — and vulnerable — population.

RECOMMENDATION: ESTABLISH A CHILDREN'S HEALTH BOARD

The Task Force recommends that Texas establish a Children's Health Board under the umbrella of the new Health and Human Services Commission. The Children's Health Board would administer and monitor implementation of the Texas Children's Health Plan.

To finance the program, the Task Force recommends that the state obtain approximately 65% of financing through the federal Medicaid program. A variety of funding options should be explored by the legislature to generate needed state dollars for TCHP.

Applying the 1994 projected Medicaid payment rates, TCHP in 1994 would cost approximately $4.2 billion more than the anticipated 1994 expenditures under the current Medicaid coverage.

Of this $4.2 billion, $1.5 billion would be state dollars. The return on this investment would be health care coverage for an additional 4,000,000 children and 200,000 pregnant women.

Actual payment rates in the TCHP will be negotiated. The actual costs may differ from current Medicaid costs when the following factors are taken into account:

- ★ Prevailing private rates,
- ★ Cost savings in administration,
- ★ Reduced paperwork, and
- ★ Elimination of ***uncompensated care*** and ***cost shifting*** for children and pregnant women.

It is also important to note that TCHP would build on the foundation of many existing state and local health programs for children and pregnant women.

PUBLIC TESTIMONY

"I'm a public school teacher from the Valley. My insurance plan covers my family of five.

My premiums are $350 per month with a $1,250 deductible ($250 per person)

That means that I must spend $5,450 a year out of my teacher's salary before I benefit from heath insurance.

Since I can barely make ends meet, we put off going to the doctor until conditions become much worse.

This system makes no sense to me."

Delivery of TCHP Services

Under the Texas Children's Health Plan, Texans would continue to have the freedom to choose their own ***health care providers.***

There would be no need for families to change a child's provider:

- ★ When joining TCHP,
- ★ When a parent changes jobs, or
- ★ When an employer changes health care coverage.

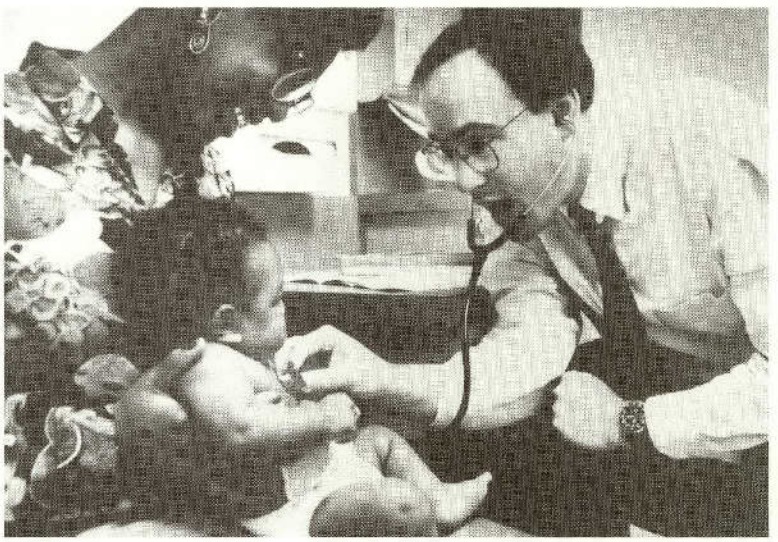
RECOMMENDATION: UTILIZE BOTH PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

For cost-effective and convenient delivery of health care service, the Task Force recommends the expanded use of physicians, licensed health care providers and physicians assistants.

We also recommend that a quality assurance mechanism be integral to TCHP from the start.

HEALTH CARE PROVIDERS

Health professionals — such as physicians, dentists, nurses, physician assistants, health educators, dietitians, pharmacists, therapists and others.



UNDER THE NEW PLAN, YOU GET TO KEEP OR CHOOSE YOUR PROVIDER

Under the Texas Children's Health Plan, Texans would continue to have the freedom to choose their own health care providers.

TCHP Cost Containment Measures

Cost containment is critical to the success of any plan. A number of recommendations are made to address the cost-effectiveness of TCHP.

GENERAL RECOMMENDATION: MAKE COST CONTAINMENT REFORMS IN FIVE AREAS

The Task Force recommends reforms in five areas: negotiated rates, billing procedures, administrative costs, utilization review and data collection.

These reforms also apply to coverage for all Texans and are described in greater detail in this report in the section titled *"Reforms To the Current System: Cost Containment."* They are included in the TCHP cost containment section because they are an integral part of this program as well as the section of this report regarding reform recommendations.

The Task Force recognizes that these cost containment measures will have far greater impact if applied to the ***entire*** *health coverage system rather than only to the Texas Children's Health Plan.*

RECOMMENDATION 1: ESTABLISH UNIFORM RATES

- ★ Rates would be negotiated by a group composed of providers, consumers, business representatives and public officials.
- ★ Rates must be adequate to avoid cost-shifting and to provide reasonable and fair compensation for providers.
- ★ Providers may not charge patient fees higher than the established, uniform rate schedule.
- ★ Because federal anti-trust laws prohibit collaborative rate-setting by health providers alone, the state will be required to be an active participant in the negotiation process.

PUBLIC TESTIMONY

"I'm a 27 year old mother of four from Lufkin.

My husband was laid off a year ago. He has a new job now, but they provide no health insurance.

I have a 3 year old child with severe asthma. He has to have treatments that cost $90 each. Another child needs an operation.

I'm here because I just need to ask someone . . .

What are parents supposed to do?"

RECOMMENDATION 2: UTILIZE STANDARDIZED BILLING

- ★ We recommend uniform and simple billing procedures for providers.
- ★ This standardization should facilitate prompt payment to providers by TCHP.
- ★ TCHP will guarantee provider payment and eliminate the provider's "hassle" of dealing with multiple payers, variations in benefits, different utilization review standards and patients' inability to pay.

RECOMMENDATION 3: LIMIT ADMINISTRATIVE COSTS

The Task Force recommends limiting TCHP administrative costs to 10%. The Task Force points out, however, that these costs are expected to be less than 5%.

RECOMMENDATION 4: INTEGRATE A UTILIZATION REVIEW PROCESS

We also recommend that a ***utilization review*** process be integrated into TCHP. Such a process would monitor claims to prevent over-utilization — the provision of unnecessary procedures or services, and fraud.

RECOMMENDATION 5: ESTABLISH A DATA COLLECTION SYSTEM

The Task Force recommends that data be collected to determine utilization patterns. Collected data would help

- ★ Establish reasonable practice standards, and
- ★ Serve as a basis for changes to services covered and rates charged.

For women with non-maternity coverage from one source and TCHP coverage for pregnancy-related needs, policies must ensure that gaps in maternity care coverage are eliminated. TCHP would pay for all health needs throughout pregnancy, and for up to 60 days following childbirth.

UTILIZATION REVIEW

A procedure whereby outside parties review health care practices for the purpose of controlling costs.

REFORMS TO THE CURRENT SYSTEM

An Introduction To The Reforms

The Task Force arrived at the reforms contained in this section after careful and intensive study regarding problems that exist within our current health care system.

THE GOAL

The reforms presented in this section are intended as reforms to the current system. They would extend coverage to those who are uninsured or underinsured and would expand the infrastructure required to provide expanded health care coverage to all Texans.

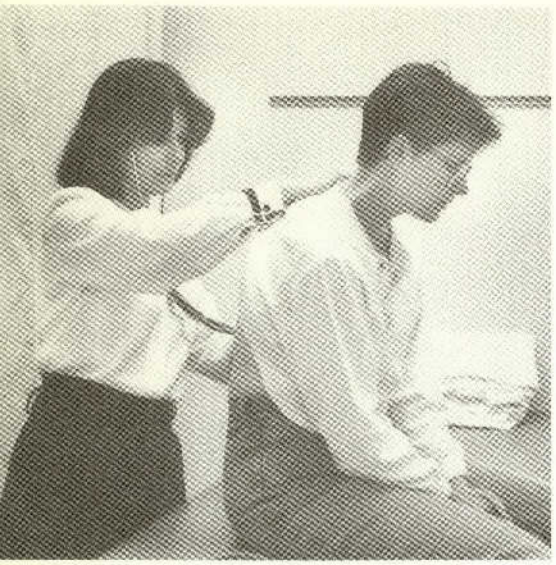
THE REFORM RECOMMENDATIONS

The reforms are divided into four categories:

- ★ *"Reforms in Access to Coverage,"* which includes reforms in Medicaid and private health care coverage;
- ★ *"Reforms in Provider Services,"* a discussion of needed reforms in supply and distribution of providers, Medicare and Medicaid acceptance, the Texas State Board of Medical Examiners and self-referral;
- ★ *"Reforms in Infrastructure,"* which focuses on delivery changes in primary and preventive care, school-based health care services, tax-exempt hospitals, trauma care delivery, transportation, technology and health care planning; and
- ★ *"Reforms in Cost Containment,"* which is directed at negotiated rate regulation, pharmaceutical cost containment, standardization and streamlining, competitive market improvements and medical malpractice issues.

THE BENEFIT

We believe that the changes recommended are necessary in order to have a health care system that is accessible to all.



SAVING LIVES, SAVING MONEY

The Task Force recommends the following additions to services now covered: preventive and screening services, and speech, language and hearing therapy.

Reforms in Access To Coverage

The Task Force recommends comprehensive reforms to expand health care coverage. Adoption of these reforms will extend health care benefits to many who are presently uninsured or underinsured. This group includes:

- ★ Employees of small businesses and the self-employed (also called small groups),
- ★ Individuals with ***pre-existing conditions***,
- ★ People with limited incomes and
- ★ Children.

Reforms in access to coverage fall into two major categories:

- ★ **Medicaid Reforms**, and
- ★ **Private Health Care Coverage Reforms**.

MEDICAID REFORMS

GENERAL RECOMMENDATION: MAXIMIZE PARTICIPATION IN FEDERALLY FUNDED HEALTH CARE PROGRAMS

- ★ The Task Force recommends that Texas take maximum advantage of generous federal matching funds available through Medicaid to finance health care for all Texans.
- ★ The Task Force notes that implementation of the *Texas Children's Health Plan* will largely preempt this recommendation because TCHP's federal-state financing mechanism would be Medicaid-based. Even so, we recommend incremental Medicaid expansion for other populations as well.
- ★ The Task Force also recommends increasing the number of services offered. For children from birth through age 18, the Medicaid program already contains provisions requiring payment for treatment of most conditions detected during a checkup under Medicaid's well-child program, "Early Periodic Screening, Diagnosis and Treatment" (EPSDT)
- ★ For adult Medicaid clients, the Task Force recommends the following additions to services now covered:
  - ★ Preventive and screening services, and
  - ★ Speech, language and hearing therapy.

PRE-EXISTING CONDITIONS

Health conditions that exist prior to the beginning date of a health coverage policy.

SELF-INSURED PLANS

A procedure by which a company sets aside money to pay health care costs directly rather than purchasing coverage from an insurance company.

MANDATED BENEFITS

Benefits - governed by state law - that are required ("mandated") to be included in health coverage plans.

PRIVATE HEALTH CARE COVERAGE REFORMS

GENERAL RECOMMENDATION: STRENGTHEN THE EXISTING HEALTH CARE COVERAGE STRUCTURE

Private health care coverage is a portion of the health care coverage market over which the state has regulatory authority. States are prohibited by federal law from regulating ***self-insured*** employer health benefit plans. Over half of all Texans are covered under such self-insured plans.

In attempting to expand access and availability of health care to more of the population, the Task Force recommends **eight changes** *in the way the private health care coverage market functions.*

RECOMMENDATION 1: ELIMINATE DEDUCTIBLES FOR SELECTED PREVENTIVE SERVICES

The Task Force recommends eliminating deductibles for the following selected preventive care services:

- ★ Immunizations
- ★ Pap Tests
- ★ Mammography
- ★ Colo-Rectal Screening
- ★ Prostate Screening

★ Revisions of ***mandated benefits*** were debated at length. The Task Force agrees that revisions may be necessary. However, in order to make revisions effective, it is necessary to clearly identify the effects of mandated benefits on both cost and availability of health care coverage. Studies detailing the effects of mandated benefits are largely anecdotal, limited in scope and sometimes contradictory in their results. These studies do not conclusively identify the costs of mandates. Also, omitting private health coverage for certain conditions does not eliminate the need for treatment. It simply shifts the cost and delivery of care completely into the public health system. *Lacking clear evidence on trade-offs between the costs and benefits of mandates, the Task Force agrees that specific mandate deletions cannot be recommended at this time.*

TASK FORCE MEMBER

"The most impressive testimony I heard was in Dallas.

A small business owner with a heart condition told us that he had no choice but to keep his business open and make minimum wage — just to retain his insurance coverage.

The reality of pre-existing conditions was a problem many of us had never even considered.

This man's predicament stayed with me throughout my work on the Task Force."

★ *Other than mammography, which is currently mandated, it may be necessary to add the preventive services listed on the previous page to existing state mandates to assure their inclusion in health care coverage.* These particular services — which have been **conclusively** demonstrated to save money through prevention or early detection of costly illness — are inexpensive to provide. Providing first dollar coverage for these services will reduce financial barriers that hinder people from seeking this care. This is especially true for low income families.

★ *The benefits of providing coverage for treatment of serious mental illness are also well established. The benefits far exceed the costs.* Texas law currently requires coverage of serious, biologically-based mental illness under the Uniform Group Insurance Benefits Act, which governs health benefits for state employees. *The Task Force recommends extension of this requirement to all health coverage plans.*

The Task Force believes that future additions to mandated benefits must be reviewed by an expert panel to determine if the proposed mandate is cost-effective. Benefits must clearly outweigh costs.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)
Groups of small employers who form a group large enough to self-insure.

PURCHASING POOLS
A non-profit organization that would allow small groups to pool together to purchase health care coverage at a reasonable rate.

UNDERWRITING
The practice of basing insurance rates on the health status or medical history of an individual or group.

GUARANTEED ISSUE
The issuance of health care coverage to everyone regardless of health status or medical history.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)
A pre-paid plan whereby the organization agrees to provide necessary medical care for a fixed price.

REDLINING
A term used to describe the practice by insurers and HMOs of entirely refusing coverage to certain kinds of businesses or occupations.

RECOMMENDATION 2: STRENGTHEN FINANCIAL RESERVE REQUIREMENTS

The Task Force recommends strengthening laws regarding financial reserves of health coverage plans.

A major state-federal effort now underway is aimed at creating federal laws to regulate the solvency of ***multiple employer welfare arrangements*** (MEWAs). These organizations are groups of small employers who band together into self-insured health coverage plans. Under federal law, states have clear authority to: (1) regulate MEWAs that are not fully insured, and (2) regulate insurance companies providing coverage for fully insured MEWAs. In Texas, however, the regulatory environment regarding MEWAs is poorly defined. This creates uncertainty on the part of both MEWAs and the regulators.

The Texas Department of Insurance has recently required regulated health plans to increase reserves, but the effect of these new requirements will not be felt by the industry for approximately two years.

RECOMMENDATION 3: CREATE PURCHASING POOLS

The Task Force recommends creating an organization that would enable small groups to pool together to purchase health care coverage.

This non-profit organization would select carriers that would furnish quality care in an affordable manner. Small groups seeking coverage would make contributions to the pool. Members would choose a health plan from among those made available by the group. The group would handle claims and administrative functions. This pool of small groups would reduce many of the ***underwriting*** and rating concerns.

RECOMMENDATION 4: ENSURE GUARANTEED ISSUE

To ensure that coverage is available to more Texans, the Task Force recommends that ***guaranteed issue*** *for health care coverage be provided for all groups, group members and individuals.*

Under this system, insurers and ***HMOs*** would be required to sell insurance to all who seek to purchase coverage. Insurers would be required to accept whole groups. No member(s) of the group could be excluded because of health status. *To ensure that individuals do not postpone the purchase of insurance until an illness is discovered or a medical emergency arises, the Task Force recommends the following* ***five guidelines regarding guaranteed issue****:*

- ★ The Task Force recommends a ***six month grace period*** — for individuals only — immediately after any legislation providing guaranteed issue goes into effect.
- ★ During the grace period, a policy must be issued at the time of application — without a waiting period.
- ★ After the grace period insurers may be allowed to require a six month waiting period for issuance of insurance to individuals who have not had insurance for the previous six consecutive months.
- ★ *The* ***redlining*** *of certain occupations should be prohibited.*
- ★ A reinsurance pool should be developed to prevent any insurer or HMO from having to absorb a disproportionate load of high risk groups.

PUBLIC TESTIMONY

"I'm a middle-class employee from the Panhandle. I'm here because I just want to say that something has to be done to change our health care system.

My wife has epilepsy with uncontrollable seizures. Right now I pay 60% of my salary for her coverage only.

If I were to lose my job, we couldn't get coverage for my wife. We would be financially devastated in a very short time.

Insurance is going up. Hospital bills are going up. And, benefits are going down.

We're all hurting. We need help."

RECOMMENDATION 5: PROHIBIT PRE-EXISTING EXCLUSION

The Task Force recommends standardizing the treatment of pre-existing conditions by regulated health coverage plans. Permanently excluding — never paying claims for — a pre-existing condition should be completely prohibited.

★ A ***maximum waiting period*** during which claims will not be paid should be established. The Task Force did not specify what that maximum should be. We note, however, that separate bills have been filed by:

- ★ The U.S. House Republican Leadership,
- ★ The U.S. House Democratic Leadership, and
- ★ Senator Lloyd Bentsen.

Also, model legislation has been drafted by the National Association of Insurance Commissioners (NAIC).

These recommendations provide for a maximum 6 month exclusion for conditions treated or diagnosed in the 3 months prior to the beginning date of coverage.

★ *Individuals with pre-existing conditions should only be subject to a single waiting period for health care coverage, assuming that they have not gone uninsured for more than a brief grace period between coverages.*

These recommendations, which are directed to the health care coverage of individuals and members of small and large groups, address the problem of ***job lock***.

JOB LOCK
The dilemma of becoming locked into a job for fear of losing health care benefits for yourself or your family.

PORTABILITY
The ability to transfer health care coverage from one job to another without loss of coverage.

COMMUNITY RATING
The practice of setting rates based on average health care costs for the population of an area rather than for a particular group.

MODIFIED COMMUNITY RATING
A community rating with deviation only for age, gender and occupation.

COMMUNITY RATING LAWS
Laws that ensure that small group benefits plans and individual plans function like large group plans.

RECOMMENDATION 6: GUARANTEE PORTABILITY

Persons changing jobs should not be subject to coverage restrictions for themselves and/or their dependents.

The Task Force strongly supports the concept of portability. All health care coverage, once attained, should be fully movable from one employer to another insofar as possible.

RECOMMENDATION 7: SET LIMITS ON PREMIUM RATE INCREASES

The Task Force recommends imposing limits on health coverage premium rate increases.

Recognizing legitimate cost increases, *a regulatory mechanism should be developed whereby annual premium increases would not exceed a given inflation factor.* Since a reinsurance mechanism would protect health coverage plans from large losses due to an excess of enrollees with high health costs, this regulatory mechanism could be designed in a manner that would not harm health plans.

Rates should be guaranteed for one calendar year. Rate increases should be limited through a mechanism to be determined by the legislature. This would eliminate monthly and semi-annual escalation.

A. Adopt Modified Community Rating

A modified community rating approach is recommended for all group and individual markets that allows health coverage plans to vary premiums only according to:

- ★ Age and gender mix, and
- ★ Type of industry of the group.

Health status, prior insurance claims history or expected future claims of a particular group could not figure into the determination of the premium.

The Task Force affirms that discrimination in the rating process because of pregnancy should be prohibited.

B. Include A Small Group Benefits Package

Community rating laws for small groups in other states are often tied to a specific benefits package. To successfully implement a community rating system, the Task Force recommends a standardized benefits package for small group and individual policies.

- ★ The principle objective of the ***community rating laws*** enacted in other states is to make small group and individual markets function like large group markets. With this approach, individual medical underwriting is avoided and risks are spread across a larger pool or "community".

TASK FORCE MEMBER

"At the beginning of each site hearing, I remember asking the chair if the invariably full hearing rooms were reflected in the witness affirmation forms.

I was never disappointed; thus guaranteeing a long evening of impassioned pleas for help.

There always seemed to be literally hundreds of people wanting to testify.

It was both uplifting, because health care was a priority . . . and depressing, because needs are so great."

"We must deal with the health care issue boldly and compassionately.

The problem affects all Texans; it requires each of us to work together toward fair and equitable solutions."

- ★ This "community" is determined by the population affected and by the particular set of benefits offered.
- ★ Groups receiving substantially different benefits cannot be considered to be in the same community, since their average costs are not exactly comparable.
- ★ The same would be true for non-comparable delivery systems. That is, ***HMO purchasers' rates*** would not be comparable to ***fee for service rates***.
- ★ If the legislature chooses to implement small group insurance reform, the Task Force recommends the set of benefits listed in Appendix-2.

RECOMMENDATION 8: ESTABLISH A MAXIMUM OVERHEAD LIMIT

The Task Force recommends establishing a predetermined maximum level of spending on overhead in the health care coverage industry.

- ★ This limitation should make more of the funds spent on health care coverage available for the direct provision of health care services.
- ★ To provide a basis for specifying this limitation, the Task Force recommends that the Texas Department of Insurance (TDI) initiate a comprehensive study of the health coverage industry — including insurance, HMOs, and other ***managed care networks***.
- ★ This study should evaluate the proportion of premium dollars expended on:
  - ★ Patient care,
  - ★ Administrative and marketing costs, and
  - ★ Other areas.
- ★ TDI should promptly analyze these costs and be given responsibility and power to institute regulations.

HMO PURCHASERS' RATES

Rates paid by those whose health care is provided by an HMO, a given pre-paid fee per patient per year.

FEE FOR SERVICE

The traditional method of paying for services at the time they are rendered.

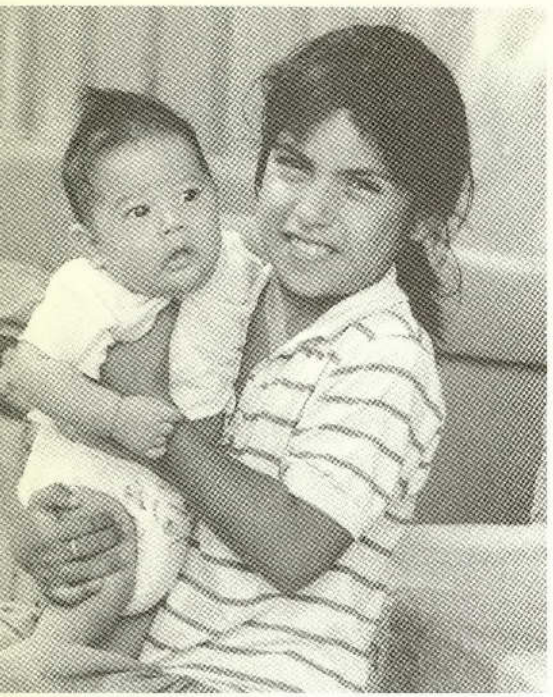
MANAGED CARE NETWORKS

A mechanism which manages health care costs by placing controls or limits on the various elements of cost.

SMALL GROUP BENEFITS PACKAGE

If the Legislature chooses to implement small business insurance reform, the following set of benefits is recommended for the Small Group Benefits Package:

- ★ Physicians, Licensed Health Care Providers and Physician Assistant Services *(including consultant and referral services)*
- ★ Inpatient and Outpatient Hospital Services
- ★ Medically Necessary Emergency Health Services
- ★ Pregnancy-Related Care for Women including:
  - ★ Prenatal
  - ★ Postnatal
  - ★ High-Risk Pregnancy Care *(excluding in-vitro fertilization)*
- ★ Well-Baby Care, Including Neonatal Screening
- ★ Well-Child Care
- ★ Adult Primary and Preventive Care
- ★ Outpatient Evaluative and Crisis Intervention and Mental Health Services *(including serious mental illness as defined by Section 3.51-14 of the Insurance Code)*
- ★ Medical Treatment and Referral Services for the Abuse of or Addiction to Alcohol and Drugs
- ★ Diagnostic Treatment, Laboratory, and X-ray Services
- ★ Rehabilitation
- ★ Home-Health Services
- ★ First Dollar Coverage for Preventive Services Including But Not Limited To:
  - ★ Immunizations
  - ★ Pap Tests
  - ★ Colo-Rectal Screening
  - ★ Prostate Cancer Screening
  - ★ Mammography
  - ★ Children's Eye and Ear Exams
- ★ Prescription Drugs



A MADRAS DE MADRAS

In Houston, new mothers teach "mothers-to-be" prenatal care and parenting skills. Volunteers started coaching and teaching in grocery stores and churches. With foundation funding, they now have their own center.

ADVANCED NURSE PRACTITIONERS - ANPs

Registered Nurses who are educated, certified and licensed to provide primary care to specialized populations. ANPs specialize in a variety of areas, including family, pediatric, obstetric and geriatric care.

PHYSICIAN ASSISTANTS - PAs

Allied health professionals who are educated to perform designated procedures and assist physicians in delivering care.

Reforms in Provider Services

The backbone of health care in Texas, as in America, is its providers. The term "providers" covers a wide variety of care givers, including, *but not limited* to:

- ★ Physicians,
- ★ Advanced Nurse Practitioners (ANPs),
- ★ Physician Assistants (PAs),
- ★ Nurses,
- ★ Emergency Medical Personnel,
- ★ Physical, Occupational and Speech Therapists,
- ★ Dentists,
- ★ Dental Hygienists,
- ★ Technicians,
- ★ Case Managers,
- ★ Aides, volunteers, and others.

The Task Force makes a number of recommendations encouraging the development and utilization of these providers. Effective use of health care providers will produce two benefits for the state of Texas — increased access to health care and heightened quality of care. Several recommendations address methods directed at serving the needs of medically underserved populations and those living in medically underserved areas. Others are designed to assure the quality and integrity of services provided by health care professionals.

These recommendations are grouped into four major areas:

- ★ Supply and Distribution of Providers,
- ★ Medicare and Medicaid Acceptance,
- ★ Texas State Board of Medical Examiners, and
- ★ Self-Referral.

GENERAL RECOMMENDATION: DEVELOP A PLAN TO ENSURE A REQUIRED MIX OF PROVIDERS

The Task Force recommends developing a comprehensive health care/human resource plan to ensure future development of the required mix of providers. The plan would be a joint effort of public and private education, health, human service and employment agencies.

The plan would identify the number and types of health providers needed in various regions of the state. Development of the plan would involve all levels of the education system in specifying programs and policies required to ensure availability of the targeted mix of providers for the future.

The Task Force has recommended a continuum of strategies to address the state's crisis in the supply and distribution of health care providers. These strategies are designed to: (1) meet the need for more primary care providers, (2) provide greater equality in the distribution of providers, and (3) allow full utilization of all licensed providers. *We note here that a proper provider mix is essential to the success of the Texas Children's Health Plan.*

Our discussion of the supply and distribution of providers is divided into **two areas of focus** — education and other health care providers.

TASK FORCE MEMBER

"I remember the very gutsy lady in McAllen who lived in the Colonias — a community with no paved roads, running water or inside bathrooms.

She served on the board of a health clinic, and without speaking English, managed to demand services the people needed.

She told us about the long wait at the clinic, the lack of doctors, and how the remedies prescribed were often unattainable for various reasons, such as lack of water for cleansing wounds.

I admired her values and her strong commitment to her community."

A. Education Improvements

RECOMMENDATION 1: ENCOURAGE AND PREPARE STUDENTS FOR HEALTH CAREERS

The Task Force recommends that the public school system — beginning in elementary school — aggressively promote preparation of students for the health care professions.

We must provide a strong math and science curriculum and encourage students to view themselves as potential health care providers. For example, schools could provide mentoring programs, develop volunteer opportunities and/or entry-level, part-time jobs in the health care professions, and enhance hands-on education in areas such as CPR and first aid. *It is especially important that actions be targeted where needs are greatest.*

RECOMMENDATION 2: IMPROVE REPRESENTATION

Several populations are currently under-represented in the health care professions. They include: rural, border, poor inner-city residents and minorities. Improving representation of these populations in the health care professions is an important step toward increasing the number of primary care providers practicing in underserved areas.

Recruiting these groups could promote an expanded economic base in underserved areas, provide appropriate health care role models for the next generation, and ensure delivery of health care services in a culturally sensitive manner. *We note that in many parts of the state, these incentives could also help overcome language barriers.* The Task Force also recommends that

- ★ Minority faculty serve on admission committees of health profession programs at academic institutions.
- ★ Incentives to attract and recruit under-represented populations into health care professions be developed, including increased funding for minority faculty positions and increased financial aid for students.
- ★ The Office of Minority Health (at the Texas Department of Public Health) be adequately funded to provide for ongoing research and data collection regarding health issues specific to minority populations.

RECOMMENDATION 3: IDENTIFY THOSE MOST LIKELY TO RETURN TO UNDERSERVED AREAS

The Task Force recommends the development and use of specific screening techniques to identify students likely to return and work in underserved areas. Screening could be used at the high school or undergraduate level to: (1) identify interested students, and (2) provide them with an early connection with health profession mentors and educators.

RECOMMENDATION 4: DEVELOP STRATEGIES TO ENCOURAGE PROVIDERS TO ENTER PRIMARY CARE AND TO WORK IN UNDERSERVED AREAS

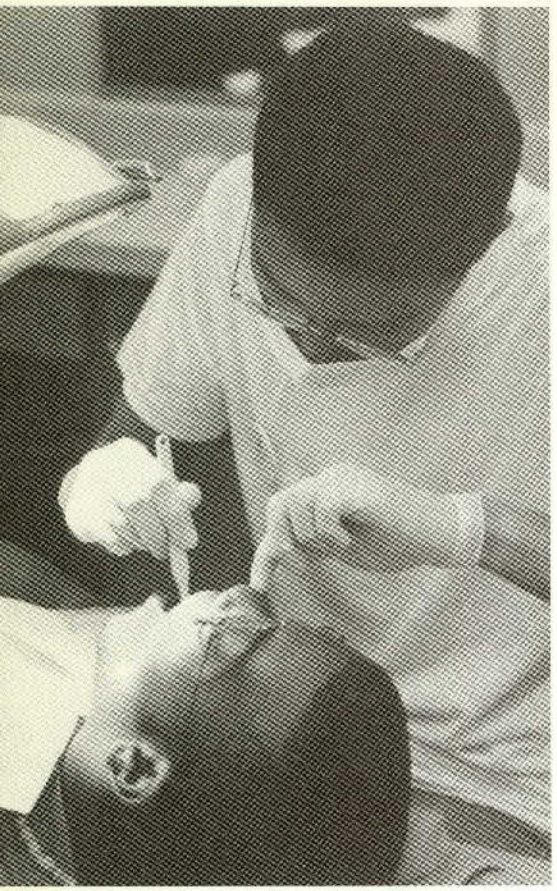
We recommend a refocus of priorities for medical schools and other institutions that provide health care education. Strategies should be designed to encourage medical students and other providers to choose: (1) primary care specializations, and (2) work settings in underserved areas.

Strategies could be implemented without increases in overall spending. Options include:

- ★ Limiting the number of non-primary care specialty residencies,
- ★ Funding and expanding the number of positions in primary care residency and fellowship programs,
- ★ Providing incentives for primary care specializations,
- ★ Increasing the number of primary care faculty positions, and
- ★ Improving incentives for primary care faculty.

a. *Medical schools can also draw more attention to the importance of primary care by giving it greater emphasis within the curriculum. The Task Force recommends expansion of the block of time the curriculum devotes to primary care and the length of the family practice clerkship. Full funding for the third-year primary care clerkship must be a part of this effort.*

As the primary care residency programs are expanded, regular monitoring will be needed to ensure that: (1) there is an adequate number of positions, and (2) the positions are adequately funded.



ROLE MODELS

Students in primary care fields need conspicuous role models.

b. *Students in primary care fields need conspicuous role models. Educational institutions should promote increased status for primary care faculty. Their representation on admissions, promotions, and tenure committees should be assured, and they should be recognized and rewarded for excellence and scholarship in their teaching fields.*

c. *We recommend steps be taken to improve financial and social incentives to attract physicians and other providers into primary care and into underserved areas.* For instance, programs providing "substitutes" for rural health professionals — which allow them to attend continuing education courses or simply take a break from the intensity of their work — are widely recognized for improving conditions for rural primary care practitioners.

d. *To encourage young health professionals to locate in rural and underserved areas, we suggest* ***loan forgiveness programs.***

These programs allow professionals to "pay off" educational costs by completing a primary care residency, locating in a medically underserved area for a period of several years — or both.

Loan forgiveness programs could be modeled after the G.I. Bill. That is, a given number of years of service in a medically underserved area would be exchanged for a free medical education. A second model for consideration features a state clearinghouse that matches interested 4th-year medical students and recent graduates with qualified underserved communities. When matched, the community and the physician create an agreement tailored to their specific needs.

It is important to note that both models incorporate strict pay-back requirements for any who drop out before fulfilling their obligations.

B. Other Health Professionals

RECOMMENDATION 5: INCREASE THE NUMBER AND UTILIZATION OF OTHER HEALTH CARE PROFESSIONALS

The Task Force recommends increasing both the numbers and the utilization of health care providers other than physicians.

Innovative approaches must be developed to meet the health care needs of medically underserved populations and those living in medically underserved areas. Providers other than physicians — such as nurses, physician assistants, dentists, physical therapists, occupational therapists, dietitians, etc. — possess the education and skills to perform in a variety of roles.

In a number of other states, health professionals practice with greater flexibility than in Texas. Greater flexibility allows these providers to fill needs in areas where health care is presently inadequate or unavailable. It has been demonstrated that when given expanded roles, these health professionals provide high quality care. We also point out that the important role that aides and volunteers can play must be recognized.

An increase in the number and utilization of these providers can be achieved in a relatively short period of time. These increases can also be achieved in a cost efficient manner.

a. *In an effort to increase the number of providers other than physicians, we recommend increasing both the number and the salaries of faculties at institutions and programs educating these providers.*

Increasing faculty will enlarge the number of enrollment slots, permitting an increase in the number of these providers. It is important that a net increase in the number of these providers results from these changes.

b. *Strategies should be provided to create financial incentives that encourage these providers to work in medically underserved areas.*

A **loan forgiveness program** in exchange for work in underserved areas is one example.

EDUCATION AND SKILLS AT WORK

Providers other than physicians — such as nurses, physician assistants, dentists, physical therapists, occupational therapists, dietitians, etc. — possess the education and skills to perform in a variety of roles.

IMPROVING ACCESS

Barriers currently exist that prevent full utilization of providers such as advanced nurse practitioners (ANPs) and physician assistants (PAs). Greater utilization of these providers would improve access to preventive and primary care.

c. *The Task Force recommends more efficient use of providers other than physicians.*

For example, various health care services — including immunizations — can be provided through the empowerment of school nurses. In addition, barriers currently exist that prevent full utilization of providers such as advanced nurse practitioners (ANPs) and physician assistants (PAs). Greater utilization of these providers would improve access to preventive and primary care.

d. *The Task Force recommends removal of barriers that hinder ANPs and PAs from participating to the full extent of their education and skills.* Included in this recommendation are removal of barriers involving:

- ★ *Limited prescriptive authority,*
- ★ Clinical privileges, and
- ★ Third party reimbursement.

e. *The Task Force recommends that ANPs and PAs receive fair and equitable reimbursement for services rendered with any differences in their reimbursement rate being based only on those costs which may vary among provider type, such as malpractice insurance.*

It is recognized that adequate access to preventive and primary care requires networking among various types of providers, including appropriate consultative and referral relationships between ANPs, PAs and physicians.

- ★ To meet the shortage of ANPs and PAs that exists, the state should provide support for the expansion of current ANP and PA education programs and the establishment of additional programs.
- ★ Special effort should be made to recruit students to these additional educational slots who have a high likelihood of practicing in underserved areas.
- ★ Aides, nurses, and other health care providers should be encouraged to be upwardly mobile in their careers. Incentives should be created to inspire these providers to continue their educations, enhance their skills and move up the career ladder.

MEDICARE AND MEDICAID ACCEPTANCE

GENERAL RECOMMENDATION: DESIGN INCENTIVES ENCOURAGING MEDICARE AND MEDICAID ACCEPTANCE

To increase access for persons covered by Medicare or Medicaid, and to spread the provision of their care more equitably among providers, we recommend developing incentives - rather than regulations - to encourage providers to accept Medicare and Medicaid patients.

a. *For Medicare, we recommend monitoring the reactions of providers to recent changes in federal payment policies.*

b. *For Medicaid, incentives could include improvements in state-set reimbursement rates, as well as reductions in the "hassle factors" involved in getting approval and/or payment for services rendered.*

If more physicians accept Medicare and Medicaid patients, the burden on the public health system will be reduced. There are early indications that primary care physician participation in Medicaid may be improving.

Participation trends should be monitored. If providers do not respond to these voluntary incentives, the Task Force recommends that further steps be taken.

This principle was carried by strong agreement in the Task Force. It should be noted, however, that if all payers used identical rates — as would ultimately be the case under negotiated rate setting for all payers — the need for further action might be eliminated. For more information, see the cost containment recommendations of this report on page 116.

TASK FORCE MEMBER

"In San Antonio we visited in the home of a woman who was being cared for by visiting nurses.

Her husband was very endearing.

He had lowered his wife's hospital bed to the level of his own so that they could continue to sleep next to one another - as they had always done.

He wanted so much to keep his wife at home for as long as possible.

It made an impression on me about the importance of health care services for the elderly."

TEXAS STATE BOARD OF MEDICAL EXAMINERS

GENERAL RECOMMENDATION: CHANGE POLICIES REGARDING SUBSTANDARD PRACTICE OF MEDICINE

To remove physicians engaged in substandard medical practice in a more timely manner, the Task Force recommends changes in policy at the Texas State Board of Medical Examiners (TSBME). The Task Force recognizes that TSBME will be reviewed by the Sunset Commission and hopes that the review will yield the needed changes.

The importance of this issue requires strict legislative oversight. Therefore, we present the following **seven recommendations**.

RECOMMENDATION 1: IMPROVE GOOD-FAITH REPORTING ASSURANCES

We recommend the consideration of additional measures to provide assurance to physicians that they will not be held liable for good-faith reporting of incompetent, improper, or impaired medical practice by physicians.

The failure of physicians to diligently report substandard practice has been attributed to highly publicized instances in which such reporting resulted in lawsuits being filed against the reporting physician by the questioned physician.

RECOMMENDATION 2: STRENGTHEN REPORTING REQUIREMENTS

The Task Force recommends strengthening the requirement that physicians inform the TSBME about incompetent, improper or impaired practice by physicians.

Though current law nominally requires physicians to report substandard or impaired colleagues, there is little in the way of meaningful sanctions against doctors who refuse to do so. Sanctions for physicians should be at least as stringent as those applied to registered nurses who fail to report impaired nurses.

GOOD FAITH REPORTING

Reporting done in a bonafide attempt to protect the public and the profession.

SUBSTANDARD PHYSICIAN

One who falls below the standards, rules and regulations set by the TSBME.

IMPAIRED PHYSICIAN

One whose ability to function according to the standards, rules and regulations set by the TSBME is impaired by drugs, alcohol or mental illness.

RECOMMENDATION 3: AMEND EXEMPTION OF HEALTH CARE PROVIDERS FROM THE DECEPTIVE TRADE PRACTICES ACT

The Task Force recommends the removal of certain exemptions to the Deceptive Trade Practices Act for purposes of public enforcement. A section of the 1977 Medical Liabilities Act now exempts health care providers from the Deceptive Trade Practices Act (DTPA). The DTPA was enacted to protect the public from fraud and other unscrupulous activities. *We therefore recommend amending this provision to allow the Attorney General (AG) to pursue certain cases against physicians under the DTPA.* The AG would then have the authority to ask for damages on behalf of the public. This amendment would help protect the public from deceptive trade practices by health care professionals.

RECOMMENDATION 4: SPEED UP HEARING PROCESS

The Task Force recommends speeding up the hearing process for substandard and/or impaired physicians.

As the hearing process exists, ***substandard*** and/or ***impaired physicians*** may continue in practice for an inappropriate length of time, potentially presenting a threat to public safety. Equally important, physicians who have been wrongly accused deserve prompt exoneration. We urge the legislature to consider the hearing processes used by other industries — such as the Federal Aviation Administration — to find a better method of review.

RECOMMENDATION 5: INCREASE NON-PHYSICIAN TSBME MEMBERSHIP

We recommend increasing the number of consumer (non-physician) members on the TSBME.

Since non-physician members should never constitute a majority of the voting quorum, we specifically recommend that one third of the board — no more, no less — be consumer members.

This principle of increased consumer membership is also recommended for other health professional licensing boards.

We recommend that providers be prohibited from making referrals to facilities in which they have a financial interest, with waivers for areas of need allowed. Full disclosure of ownership interests should be required for all providers, including those with a waiver.

RECOMMENDATION 6: RETAIN MORE AND BETTER QUALIFIED LEGAL AND INVESTIGATIVE STAFF

The Task Force recommends the TSBME retain greater numbers of highly qualified legal and investigative staff. In the hearings process, TSBME is often at a disadvantage because physicians who are brought before the board are often financially able to hire the most qualified and experienced legal counsel. Additional funds in TSBME's operating budget will provide financial incentives, such as higher salaries or bonuses, to retain adequate numbers of highly qualified and experienced legal and investigative staff.

RECOMMENDATION 7: USE PRACTICE STANDARDS TO EVALUATE CLAIMS

Once ***practice standards*** are developed — as discussed in this report on page 125 — the Task Force recommends that TSBME use those standards in the evaluation process of medical liability claims and any disciplinary actions taken against physicians.

SELF-REFERRAL

GENERAL RECOMMENDATION: PROHIBIT REFERRALS TO PROVIDER OWNED FACILITIES

We recommend that providers be prohibited from making referrals to facilities in which they have a financial interest, with waivers for areas of need allowed. Full disclosure of ownership interests should be required for all providers, including those with a waiver.

The Task Force is concerned about ethical problems and increased costs that may result from physicians and other professionals referring patients to health care facilities in which they have financial interest. Studies demonstrate that when providers have financial interests in ***freestanding facilities***, both frequency of referrals and average cost per patient increase significantly. We believe this practice needs to be restricted. Waivers should be limited to instances where need is demonstrated and the only way to finance the necessary facility is through investment or ownership by physicians or other providers. Referral patterns in waiver situations should be monitored.

PRACTICE STANDARDS
Guidelines which would promote the use of the most effective treatments.

FREE-STANDING FACILITIES
Health care facilities, such as emergency care centers or surgical centers, that are not situated at hospitals.

Reforms In Infrastructure

The infrastructure of the health care system can be defined as the foundation that underlies health care delivery. Included in the infrastructure are:

- ★ Facilities, such as hospitals and clinics,
- ★ Equipment, and
- ★ Health care services, such as emergency care and transportation.

Equally important are links, networks, and planning within and among these elements. There is little history of coordinated development of the health care infrastructure in Texas. This deficiency creates both holes and duplications in the apportionment of the infrastructure at all levels — local, county and state.

To improve coordination in the development and apportionment of the infrastructure, the Task Force believes fundamental changes are necessary.

The changes we recommend are designed to enhance quality, efficiency and availability of health care delivery in Texas. They are divided into **seven categories**: (1) primary and preventive care, (2) school-based health care services, (3) tax-exempt hospitals, (4) trauma care delivery, (5) transportation, (6) technology, and (7) health care planning.

PRIMARY AND PREVENTIVE CARE

GENERAL RECOMMENDATION: MAKE PRIMARY AND PREVENTIVE CARE A TOP PRIORITY

The Task Force designates the provision of primary and preventive care as a top priority.

Primary care is the first contact in a given episode of illness that leads to a decision regarding a course of action to resolve the health problem. Primary health care includes programs directed at health promotion, early diagnosis of disease or disability and disease prevention. *Preventive care, a component of primary care, is a way of delivering health care that focuses on the prevention of disease and the maintenance of good health.* Screening tests, health education, and immunization programs are examples.

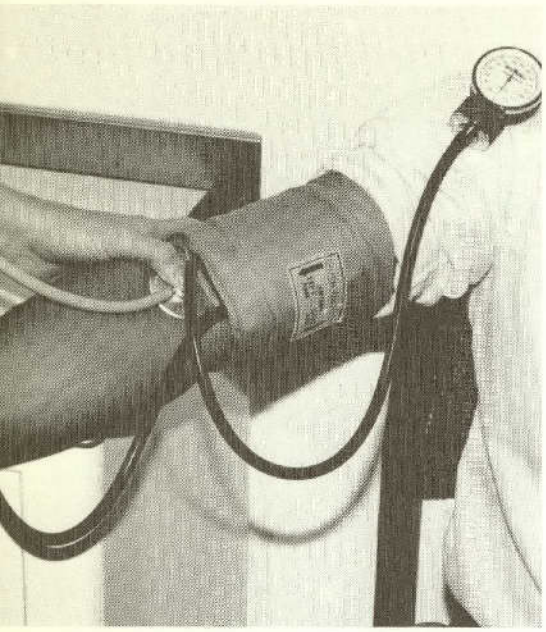
TASK FORCE MEMBER

"A grade school principal told us most of his teachers were uninsured because his school district only paid a small portion of health insurance premiums.

When a flu epidemic hit, arrangements were made to buy vaccine in bulk so that teachers could be vaccinated. But local doctors set such high service fees - to cover their liability - that the district had to abandon the plan.

As a result, a high percentage of teachers came down with the flu, which cost the district a substantial amount in substitute salaries — as well as long interruptions in classroom learning.

This was a classic example of the serious problems in our health care system."



EFFICIENT AND RESPONSIBLE CARE MANAGEMENT

We believe providing basic primary and preventive health care services is the foundation for efficient and responsible health care delivery.

We believe providing these primary and preventive health care services lays the foundation for an efficient and responsible health care delivery system.

RECOMMENDATION 1: CREATE A NETWORK OF RURAL HOSPITALS AND/OR PRIMARY CARE FACILITIES

To more efficiently deliver primary and preventive care to a greater segment of our population, the Task Force recommends creating networks of hospitals and/or primary care facilities in rural areas with larger, support facilities located elsewhere.

Networking is essential in the ***triage*** of more complicated health care cases. In addition, networks would encourage the development and survival of a comprehensive system of rural primary care facilities and hospitals.

Within each network, most health needs will be handled in the primary care facilities. Some patients with complicated problems could be treated in local hospitals. Other, more complicated cases would require transfer to major hospitals for the appropriate treatment.

RECOMMENDATION 2: INCREASE THE "PRIMARY HEALTH CARE PROGRAM" FUNDING, AVAILABILITY, ACCESSIBILITY AND SERVICES

The Task Force recommends increasing the funding, availability, and accessibility of the Primary Health Care Program administered by the Texas Department of Public Health and phasing in certain new services.

A two part phase-in of services has been defined and is recommended. (See Appendix-3.)

TRIAGE

A medical term used to describe the screening and classification of emergency situations, injuries or cases to determine treatment priority.

PRIMARY HEALTH CARE PROGRAM

A primary care program currently available in limited public health clinics.

THE PRIMARY HEALTH CARE PROGRAM EXPANSION

The Task Force recommends expanding the services currently listed in the *Texas Primary Health Care Act* to include the following:

FOR CHILDREN*

To Be Phased-in In 1993

- ★ Physician, Licensed Health Care Provider, or Physician Assistant (outpatient care)
- ★ Rehabilitation Therapy
- ★ Medical Supplies, Devices, and Durable Supplies
- ★ Prescription Eyeglasses and Vision Care
- ★ Home-Health Care Services
- ★ Outpatient mental health
- ★ Outpatient substance abuse
- ★ Transportation
- ★ Hospice
- ★ Long-term Care

Dental care is currently covered under the Early Periodic Screening Diagnosis and Treatment Program (EPSDT)

FOR PREGNANT WOMEN*

To Be Phased-in In 1993

- ★ Pregnancy Related Care, including:
  - ★ Prenatal
  - ★ Postnatal, and
  - ★ Parenting Skills Education

FOR ADULTS*

To Be Phased-in In 1994

- ★ Diagnosis and Treatment
- ★ Emergency Services
- ★ Family Planning
- ★ Preventive Services
- ★ Health Education
- ★ Lab and X-ray
- ★ Psychological and Social Services
- ★ Environmental Health Services
- ★ Nutrition Counseling
- ★ Health Screening
- ★ Home-Health Care
- ★ Dental Care
- ★ Transportation
- ★ Prescription Drugs, Devices and Durable Supplies
- ★ Podiatry services

**Require provision of "mandatory" as well as "allowable" services listed in the Texas Primary Health Care Act*

RECOMMENDATION 3: DEVELOP NEW AND EXPAND EXISTING PRIMARY CARE SITES

The Task Force recommends the development of new — and the expansion of existing — primary care delivery sites in areas of need.

Included in primary health centers are:

- ★ Rural Health Clinics,
- ★ Community Health Centers, and
- ★ Other Public and Private Local Health Care Organizations.

These centers have proven to be an effective and cost efficient means of primary and preventive health care delivery. Federal funding, available under a variety of programs for these sites, should be vigorously pursued with technical assistance from state agencies.

In counties with hospital districts, the Texas Department of Public Health should contract with the district to avoid duplication of services. In rural counties, TDPH should give funding priority to comprehensive service settings. Duplication of services should be eliminated, and contracts for delivery of care should be instituted with rural health clinics, community health centers, and other private local organizations.

In some areas, a local hospital — public, private, or non-profit — might take on the role of a primary health care center. In many communities school-based services, located at or near public schools, could also provide easier access.

★ ★ ★ ★ ★ ★ ★ ★ ★

Federal funding, available under a variety of programs, to develop new and expand existing primary care sites should be vigorously pursued with technical assistance from state agencies.

★ ★ ★ ★ ★ ★ ★ ★ ★

GENERAL RECOMMENDATION : INCREASE UTILIZATION OF SCHOOL-BASED HEALTH CARE SERVICES

The Task Force recommends increased utilization of school-based health care services.

School-based health care services are an excellent means of increasing access to quality health care for children and their families. *Two important points* should be noted regarding this recommendation:

- ★ School-based clinics should be created **only** with the consent of local school districts, and services provided **only** with the consent of parents.
- ★ Funding for school-based clinics would not be assumed to come from already-strained school district funds.

Health care services may be delivered either in schools (on-site) and/or in other facilities (off-site). This delivery system would provide a cost-efficient and easily accessible means of delivering health care.

School-based health services take maximum advantage of existing resources, such as:

- ★ Actual building space and basic equipment,
- ★ Availability of area school nurses,
- ★ Familiar, centrally located/easy access for children (an important feature, given the fact that a majority of children now live either in two-parent homes with both parents working or in single-parent homes).

RECOMMENDATION 1: DEVELOP A STATE-LEVEL INTERAGENCY GROUP TO PROVIDE TECHNICAL ASSISTANCE

We recommend developing a state-level interagency group to provide technical assistance with the establishment of school-based health service programs. Such a group could link school systems to funding sources, assist in developing programs and document program outcomes. This interagency group should include the Texas Education Agency, as well as appropriate health and human service agencies.

RECOMMENDATION 2: EXPLORE MEDICAID FUNDING FOR SCHOOL-BASED CLINICS

The Task Force recommends that school-based clinics provide a defined package of services as listed in ***Appendix-4****. In recognition of the cost associated with establishing school-based clinics, we suggest that the state aggressively support the enrollment of school districts as Medicaid providers.*

The Task Force notes that this step will be even more important if the **Texas Children's Health Plan** is implemented.

APPENDIX-4

SCHOOL-BASED HEALTH CARE EXPANSION

The Task Force recommends that school-based clinics be expanded to provide the following services, **subject to** parental consent:

PRIMARY HEALTH CARE

- ★ First-Level Diagnosis and Treatment

PREVENTIVE CARE, INCLUDING BUT NOT LIMITED TO:

- ★ Booster Immunizations
- ★ HIV Prevention
- ★ Family Planning
- ★ Sexually-Transmitted Disease Prevention
- ★ Suicide Prevention

HEALTH EDUCATION, INCLUDING BUT NOT LIMITED TO:

- ★ Nutrition
- ★ Parenting and Daily Living Skills
- ★ Physical Education
- ★ Safety
- ★ First Aid
- ★ Violence and Gang-Related Prevention Education
- ★ Mental Health Services
- ★ Substance Abuse Services

GENERAL RECOMMENDATION: REFORM "CHARITY CARE" REGULATIONS AND REQUIREMENTS

The Task Force recommends reforming regulations and reporting requirements related to the provision of charity care by private, non-profit hospitals.

RECOMMENDATION 1: REQUIRE PRIVATE, NON-PROFIT HOSPITALS TO PROVIDE AN AMOUNT OF CHARITY CARE COMMENSURATE WITH TAX EXEMPTION BENEFITS

We recommend that private, non-profit hospitals, which are exempt from federal, state and local taxes, provide an amount of charity care commensurate with the economic benefit conferred by those tax exemptions, taking into account the needs of the community.

Medicaid patient load, acceptance of transfers of indigent patients from public hospitals, and other criteria would be considered components of "charity care." Bad debt and "contractual allowances" — the difference between billed charges and Medicare payments — should not be permitted to satisfy this requirement.

The Task Force emphasizes that while some private, non-profit hospitals are major providers of charity care in their communities, others deliver little or no free care. Regulations should be carefully worded to increase the total amount of charity care without discouraging hospitals which already provide exceptional amounts of charity care.

Private, non-profit hospitals should be required to submit plans for charity care along with annual financial statements to the Texas Department of Public Health (TDPH) and to local government health officials.

Charity care plans should include target levels of charity care, based on objective evidence of community needs.

★ ★ ★ ★ ★ ★ ★ ★ ★

We recommend that private, non-profit hospitals, which are exempt from federal, state and local taxes, provide an amount of charity care commensurate with the economic benefit conferred by those tax exemptions, taking into account the needs of the community.

★ ★ ★ ★ ★ ★ ★ ★ ★

We recommend that charity care plans and financial statements regarding charity care be made available to the public, both for individual hospitals and on an aggregate basis.

RECOMMENDATION 2: MAKE INFORMATION AVAILABLE TO THE PUBLIC

We recommend that charity care plans and financial statements regarding charity care be made available to the public, both for individual hospitals and on an aggregate basis.

This recommendation would require the removal of the confidentiality provision which currently prohibits dissemination of hospital financial data collected by TDPH.

Implementing these recommendations would:

- ★ Result in the provision of millions of dollars in additional services that would significantly enhance the delivery of health care to those who cannot afford it, and in many cases —
- ★ Reduce the charity care burden of public hospitals.

To ensure that these requirements are met, we recommend enforcement mechanisms be established. These mechanisms could take the form of:

- ★ Injunctive relief,
- ★ Penalties, and/or
- ★ Revocation of tax-exempt status with respect to state and local taxes.

Furthermore, these mechanisms should be designed to reaffirm the accountability of the board of directors and chief executive officers of tax-exempt hospitals.

TRAUMA PREVENTION
The process of educating the public regarding health beliefs and resulting health behaviors that can reduce or prevent accidents. Examples include safety belt and child car seat usage, defensive driving, helmet use, child safety parenting tips, etc.

TRAUMA CARE DELIVERY

GENERAL RECOMMENDATION: DEVELOP A COMPREHENSIVE TRAUMA CARE SYSTEM

The Task Force recommends a state-wide comprehensive trauma care system. We note that in a comprehensive trauma delivery system, hospitals should be designated as belonging to one of four trauma categories, depending on how extensive their trauma services are.

Patients should receive adequate on-the-scene emergency medical attention, and transportation to an appropriate hospital setting for treatment or stabilization. Transfer to a more capable facility in a rapid and routine manner should be readily available as needed.

RECOMMENDATION 1: FUND THE TRAUMA PLAN PRESENTED IN HOUSE BILL 18

The Task Force believes well-developed systems for delivery of trauma care are critical areas of need. For this reason, we recommend that the state explore options to secure funding for the trauma system plan developed in 1989 by House Bill 18 to enable full implementation.

This Bill includes provisions allowing the TDPH to extend grants promoting pre-hospital care; communication links; interhospital transfers; acute, chronic, and rehabilitative care, and — most importantly — ***trauma prevention***.

RECOMMENDATION 2: DEVELOP A COMPREHENSIVE, SCHOOL AND PUBLIC HEALTH TRAUMA PREVENTION CAMPAIGN

Recognizing that the most cost-effective way to reduce expenditures related to this issue is through trauma prevention, the Task Force recommends the development of a comprehensive school/public health trauma prevention campaign.

RECOMMENDATION 3: COMPLETE IMPLEMENTATION OF AN ENHANCED 911 SYSTEM

The Task Force notes that a few rural areas still lack basic 911 service and that many areas lack enhanced 911 service. We recommend complete implementation of an enhanced 911 system to provide automated routing of the closest emergency personnel to the location of the incoming call.

TASK FORCE MEMBER

"Our trauma care system is in real crisis.

We need more hospitals taking care of charity cases and better equipped and better trained on-the-scene personnel.

In small towns and rural areas there are wide gaps in the care trauma patients receive.

Small hospitals and emergency services in these areas need to be linked to larger hospitals across the state to expedite quick, efficient and appropriate care."

RECOMMENDATION 4: UPGRADE PERSONNEL AND EQUIPMENT IN THE PRE-HOSPITAL TRAUMA SYSTEM

We recommend upgrading the quality and capacity of the first line of trauma care — the pre-hospital system.

The pre-hospital system includes appropriately educated personnel, such as emergency medical technicians, paramedics, firefighters and appropriate equipment, such as transportation equipment and essential medical and rescue equipment. Improvements should include grants to: (1) develop outreach training for continuing education of emergency personnel, and (2) maintain emergency equipment in rural, border and frontier areas in an up-to-date manner.

RECOMMENDATION 5: REVIEW EXISTING REGULATORY REQUIREMENTS

We recommend a periodic review of existing regulatory requirements affecting statewide trauma systems to ensure that they remain up to date.

RECOMMENDATION 6: DEVELOP A MEDICAID REIMBURSEMENT PROCEDURE

The Task Force recommends developing a cost-based Medicaid reimbursement procedure to better reflect the true costs of ambulance service in rural areas.

RECOMMENDATION 7: CONDUCT ONGOING TRAUMA EPIDEMIOLOGY ASSESSMENTS

We also recommend giving the Texas Department of Public Health clear responsibility and resources to conduct ongoing assessments of the epidemiology of trauma in Texas.

This assessment should include the creation of trauma and poison registries to monitor the frequency and causes of these events. Additionally, local and state injury prevention initiatives which establish and maintain the proactive position of the TDPH in meeting the changing issues of trauma care should be encouraged, developed and coordinated. One example is the promotion of seat belt and child car seat use.

PROACTIVE POSITION

Local and state injury prevention initiatives should be encouraged, developed and coordinated which establish and maintain the proactive position of the TDPH in meeting the changing issues of trauma care. One example is the promotion of seat belt and child car seat use.

TRANSPORTATION

GENERAL RECOMMENDATION: IMPLEMENT A STATE-WIDE TRANSPORTATION SYSTEM TO INCREASE ACCESS

The Task Force recommends developing and implementing a statewide transportation system to increase access to all health and human services.

The Task Force recognizes the linkage between health services and human services. We believe an effective transportation system is vital for successful delivery of these linked services. Implementation of the following recommendations should improve coordination and utilization of health and human services.

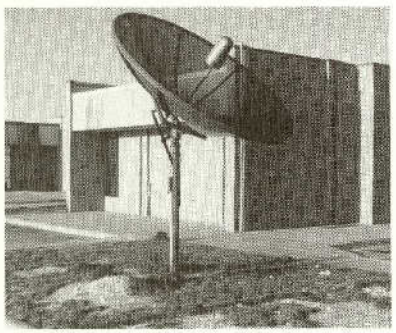
First, the Task Force notes the establishment of the Health and Human Services Transportation and Planning Office, in the fall of 1992, as required by House Bill 7. The primary function of this office is to eliminate duplication of services and improve the provision and coordination of public health and human service transportation.

The Task Force recommends the Health and Human Services Transportation and Planning Office review the Medical Transportation Program under the Texas Medicaid program.

This office should: (1) identify changes needed to make the transportation system more responsive to client needs, and (2) ensure that federal funding is being fully utilized for medical transportation.

The Task Force urges the Department of Transportation to take into account health and human service needs as funds become available.

The Task Force recognizes the linkage between health services and human services. We believe an effective transportation system is vital for successful delivery of these linked services.



USING TECHNOLOGY TO IMPROVE ACCESS

The Task Force recommends expanding and coordinating projects using technology to improve access to health services.
Telemedicine projects should be coordinated with other uses of video technology, such as "distance learning" projects in the education system. These projects could play a key role in preparing rural students to enter health care careers.

TECHNOLOGY

GENERAL RECOMMENDATION: EXTEND USE OF TECHNOLOGY TO EXPAND AND INCREASE ACCESS

The Task Force recommends expanding and coordinating projects using technology to improve access to health services.

Examples of such networks are Telemedicine, InfoMed and MEDNET. These networks use video link-ups to allow medical information to be exchanged between remote locations.

Appropriate telemedicine reduces the need for patient transportation by allowing medical personnel to view problems and solutions to medical problems over televised networks. Development and funding of additional demonstration projects, and the expansion of cost-effective networks, will extend the accessibility and availability of health care into rural, frontier and border regions of the state.

If telemedicine in Texas is to be used with maximum efficiency, it is necessary to compile an inventory of what currently exists. This inventory would provide the basis for further development by attempting to eliminate duplication of effort.

In addition, telemedicine projects should be coordinated with other uses of video technology, such as "distance learning" projects in the education system. These projects could play a key role in preparing rural students to enter health care careers.

HEALTH CARE PLANNING

GENERAL RECOMMENDATION: ESTABLISH A MECHANISM FOR PROSPECTIVE PLANNING

The Task Force recommends establishing a mechanism for state and regional prospective planning for the supply and distribution of facilities, providers, high-tech equipment and health care services.

The comprehensive human resource plan previously described would complement this infrastructure planning mechanism by directing health care professional resources to areas of need. A community-oriented approach to regional planning would involve consumers, local governments, providers, insurers, businesses and all participants in health care delivery and financing.

Under this approach, decisions regarding the location or expansion of hospitals, clinics and other health care entities will be based primarily on community need for affordable services — rather than economic development or potential profit. Decisions should be based on real needs, rather than arbitrary standards.

RECOMMENDATION 1: ESTABLISH REGIONAL TARGET STANDARDS

We recommend that target standards be established for the number of beds, the amount of expensive equipment, and the appropriate mix of services for each health care facility — including outpatient clinics, rehabilitation facilities, psychiatric facilities, etc.

These standards should be established by region in cooperation with the state. The state would give final approval to these standards and enforce compliance. Expansion, new construction, and/or new high-tech equipment would be measured against the regional standard. If the project is deemed necessary, a subsequent "permit of approval" would be issued.

A strong enforcement authority is essential to assure compliance and achieve true cost containment. Fines, loss of license, probation, and/or other penalties for failure to follow the planning process should be considered.

PUBLIC TESTIMONY

"I'm here because I want to help other people with sick children.

My daughter was diagnosed with a chronic disease when she was just a few months old.

When her medical bills hit $400,000, I desperately began searching for some assistance.

I was told to go to various agencies. But what invariably would happen was that I would be sent to yet another agency.

I was even informed that because my daughter was at Texas Children's Hospital for two months that she could be defined as an independent person, and thus qualify for the spend down deductible program.

That was three weeks before my daughter died.

There's got to be something that can be done so that children with chronic illnesses can get help without going on welfare."

The Task Force notes that it is not our intent to reinstate or recreate the old certificate of need (CON) process.

Instead, the new system should be:

- ★ Non-adversarial, and
- ★ Based on strong community and regional participation.

Since systematic data collection is essential to all planning, the Task Force recommends creating and/or funding registries to track the occurrence of trauma, poisoning, cancer and birth defects, with safeguards for patient confidentiality.

In the spirit of House Bill 7, this program, including the enforcement authority, should be under the leadership of the Director of Health and Human Services, rather than existing as a separate agency. A special division of the Texas Department of Public Health could be empowered to coordinate regional planning forums.

Reforms In Cost Containment

A number of strategies must be used to bring health care costs under control in the state of Texas. Containing health care costs should improve efficiency in the management of health care.

The Task Force recognizes that cost containment is critical to health care reform; nevertheless, we do not advocate subordination of quality of care considerations to cost considerations.

We strongly recommend that decisions regarding the direction of health care be based on an equal balance of both cost and quality.

We also point out that individuals can effectively contain some health care costs by assuming responsibility for their own health. For this important reason, we recommend developing incentives that encourage individuals to pursue health promoting habits and activities. These incentives should also be integrated into health care coverage.

As a Task Force, we recommend a series of reforms designed to help contain and control health care costs. These recommendations are presented in **five categories**:

- ★ Negotiated Rate Regulation,
- ★ Controlling Pharmaceutical Costs ,
- ★ Standardizing and Streamlining,
- ★ Competitive Market Improvements, and
- ★ Medical Malpractice Issues.

SUPPORTING RESPONSIBILITY

We also point out that individuals can effectively contain some health care costs by assuming responsibility for their own health. For this important reason, we recommend developing incentives that encourage individuals to pursue health promoting habits and activities. These incentives should also be integrated into health care coverage.

NEGOTIATED RATE REGULATION

GENERAL RECOMMENDATION: ESTABLISH A MECHANISM TO ENSURE NEGOTIATED RATE REGULATION

The Task Force recommends establishing a mechanism to ensure negotiated rate regulation for all providers.

Negotiated rate regulation is seen as a cornerstone in the containment of health care costs. This has been proven effective in Maryland, New Jersey, New York and Massachusetts. Effective rate negotiation is comprised of three parts:

- ★ Collection of extensive data relating to rates charged for services,
- ★ Full participation of health care providers in the negotiation of rates, and
- ★ Establishment of health care expenditure limits, calculated on a yearly basis.

Negotiated rates should safeguard the establishment of fair and reasonable rates for the provision of health care. This should eliminate cost shifting among payers. State-set reimbursement rates for Medicaid must cover appropriate costs of services rendered to prevent further cost-shifting. Initial participation in negotiations and adoption of rates should be voluntary.

RECOMMENDATION 1: REQUIRE DATA COLLECTION OF RATES CHARGED

The Task Force recommends enacting legislation that would require the collection of data on the rates charged by health care providers.

Data must be collected in uniform, exact and clearly defined categories. Currently available data from existing sources is adequate to form the basis for the "start-up" of rate-setting. The Task Force notes, however, that improvement is needed. The data collected would furnish the necessary basis for effective negotiations.

RECOMMENDATION 2: ENCOURAGE PARTICIPATION FROM ALL ENTITIES

The Task Force recommends participation by the full spectrum of providers — physicians, hospital and clinic administrators, other health care providers, pharmaceutical industry representatives, etc. — as well as businesses, insurers and consumers.

We believe this full participation is necessary for effective and equitable rate regulation. As previously noted, state involvement in the process is required to avoid violations of federal anti-trust laws.

RECOMMENDATION 3: ESTABLISH EXPENDITURE LIMITS

The Task Force recommends that expenditure limits be established, based on data collected within a specified geographic area.

Once a data base exists, it should be possible to negotiate an expenditure limit for a given geographic area. The team of negotiators should then establish rates within these expenditure limits for the fiscal year. If expenditure limits for any given year are exceeded, the negotiating team must compensate for this shortfall in the budget for the next year.

FULL PARTICIPATION BY PROVIDERS, BUSINESSES, INSURERS AND CONSUMERS

The Task Force recommends participation by the full spectrum of providers — physicians, hospital and clinic administrators, other health care providers, pharmaceutical industry representatives, etc. — as well as businesses, insurers and consumers.

TASK FORCE MEMBER

"We listened as an East Texas woman related her experience. Her husband lost his job because of periodic episodes with insulin shock. Her husband goes on and off Medicaid for a month at a time and must re-qualify each time.

She told of long waits in the clinic — only to be sent to the Emergency Room for the much needed shot of insulin.

This couple wants desperately to work and support their family — and to contribute to society.

But at age 36, his kidneys are rapidly failing as a result of complications, worsened by lack of coverage and inadequate medical management.

It was crystal clear that the hassles these people endure are demoralizing, debilitating - and dehumanizing.

This man now faces dialysis, potential kidney transplant and a brutal battle with diabetes.

The costs will be exorbitant."

CONTROLLING PHARMACEUTICAL COSTS

GENERAL RECOMMENDATION: DESIGNATE HHSC TO IDENTIFY AND EVALUATE COST-CONTROL APPROACHES

The Task Force recommends that the Health and Human Service Commission: (1) identify promising approaches to controlling pharmaceutical costs, (2) develop pilot programs to test their effectiveness in Texas communities, and (3) include pharmaceutical charges as part of rate negotiations.

Pharmaceuticals are a cornerstone of modern medicine. They create enormous cost-savings from avoidance of serious illness, surgery or institutionalization.

In making the above recommendation, the Task Force recognizes that pharmaceutical manufacturers can incur great costs associated with research and development, as well as compliance with federal Food and Drug Administration requirements. However, the cost of pharmaceuticals is rising so rapidly that the public's access to needed drugs is now threatened.

STANDARDIZING AND STREAMLINING

GENERAL RECOMMENDATION: STANDARDIZE AND STREAMLINE TO REDUCE WASTE

The Task Force recommends standardizing and streamlining health care benefits and management to reduce waste in health care that occurs at the administrative level.

In order to effectively standardize and streamline the administration of health care coverage, the Task Force makes **recommendations in three areas**:

- ★ Standardized Forms and Benefits Packages
- ★ Electronic Claims and Billing, and
- ★ Standardized Utilization Review.

RECOMMENDATION 1: STANDARDIZE BENEFITS AND FORMS

The Task Force recommends that all health coverage providers be required to offer a maximum of five standard benefit packages with the gradual reduction to one policy within 10 years. A limited number of optional coverages — or so-called endorsements (such as dental care, vision care and private rooms) — could be added.

In addition to the reduction to one standard health benefit package, the Task Force recommends that all health coverage plans be required — to the greatest extent possible — to use one common claim form, one billing form and one application form.

Each of these forms should be in clear and simple English, as well as Spanish. Distinct categories of health coverage, such as dread disease or accident-only coverage, should come under similar requirements.

The Task Force makes these recommendations based on the reality that Texans are prevented from shopping for health coverage like true consumers because of the multitude of health packages offered. Literally tens of thousands of different health policies are filed each year with the Texas Department of Insurance. Each policy may contain a slightly different array of benefits which are covered at different levels of deductibles requiring different amounts of co-payments.

With this current system, comparison shopping is simply **not** a practical reality.

RECOMMENDATION 2: INITIATE ELECTRONIC CLAIMS, BILLING AND REPORTING OF DATA

The Task Force recommends that Texas develop an electronic clearinghouse for health coverage claims and billing — similar to the program being demonstrated in the state of New York — which has received bipartisan support in the U.S. Congress.

We also recommend standard electronic reporting of health coverage plan data to the Texas Department of Insurance.

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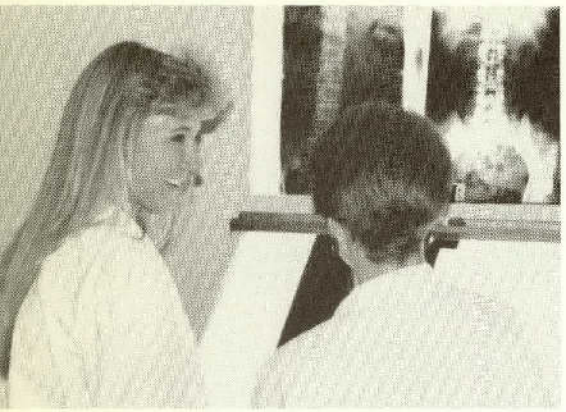
In addition to one standard health benefit package, the Task Force recommends that all health coverage plans be required — to the greatest extent possible — to use one common claim form, one billing form and one application form.

★ ★ ★ ★ ★ ★ ★ ★ ★

The format for this reporting should be designed and negotiated in conjunction with TDI:

- ★ The health care coverage industry,
- ★ Consumers,
- ★ Representatives from business,
- ★ Health providers, and
- ★ Health planners.



MAKING PRICES, FEES AVAILABLE TO THE PUBLIC

The Task Force recommends that prices, fees and other pertinent information regarding all providers of care — including hospitals, physicians, laboratories, clinics, etc. — be collected, analyzed and reported to the public.

RECOMMENDATION 3: DESIGNATE THE DEPARTMENT OF INSURANCE TO CONTINUE STANDARDIZATION

Lastly, the Task Force recommends continued standardizing utilization review systems and activities introduced by the ***Insurance Reform Act of 1991.***

It is important to point out that implementing this recommendation should reduce the amount of time that physicians, nurses and other hospital personnel spend with utilization review representatives. This, in turn, should reduce delays in patient treatment.

COMPETITIVE MARKET IMPROVEMENTS

GENERAL RECOMMENDATION: MAKE CHANGES TO IMPROVE THE PUBLIC'S KNOWLEDGE OF COMPETITIVE MARKETS

The Task Force notes that consumers must be well-informed in order to make appropriate decisions about their health care. Therefore, we recommend competitive market ***improvements in three areas.***

RECOMMENDATION 1: ANALYZE AND REPORT TO THE PUBLIC PRICES AND FEES FOR ALL HEALTH SERVICES

The Task Force recommends that prices, fees and other pertinent information regarding all providers of care — including hospitals, physicians, laboratories, clinics, etc. — be collected, analyzed and reported to the public.

OUTCOMES RESEARCH

Research evaluating which treatments and procedures are the most effective. This data is disseminated to providers and the public to decrease the use of ineffective treatments and procedures.

In making this recommendation, we acknowledge that prior knowledge of prices and fees for health services will aid consumers and purchasers in making choices that can limit health care costs. We note that such approaches are operating in Pennsylvania and Florida with notable success.

RECOMMENDATION 2: DEFINE AND MEASURE OUTCOMES OF CARE

The Task Force recommends that data be collected in order to define and measure outcomes of care.

This data-collection process should be developed in cooperation with health providers and educational institutions. It should also be based on documented criteria.

The primary objective of so-called "***outcomes research***" is to systematically identify the most effective treatments and to eliminate the ineffective. In addition, certain kinds of outcomes information, such as a physician's rate of cesarean sections or hysterectomies, may be used to assist consumers in choosing their health care providers. A number of states are currently in the process of developing and/or publishing outcomes of care information.

RECOMMENDATION 3: REWARD CONSUMERS FOR OVERCHARGES THEY FIND

In order to promote consumer education and awareness of their own health care costs, we recommend that consumers be given 20% or more of any overcharges they find on personal health-related bills.

Similar policies have been voluntarily adopted by a number of health coverage plans. They are initiated because they foster the development of a greater awareness of the costs of health care services.

WRITTEN TESTIMONY

"Due to a complication during surgery, I spent twelve days in the hospital - including several in ICU.

When I received a copy of my hospital bill, it was over $18,000. As a registered nurse, I was curious about the charges.

You can imagine my shock on finding multiple charges - over $2,000 - for drugs and other items I did not receive.

My doctor confirmed that, indeed, I had not received the items in question. He said it's a common practice for hospitals to inflate charges to make up for their losses.

As a consumer, I felt I had an obligation to my insurance carrier - and my employer - to correct these errors.

With my urging, my doctor contacted the hospital and the adjustments were made.

Is this the best way for our health care system to work?"

Acknowledging the critical importance of maintaining the balance between preserving the rights of persons injured due to negligent medical practice and limiting liability costs of health care providers, we present six recommendations. Many of these recommendations center around the need to accumulate missing information.

MEDICAL MALPRACTICE ISSUES

GENERAL RECOMMENDATION: ACCUMULATE MISSING INFORMATION REGARDING MEDICAL MALPRACTICE ISSUES

The findings of a study by Tonn and Associates, described in the Problem section, note the lack of factual information and conclusive evidence surrounding medical malpractice. Acknowledging the critical importance of maintaining the balance between preserving the rights of persons injured due to negligent medical practice and limiting liability costs of health care providers, we present ***six recommendations.*** *Many of these recommendations center around the need to accumulate this missing information.*

The Task Force notes that, in response to conflicting recommendations regarding medical professional liability insurance and medical malpractice, a coalition of the Texas Medical Association, the Texas Hospital Association and the Texas Trial Lawyers Association commissioned a study, known as the Tonn Report, to address this issue. We believe this is a precedent-setting coalition — not only for Texas — but for the entire nation. We believe this coalition demonstrates the intensity of concern regarding medical malpractice and medical professional liability. We also believe it points out the desire of these three entities to *clearly* understand the impact these issues have on health care costs. Based on this report, we make the following recommendations:

RECOMMENDATION 1: COLLECT DATA USING STANDARDIZED DEFINITIONS

Believing that good policy is based on good information, the Task Force recommends standardizing definitions regarding medical malpractice claims information — as well as the uniform and timely reporting of this information.

RECOMMENDATION 2: EXPAND TDI COLLECTION MECHANISM

We also recommend expansion of the collection mechanism used by the Texas Department of Insurance to secure medical liability claims data from insurance companies and others.

INDEMNIFICATION

An agreement between the state and health care providers designed to protect them against large malpractice settlements in return for service in indigent or government health care.

The Task Force notes that under the current system, different liability insurers do not record and report the incidence and disposition of medical liability claims in precisely the same manner.

Expansion of the collection mechanism should permit accumulation of data on mediation and alternative dispute resolution (ADR). This data, in turn, should support analysis determining the cost-effectiveness of these approaches.

RECOMMENDATION 3: CONSIDER EXPANSION OF HOUSE BILL 18 TO INCLUDE HOSPITAL INDEMNIFICATION

The Task Force recommends that the Legislature consider whether to expand the House Bill 18 program to include ***indemnification*** *of hospitals.*

To increase access to health care for more of the indigent population, The Texas Legislature passed The Omnibus Health Care Rescue Act (House Bill 18) in 1989 to increase access to health care for more of the indigent population.

As an incentive for the provision of health care to poor and low-income Texans, the act created a program that provides partial indemnification — state-provided coverage of some medical liability — for certain health care professionals and federally qualified health centers who serve these populations.

In considering whether to expand the program, the legislature must take into account not only potential increases in access to care, but also the cost-effectiveness of such an expansion.

In addition, we also recommend the removal of any administrative barriers, such as reported problems with payments of claims made under the program, that limit the participation of hospitals and other providers.

The Task Force recommends that the Legislature consider whether to expand the House Bill 18 program to include indemnification of hospitals.

RECOMMENDATION 4: COMMISSION STUDIES TO ENCOURAGE EARLY MEDIATION/RESOLUTION AND REDUCE THE NUMBER OF CLAIMS FILED

The Task Force recommends commissioning studies to develop ways of encouraging earlier, rather than later, mediation or alternative dispute resolution (ADR) in the claims handling process.

We further recommend studies to develop ways of using ADR techniques to resolve smaller claims which cannot economically be pursued as medical malpractice lawsuits.

Attorneys who file medical liability claims on behalf of individuals will often name a number of providers in their original claim because they have not had time to identify the responsible party (or parties) before the normal two-year statute of limitations runs out.

This practice creates a record of claims filed against many health professionals and providers. Many of these are never pursued.

In an effort to protect providers from this "shotgun" approach — and still protect the rights of the injured parties — we recommend that the legislature study whether passage of a "John Doe" statute, allowing attorneys to retain the right to file claims without initially naming all possible defendants, would help reduce the number of claims that are closed with no indemnity paid.

RECOMMENDATION 5: CONDUCT A STUDY TO DEFINE AND QUANTIFY "DEFENSIVE MEDICINE"

The Task Force recommends a study that would attempt to define and quantify "defensive medicine," and attempt to determine whether legislation could have a significant impact on this problem.

The study should distinguish between those procedures conducted solely out of fear of lawsuit and those performed for other reasons, such as compliance with federal health and safety regulations.

This study should focus on collection of hard data, rather than opinion or speculation. The study should also develop ways to collect needed data annually, for ongoing monitoring and study. A combination of state, federal, and philanthropic financial support should be sought for this study. The federal Office of Technology Assessment (OTA) is currently conducting a study which may satisfy some of these research needs, permitting a narrower focus for any Texas study.

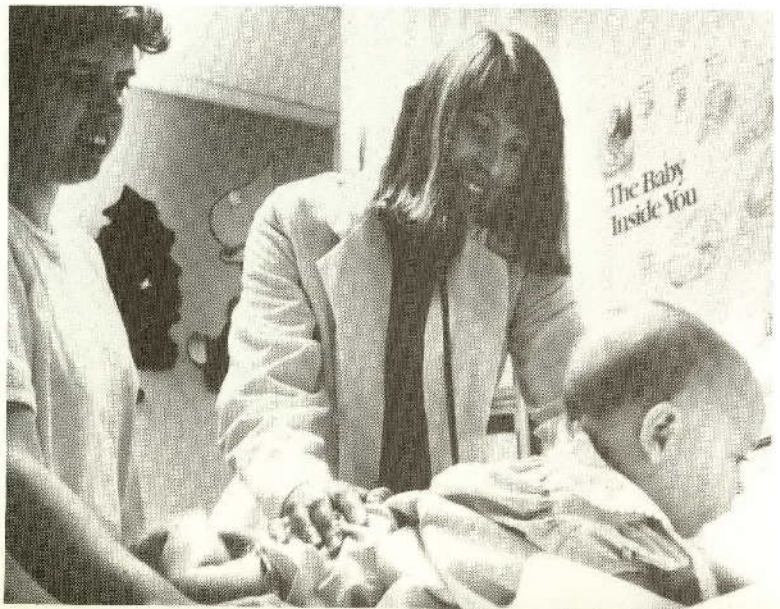
RECOMMENDATION 6: CONDUCT A STUDY ON OUTCOMES RESEARCH TO DETERMINE PRACTICE STANDARDS

The Task Force recommends a second study which would commission medical schools, professional societies and other research entities to conduct research, called "outcomes research," to determine the effectiveness of certain medical treatments.

This data could be used to develop practice standards. These practice standards may decrease costs of care by promoting use of the most effective treatments. A second benefit of practice standards is that they may also be used to evaluate the performance of physicians in questions of liability.

RECOMMENDATION 7: STRESS EFFECTIVE PATIENT COMMUNICATION IN HEALTH PROVIDER EDUCATION

We recommend stressing content about effective patient communication in the education of medical students, residents in training, faculty, and practicing providers to help decrease the number of claims resulting from poor communication, rather than those resulting from negligence or malpractice.



We recommend stressing content about effective patient communication in the education of medical students, residents in training, faculty, and practicing providers to help decrease the number of claims resulting from poor communication, rather than negligence or malpractice.

The Texas Medical Association, the Texas Trial Lawyers Association, and the Texas Hospital Association are working together to recommend necessary legislation regarding malpractice issues.

We encourage this effort.

OTHER MALPRACTICE ISSUES

The Task Force makes no recommendation regarding the issue of joint and several liability — the question of whether awards should be collected from defendants in greater amounts than their estimated percentage of responsibility for an injury. The Texas Medical Association, the Texas Trial Lawyers Association, and the Texas Hospital Association are working together to recommend necessary legislation regarding this issue. We encourage this effort.

It should also be noted that the Task Force heard testimony and considered numerous proposals regarding medical malpractice.

After considerable debate, majority support was not present for recommending the following items:

- Caps on non-economic damages,
- Imposition of contingency schedules, and
- Allocation of a percentage of awards to the state for indigent care.

An Introduction To The Texas Health Plan

The Task Force debated at length about how to improve the financing mechanism to achieve universal, comprehensive health care in Texas. Ideally, comprehensive health care provided to all citizens would best be handled at the national level, since federal laws prevent states from regulating major sectors of their health care markets.

In particular, states are limited in the degree to which they can streamline, simplify or coordinate Medicaid and Medicare programs. This is a major liability in trying to create a universal coverage system.

A second factor which makes universal health care difficult for individual states is the fact that federal law — the Employee Retirement Income Security Act (ERISA) — prohibits states from regulating the content and operations of health benefit plans of self-insured employers. *ERISA is the single greatest obstacle to attempts by individual states to take control of their own health care systems.*

However, as we have stated before, although there are now many plans before Congress, which in varying degrees try to achieve the goals of universal comprehensive health care, Texas cannot depend on passage of any national plan in the short term. The simple fact is: we cannot afford to wait.

THE PROCESS

The Task Force was guided in its debate on these issues by the principles of universality, accountability, and expenditure limits (budgets) as articulated by consultants Theodore Marmor, Ph.D., of Yale University and Larry Bartlett, Ph.D., of Health Systems Research in Washington, D.C.

- *Universality* implies that all residents must be covered equally.
- *Accountability* speaks to having a single individual or body who accepts ultimate responsibility for the success of the plan.
- *Expenditure limits* acknowledge the need to establish a budget defining the maximum number of dollars to be spent on health care.

Using these principles for guidance, the Task Force considered **three mechanisms** for financing health care.

Alternative #1

The first alternative was to continue the current system using reforms already recommended by the Task Force.

We recognized that it would be difficult to achieve any of the three principles — universality, accountability and expenditure limits — using this alternative alone. With this choice, few or no principles would be realized, and the system would continue to spiral out of control.

Alternative #2

The second alternative was to have a multiple-payer system with mandatory participation.

Under this type of system, all Texans would be required to have coverage from some source and all payers would be required to abide by regulated rates. With this option, near-universal coverage and limited cost efficiencies would be realized, but the goal of clear accountability would not be met. The result would be an unpredictable system that would be difficult to manage.

Alternative #3

The third alternative, a system using a single-payer approach, appeared to the Task Force to best meet the three principles used as our guidelines — universality, accountability and expenditure limits.

A single-payer system would provide universal coverage through one designated payment body and would have a central responsible authority. We recognized, however, that such a major reform would call for extensive economic analysis. This was far beyond the scope of this Task Force.

RECOMMENDATION: COMPARE THE FINANCIAL BENEFITS OF THP WITH OUR CURRENT SYSTEM

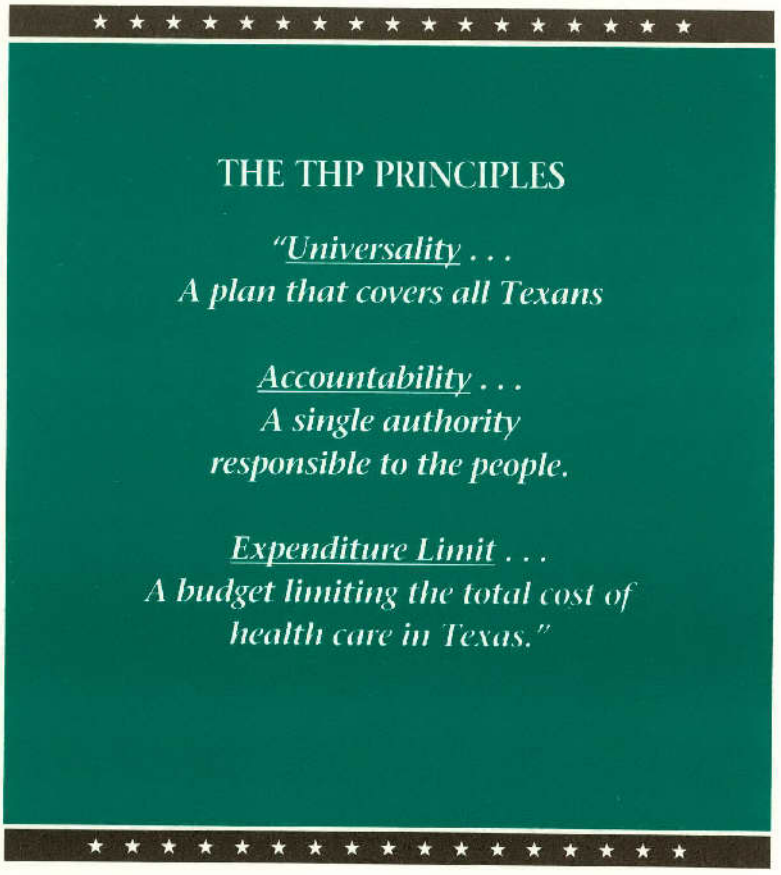
We therefore recommend that the Texas Department of Public Health, with assistance from the Comptroller's Office, assume responsibility for analysis of the proposed plan — the Texas Health Plan (THP) — compared with our current financing approach.

A DESCRIPTION OF THE THP

The THP is intended to suggest the optimal long-term direction for the future of health care in Texas.

The Task Force emphasizes the following important points regarding the Texas Health Plan:

- ★ A number of strategies previously discussed by the Task Force in this report also apply to the THP.
- ★ The THP would replace our current inefficient and inequitable system of financing and coordinating health care.
- ★ The health care system in Texas would continue to consist of both public and private providers and health care facilities.
- ★ Government would **not** become the sole provider of health care.
- ★ Government would neither own hospitals nor employ the health care providers utilized in the plan.



THE TEXAS HEALTH PLAN
COMPREHENSIVE BENEFITS PACKAGE

FOR ALL TEXAS CHILDREN

PREVENTIVE CARE PACKAGE

- ★ Well-Baby Care
- ★ Well-Child Care

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physicians, Licensed Health Care Providers and Physician Assistants
- ★ Hospitalization: Inpatient and Outpatient
- ★ Emergency Services
- ★ Diagnostic, Laboratory and X-ray Services
- ★ Acute Dental
- ★ Medical and Surgical Supplies and Biological Foods
- ★ Corrective Glasses and Lenses
- ★ Hearing Aids
- ★ Prescription Drugs
- ★ Transportation

EXTENDED/MAJOR MEDICAL PACKAGE

- ★ Mental Health Services *(including "Serious Mental Illness" as defined by Article 3.51 - 14 of the Insurance Code)*
- ★ Substance Abuse Services
- ★ Coordination of Care
- ★ Speech, Physical and Occupational Therapy
- ★ Treatment of Development and Learning Disabilities

PREGNANCY-RELATED CARE

- ★ Family Planning
- ★ Prenatal, Delivery and Postnatal Care
- ★ Risk Assessment, Care of High-Risk Pregnancies and Attendance at High-Risk Deliveries
- ★ Health Education and Parenting Skills

FOR ALL TEXAS ADULTS

PREVENTIVE CARE PACKAGE

- ★ Booster Immunization
- ★ Pap Tests
- ★ Colo-Rectal Screening
- ★ Prostate Screening
- ★ Mammography
- ★ Health Education

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physicians, Licensed Health Care Providers and Physician Assistants
- ★ Hospitalization: Inpatient and Outpatient
- ★ Emergency Services
- ★ Diagnostic, Laboratory and X-ray Services
- ★ Prescription Drugs
- ★ Transportation

EXTENDED AND ALTERNATIVE CARE

- ★ Rehabilitation
- ★ Mental Health Services *(including "Serious Mental Illness" as defined by Article 3.51 - 14 of the Insurance Code)*
- ★ Substance Abuse Services
- ★ Long-Term Care
- ★ Hospice Care
- ★ Home-Health Care
- ★ Respite Care

Benefits To Texans

One factor was clearly presented to this Task Force in every facet of our study. Our health care system fails to meet the needs of all of our citizens. In each of our visits with the people of Texas, we heard the same needs over and over. We need a more affordable, more easily accessible health care system.

We have arranged the benefits of the THP into **five areas**: (1) guaranteed, universal access and coverage, (2) greater utilization of providers, (3) a coordinated infrastructure, (4) control of cost escalation, and (5) a responsible system of finance.

TASK FORCE IN SESSION

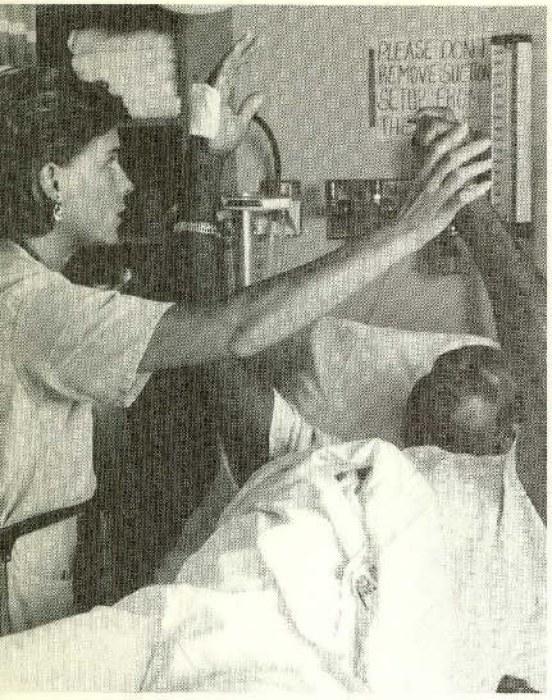
In all of our visits with the people of Texas, we heard the same needs over and over. We need a more affordable, more easily accessible health care system.

GUARANTEED UNIVERSAL ACCESS AND COVERAGE

- ★ The THP includes a comprehensive benefits package — defined by the Task Force — which places strong emphasis on primary and preventive care (see Appendix 5).
- ★ The THP would cover all Texans, guaranteeing access to comprehensive, quality health care.
- ★ Cultural and geographical barriers would be greatly reduced and all Texans would be allowed to choose the health care providers they believe will provide the highest quality care.
- ★ Supplemental private coverage would be permitted to cover any benefits not covered by the THP, such as over-the-counter drugs, elective cosmetic surgery, etc.

GREATER UTILIZATION OF HEALTH CARE PROVIDERS

- ★ Texans would continue to have the freedom to choose their own health care providers.
- ★ Providers, while maintaining professional autonomy, would be guaranteed prompt payment from a single source — instead of from hundreds of different insurers as in our current system — and would no longer have to alter treatment to fit each patient's coverage status.
- ★ Providers would participate in the negotiation of payment rates, planning functions, and governance.
- ★ The THP would allow providers to do what they do best — provide care — rather than waste time and resources on paperwork and billing.



MORE TIME FOR PATIENT CARE

The THP would streamline and standardize the administration of health care. As a result, the amount of time and money health care providers spend on paperwork would be reduced, leaving more time for direct patient care.

GLOBAL BUDGETING

A process that allows a limit — based on population growth and general inflation — to be set on the amount to be spent per year.

A COORDINATED INFRASTRUCTURE

- ★ Under the THP the state would play an active role in the planning of health care.
- ★ This planning would: (1) improve the integration of the health care infrastructure, (2) increase access to primary and preventive care, and (3) improve the coordination of trauma care and transportation.
- ★ Planning would also reduce duplication of unnecessary health care facilities, high-tech equipment and services.

CONTROL OF COST ESCALATION

- ★ The Task Force believes that the THP should end the upward spiral of health care costs and spending by reducing inefficiencies and setting state and regional health care spending caps.
- ★ The THP would streamline and standardize the administration of health care.
- ★ As a result, the amount of time and money health care providers spend on paperwork would be reduced, leaving more time for direct patient care.
- ★ Physicians would have fewer interruptions by utilization reviewers, representing many different companies.
- ★ All benefits of negotiated rate regulations discussed previously in this report would be enhanced by the implementation of ***global budgeting***.
- ★ Global budgeting would set annual spending limits, based on population growth and general inflation, for the total amount to be spent on health care in Texas. This budget, which would also set limits for rate negotiations, is the single most effective tool for controlling the tendency of providers to increase the volume of services provided when the price per unit is reduced.
- ★ To achieve optimal cost containment, all parties to health care should eventually be included.

A RESPONSIBLE SYSTEM OF FINANCE

Many details on financing this plan remain to be determined. Although some facets of finance are not yet known, the Task Force points out the following financial benefits:

- ★ Most costs would not be "new." Instead, costs that are now being paid "out-of-pocket," and through federal income tax, sales and property taxes, employer-provided insurance, etc. would be replaced by direct financing.
- ★ A variety of national studies, conducted by the U.S. Government Accounting Office, Lewin Associates, and others, conclude that while the costs of providing health care for the many who are now shut out of the system will be significant, the administrative savings alone in eliminating multiple payers is expected to at least cover those costs.
- ★ The THP could be progressively financed through an array of funding options that would replace premiums and "out-of-pocket" costs now paid by businesses and families.
- ★ There would be no co-payments or deductibles under this plan.
- ★ All health care revenues would be placed in a state health trust fund that would be used only for health care expenditures.
- ★ Overall, individual and corporate health care costs should be reduced.
- ★ All Texans would receive the health care they need.

TEXAS HEALTH CARE
★
NEW DIRECTIONS
All Texans would receive the health care they need.

THE CONCLUDING STATEMENT

During the first ten months of 1992, the twenty-nine member *Texas Health Policy Task Force* — appointed by Governor Richards, Lt. Governor Bullock and Speaker Lewis — attended a three-day seminar on national and state-related health issues; met often in four subcommittees: (1) essential services, (2) access and availability, (3) cost containment, and (4) finance; listened to expert testimony; visited eight cities across Texas to see health care delivery sites and to hear public testimony from Texas citizens; and reviewed written comments made in response to the draft of the Task Force Report.

In summary, this report from the Task Force:

RECOMMENDS

*A **Texas Children's Health Plan** within which all children from birth through 18 years of age and all pregnant women would receive comprehensive health care.*

RECOMMENDS

Reforms to the current health care system that would expand coverage to those who are underinsured or uninsured and would build the infrastructure required to provide expanded health care coverage.

SUGGESTS

*The **Texas Health Plan** as the optimal long-term direction for the future of health care in Texas.*

At the conclusion of the work of the Task Force, members were asked to indicate their support for the report.

- ★ Twenty-four members expressed support for the report in its entirety.
- ★ One member voted for the *Texas Children's Health Plan* and *Reforms to the Current System* and against the *Texas Health Plan.*
- ★ One member voted for the *Texas Children's Health Plan* and against the *Reforms to the Current System* and the *Texas Health Plan.*
- ★ Three members voted not to support the report.

We believe it is important to learn as much as possible about the cost implications and funding mechanisms inherent in the proposals for the *Texas Children's Health Plan, Reforms to the Current System* and the *Texas Health Plan.*

However, we acknowledge that the cost of maintaining the status quo is unacceptable. Despite the high and ever-increasing cost of health care, Texas still has an inaccessible, poorly accountable and socially unjust non-system of health care. This is true not only for the three to four million uninsured Texans but, in some degree, for the insured and the public or private payers of insurance.

Appoint an Advisory Committee

The members of the Task Force strongly believe that the work of the Task Force is only the beginning. Leadership must be provided for continued study of the health care issues before us. For this reason, the Task Force makes a:

FINAL RECOMMENDATION: APPOINT AN ADVISORY COMMITTEE TO IMPLEMENT THE RECOMMENDATIONS SET FORTH IN THIS REPORT

We recognize that leadership at the federal level will influence state action. We are also keenly aware that the economy of Texas will determine both the extent of these reforms and the speed with which they can be put into place.

Good health is an asset, and each Texan is responsible for protecting this valuable personal resource. It is recognized that each individual is his or her own best primary health care provider. For infants and small children, parents provide most of the basic health care and education.

As we mature, each of us must assume responsibility for our health. It is in our best interest to promote health and prevent disease or injury — to make good nutrition, routine screening exams and fastening our seat belts part of our everyday lives.

When we do need health care, we have a duty to be responsible consumers. This requires us to exercise care in our choice of providers and to participate fully in our treatment.

The health of the Lone Star State can be no better than the sum of the health of its individual citizens. Given the proper health care resources, each of us is responsible not only for our individual health but ultimately for the health of the state. ★

APPENDIX-1

THE TEXAS CHILDREN'S HEALTH PLAN BENEFITS PACKAGE *

FOR ALL TEXAS CHILDREN

PREVENTIVE PACKAGE

- ★ Child Preventive Care, including:
  - Routine Office Visits,
  - Routine Immunizations,
  - Routine Laboratory Tests, and
  - Preventive Dental Care
- ★ Care of Newborn Infants and Attendance at High-Risk Pregnancies
- ★ Comprehensive Reproductive Health Care, including:
  - Prenatal,
  - Postnatal, and
  - Family Planning Services

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physician Services
- ★ Pediatric and Family Practice Advanced Nurse Practitioner Services
- ★ Hospital Services
- ★ Emergency Services
- ★ Diagnostic Services
- ★ Outpatient Hospital Services
- ★ Ambulatory Surgical Center Services
- ★ Maternity Center Services
- ★ Home Health Services
- ★ Ambulance Services
- ★ Medical Transportation Services
- ★ Acute Dental Care
- ★ Corrective Eyeglasses or Lenses
- ★ Hearing Aids
- ★ Prescription Drugs

EXTENDED MAJOR MEDICAL PACKAGE

- ★ Case Management Services, includes
  - Chronically Ill, and
  - Other At-Risk Children
- ★ Treatment of Developmental and Learning Disabilities *(may be educational rather than medical, depending on the diagnosis and type of service)*
- ★ Mental Health Services
- ★ Substance Abuse Services
- ★ Speech Therapy
- ★ Occupational Therapy
- ★ Physical Therapy
- ★ Home Health: In-Home Care
- ★ In-Home Intravenous Therapy
- ★ In-Home Respiratory Therapy
- ★ Hospice Care
- ★ Nutritional Assessment and Counseling
- ★ Orthodontics *(other than cosmetic)*
- ★ Rehabilitation Services, including:
  - Medical Supplies, and
  - Durable Medical Equipment

  (paid for under the Comprehensive Care Program -CCP, which in Texas is available only for people under age 21)

FOR ALL PREGNANT WOMEN

- ★ Pregnancy-Related Care, including
  - Family Planning Services
  - Prenatal, Delivery and Postnatal Care

  (delivered either by a Physician, or Pediatric Advanced Nurse Practitioner, or Family Practice Advanced Nurse Practitioner)
- ★ Specialized Care for High-Risk Women
- ★ Ambulance Services and Medical Transportation Services
- ★ Home Health: In-Home Care

All of the services on the above list are currently covered by the Texas Medicaid program.

SMALL GROUP BENEFITS PACKAGE

If the Legislature chooses to implement small business insurance reform, the following set of benefits is recommended for the Small Group Benefits Package:

- ★ Physicians, Licensed Health Care Providers and Physician Assistant Services *(including consultant and referral services)*
- ★ Inpatient and Outpatient Hospital Services
- ★ Medically Necessary Emergency Health Services
- ★ Pregnancy-Related Care for Women including:
  - ★ Prenatal
  - ★ Postnatal
  - ★ High-Risk Pregnancy Care *(excluding in-vitro fertilization)*
- ★ Well-Baby Care, Including Neonatal Screening
- ★ Well-Child Care
- ★ Adult Primary and Preventive Care
- ★ Outpatient Evaluative and Crisis Intervention and Mental Health Services *(including serious mental illness as defined by Section 3.51-14 of the Insurance Code)*
- ★ Medical Treatment and Referral Services for the Abuse of or Addiction to Alcohol and Drugs
- ★ Diagnostic Treatment, Laboratory, and X-ray Services
- ★ Rehabilitation
- ★ Home-Health Services
- ★ First Dollar Coverage for Preventive Services Including But Not Limited To:
  - ★ Immunizations
  - ★ Pap Tests
  - ★ Colo-Rectal Screening
  - ★ Prostate Cancer Screening
  - ★ Mammography
  - ★ Children's Eye and Ear Exams
- ★ Prescription Drugs

THE PRIMARY HEALTH CARE PROGRAM EXPANSION

The Task Force recommends expanding the services currently listed in the *Texas Primary Health Care Act* to include the following:

FOR CHILDREN*

To Be Phased-in In 1993

- ★ Physician, Licensed Health Care Provider, or Physician Assistant (outpatient care)
- ★ Rehabilitation Therapy
- ★ Medical Supplies, Devices, and Durable Supplies
- ★ Prescription Eyeglasses and Vision Care
- ★ Home-Health Care Services
- ★ Outpatient Mental Health
- ★ Outpatient Substance Abuse
- ★ Transportation
- ★ Hospice
- ★ Long-term Care

Dental care is currently covered under the Early Periodic Screening Diagnosis and Treatment Program (EPSDT)

FOR PREGNANT WOMEN*

To Be Phased-in In 1993

- ★ Pregnancy Related Care, including:
  - ★ Prenatal
  - ★ Postnatal, and
  - ★ Parenting Skills Education

FOR ADULTS*

To Be Phased-in In 1994

- ★ Diagnosis and Treatment
- ★ Emergency Services
- ★ Family Planning
- ★ Preventive Services
- ★ Health Education
- ★ Lab and X-ray
- ★ Psychological and Social Services
- ★ Environmental Health Services
- ★ Nutrition Counseling
- ★ Health Screening
- ★ Home-Health Care
- ★ Dental Care
- ★ Transportation
- ★ Prescription Drugs, Devices and Durable Supplies
- ★ Podiatry Services

**Require provision of "mandatory" as well as "allowable" services listed in the Texas Primary Health Care Act*

SCHOOL-BASED HEALTH CARE EXPANSION

The Task Force recommends that school-based clinics be expanded to provide the following services, **subject to** parental consent:

PRIMARY HEALTH CARE

- ★ First-Level Diagnosis and Treatment

PREVENTIVE CARE,
INCLUDING BUT NOT LIMITED TO:

- ★ Booster Immunizations
- ★ HIV Prevention
- ★ Family Planning
- ★ Sexually-Transmitted Disease Prevention
- ★ Suicide Prevention

HEALTH EDUCATION,
INCLUDING BUT NOT LIMITED TO:

- ★ Nutrition
- ★ Parenting and Daily Living Skills
- ★ Physical Education
- ★ Safety
- ★ First Aid
- ★ Violence and Gang-Related Prevention Education
- ★ Mental Health Services
- ★ Substance Abuse Services

THE TEXAS HEALTH PLAN
COMPREHENSIVE BENEFITS PACKAGE

FOR ALL TEXAS CHILDREN

PREVENTIVE CARE PACKAGE

- ★ Well-Baby Care
- ★ Well-Child Care

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physicians, Licensed Health Care Providers and Physician Assistants
- ★ Hospitalization: Inpatient and Outpatient
- ★ Emergency Services
- ★ Diagnostic, Laboratory and X-ray Services
- ★ Acute Dental
- ★ Medical and Surgical Supplies and Biological Foods
- ★ Corrective Glasses and Lenses
- ★ Hearing Aids
- ★ Prescription Drugs
- ★ Transportation

EXTENDED/MAJOR MEDICAL PACKAGE

- ★ Mental Health Services *(including "Serious Mental Illness" as defined by Article 3.51 - 14 of the Insurance Code)*
- ★ Substance Abuse Services
- ★ Coordination of Care
- ★ Speech, Physical and Occupational Therapy
- ★ Treatment of Development and Learning Disabilities

PREGNANCY-RELATED CARE

- ★ Family Planning
- ★ Prenatal, Delivery and Postnatal Care
- ★ Risk Assessment, Care of High-Risk Pregnancies and Attendance at High-Risk Deliveries
- ★ Health Education and Parenting Skills

FOR ALL TEXAS ADULTS

PREVENTIVE CARE PACKAGE

- ★ Booster Immunization
- ★ Pap Tests
- ★ Colo-Rectal Screening
- ★ Prostate Screening
- ★ Mammography
- ★ Health Education

PRIMARY/MAJOR MEDICAL PACKAGE

- ★ Physicians, Licensed Health Care Providers and Physician Assistants
- ★ Hospitalization: Inpatient and Outpatient
- ★ Emergency Services
- ★ Diagnostic, Laboratory and X-ray Services
- ★ Prescription Drugs
- ★ Transportation

EXTENDED AND ALTERNATIVE CARE

- ★ Rehabilitation
- ★ Mental Health Services *(including "Serious Mental Illness" as defined by Article 3.51 - 14 of the Insurance Code)*
- ★ Substance Abuse Services
- ★ Long-Term Care
- ★ Hospice Care
- ★ Home-Health Care
- ★ Respite Care

A CROSS REFERENCE GUIDE TO THE RECOMMENDATIONS

THE RECOMMENDATIONS	PROBLEM SECTION	RECOMMENDATION SECTION	APPENDIX
RECOMMENDATION #1			
★ *Establish a statewide system for financing and ensuring access to high-quality, comprehensive health care for children (birth through age 18) and all pregnant women. This plan would be known as the* ***TEXAS CHILDREN'S HEALTH PLAN (TCHP).***	***pp. 19-22***	***pp. 73-80***	***A-1 (p. 75)***
BENEFITS		p. 74	
• Families would no longer need private insurance for children or maternity services.			
• Provider's uncompensated care would be reduced.			
• Employer health care coverage costs would be reduced.			
• Malpractice claims based on unavailable care, which are filed by parents on behalf of their children, should be reduced.			
RECOMMENDATIONS FOR DEVELOPMENT		***pp. 76-80***	
★ ESTABLISH A CHILDREN'S HEALTH BOARD			
★ Obtain approximately 65% of financing through the federal Medicaid program.		pp. 76-77	
★ UTILIZE BOTH PHYSICIANS AND OTHER LICENSED PROVIDERS		p. 78	
★ MAKE COST CONTAINMENT REFORMS IN 5 AREAS		pp. 79-80	
★ Establish uniform rates.			
★ Utilize standardized billing.			
★ Limit administrative costs.			
★ Integrate a utilization review process.			
★ Establish a data collection system.			

NOTE:

Prior to development of the *Texas Children's Health Plan*, the Task Force voted to recommend extensive reforms designed to expand health care coverage and availability for the entire population. These reforms, which maximize participation in federally-funded health care programs, apply to coverage for all Texans. They are discussed in the section titled *Reforms to the Current System*. They are included in the TCHP cost containment section because they are an integral part of this program as well as the reform recommendation section.

THE RECOMMENDATIONS	PROBLEM SECTION	RECOMMENDATION SECTION	APPENDIX
RECOMMENDATION #2			
★ *Make reforms to the current system that expand coverage to those who are uninsured or underinsured and builds the infrastructure required to provide expanded health care coverage to all Texans.*	***pp. 19-58***	***pp. 81-126***	
BENEFIT			
A health care system that is accessible to all.		p. 81	
THE REFORMS			
■ ***Reforms In Access***	***pp. 19-31***	***p. 82***	
★ *MAXIMIZE PARTICIPATION IN FEDERALLY FUNDED HEALTH CARE PROGRAMS*		*p. 82*	
■ ***Reforms In Private Health Care Coverage***	***pp. 23-31***	***pp. 83-88***	
★ *STRENGTHEN THE EXISTING INSURANCE STRUCTURE*		*pp. 83-88*	
1. ELIMINATE DEDUCTIBLE FOR SELECTED PREVENTIVE SERVICES		p. 83	
2. STRENGTHEN FINANCIAL RESERVE REQUIREMENTS		p. 84	
3. CREATE PURCHASING POOLS		p. 85	
4. ENSURE GUARANTEED ISSUE		p. 86	
★ Adopt a Six-Month Grace Period			
★ Prohibit Redlining			
★ Develop A Reinsurance Pool			
5. PROHIBIT PRE-EXISTING CONDITIONS		p. 86	
6. GUARANTEE PORTABILITY		p. 86	
7. SET LIMITS ON PREMIUM RATE INCREASES		p. 87-88	
★ Adopt A Modified Community Rating		p. 87	
★ Include A **Small Group Benefits Package**		pp. 87-88	***A-2 (p. 88)***
8. ESTABLISH A MAXIMUM OVERHEAD		p. 88	
■ ***Reforms In Provider Services***	***pp. 32-43***	***pp. 90-100***	
★ *DEVELOP A PLAN TO ENSURE A REQUIRED MIX OF PROVIDERS*		*pp. 91-96*	
1. ENCOURAGE AND PREPARE STUDENTS FOR HEALTH CAREERS		p. 92	
2. IMPROVE REPRESENTATION		p. 92	
3. IDENTIFY THOSE MOST LIKELY TO RETURN TO UNDERSERVED AREAS		p. 93	
4. DEVELOP STRATEGIES TO ENCOURAGE PROVIDERS TO ENTER PRIMARY CARE AND WORK IN UNDERSERVED AREAS		pp. 93-94	
5. INCREASE THE NUMBER AND UTILIZATION OF OTHER HEALTH CARE PROFESSIONALS		pp. 95-96	
★ *DESIGN INCENTIVES ENCOURAGING MEDICARE AND MEDICAID ACCEPTANCE*		*p. 97*	
★ *CHANGE POLICIES REGARDING SUBSTANDARD PRACTICE OF MEDICINE*		*p. 98*	
1. IMPROVE GOOD-FAITH REPORTING ASSURANCES		p. 98	
2. STRENGTHEN REPORTING REQUIREMENTS		p. 98	
3. AMEND EXEMPTION OF HEALTH CARE PROVIDERS FROM THE DECEPTIVE TRADE PRACTICES ACT		p. 99	
4. SPEED UP THE HEARING PROCESS		p. 99	

THE RECOMMENDATIONS	PROBLEM SECTION	RECOMMENDATION SECTION	APPENDIX
5. INCREASE NON-PHYSICIAN TSBME MEMBERSHIP		p. 99	
6. RETAIN MORE AND BETTER QUALIFIED LEGAL AND INVESTIGATIVE STAFF		p. 100	
7. USE PRACTICE STANDARDS TO EVALUATE CLAIMS		p. 100	
★ *PROHIBIT REFERRALS TO PROVIDER OWNED FACILITIES*		*p. 100*	
■ ***Reforms In Infrastructure***	***pp. 44-58***	***pp. 101-114***	
★ *MAKE PRIMARY AND PREVENTIVE CARE A TOP PRIORITY*		*pp. 101-104*	
1. CREATE A NETWORK OF RURAL HOSPITALS AND/OR PRIMARY CARE FACILITIES		p. 102	
2. INCREASE THE **"PRIMARY HEALTH CARE PROGRAM"** FUNDING, AVAILABILITY, ACCESSIBILITY AND SERVICES		p. 102	***A-3 (p. 103)***
3. DEVELOP NEW AND EXPAND EXISTING PRIMARY CARE SITES		p. 104	
★ *INCREASE UTILIZATION OF SCHOOL-BASED HEALTH CARE SERVICES*		*pp. 105-106*	
1. DEVELOP A STATE-LEVEL INTERAGENCY GROUP TO PROVIDE TECHNICAL ASSISTANCE		p. 105	
2. ENROLL **SCHOOL-BASED CLINICS** TO BE MEDICAID PROVIDERS		p. 106	***A-4 (p. 106)***
★ *REFORM "CHARITY CARE" REGULATIONS AND REQUIREMENTS*		*pp. 107-108*	
1. REQUIRE PRIVATE, NON-PROFIT HOSPITALS TO PROVIDE AN AMOUNT OF CHARITY CARE EQUAL TO EXEMPTION BENEFITS		p. 107	
2. MAKE INFORMATION AVAILABLE TO THE PUBLIC		p. 108	
★ *DEVELOP A COMPREHENSIVE TRAUMA CARE SYSTEM*		*p. 109-110*	
1. FUND THE TRAUMA PLAN PRESENTED IN HOUSE BILL 18		p. 109	
2. DEVELOP A COMPREHENSIVE, SCHOOL AND PUBLIC HEALTH TRAUMA PREVENTION CAMPAIGN		p. 109	
3. COMPLETE IMPLEMENTATION OF AN ENHANCED 911 SYSTEM		p. 109	
4. UPGRADE PERSONNEL AND EQUIPMENT IN THE PRE-HOSPITAL TRAUMA SYSTEM		p. 110	
5. REVIEW EXISTING REGULATORY REQUIREMENTS		p. 110	
6. DEVELOP A MEDICAID REIMBURSEMENT PROCEDURE		p. 110	
7. CONDUCT ONGOING TRAUMA EPIDEMIOLOGY ASSESSMENTS		p. 110	
★ *IMPLEMENT A STATE-WIDE TRANSPORTATION SYSTEM TO INCREASE ACCESS*		*p. 111*	
★ *EXTEND USE OF TECHNOLOGY TO EXPAND AND INCREASE ACCESS*		*p. 112*	
★ *ESTABLISH A MECHANISM FOR PROSPECTIVE PLANNING*		*pp. 113-114*	
1. ESTABLISH REGIONAL TARGET STANDARDS		pp. 113-114	

THE RECOMMENDATIONS	PROBLEM SECTION	RECOMMENDATION SECTION	APPENDIX
■ ***Reforms In Cost Containment***	***pp. 59-67***	***pp. 115-126***	
★ *ESTABLISH A MECHANISM TO ENSURE NEGOTIATED RATE REGULATION*		*pp. 116-117*	
1. REQUIRE DATA COLLECTION OF RATES CHARGED		p. 116	
2. ENCOURAGE PARTICIPATION FROM ALL ENTITIES		p. 117	
3. ESTABLISH EXPENDITURE LIMITS		p. 117	
★ *DESIGNATE HHSC TO IDENTIFY AND EVALUATE PHARMACEUTICAL COST-CONTROL APPROACHES*		*p. 118*	
★ *STANDARDIZE AND STREAMLINE TO REDUCE WASTE*		*p. 118*	
1. STANDARDIZE BENEFITS AND FORMS		p. 119	
2. INITIATE ELECTRONIC CLAIMS, BILLING AND REPORTING OF DATA		p. 119	
3. DESIGNATE HHSC TO IDENTIFY AND EVALUATE COST-CONTROL APPROACHES		p. 120	
★ *MAKE CHANGES TO IMPROVE THE PUBLIC'S KNOWLEDGE OF COMPETITIVE MARKETS*		*pp. 120-121*	
1. ANALYZE AND REPORT TO THE PUBLIC PRICES AND FEES FOR ALL HEALTH SERVICES		p. 120	
2. DEFINE AND MEASURE OUTCOMES OF CARE		p. 121	
3. REWARD CONSUMERS FOR OVERCHARGES THEY FIND		p. 121	
★ *ACCUMULATE MISSING INFORMATION REGARDING MEDICAL MALPRACTICE ISSUES*		*pp. 122-125*	
1. COLLECT DATA USING STANDARDIZED DEFINITIONS		p. 122	
2. EXPAND THE TDI COLLECTION MECHANISM		p. 122	
3. CONSIDER EXPANSION OF HOUSE BILL 18 TO INCLUDE HOSPITAL INDEMNIFICATION		p. 123	
4. COMMISSION STUDIES TO ENCOURAGE EARLY MEDIATION AND RESOLUTION		p. 124	
5. CONDUCT A STUDY TO DEFINE AND QUANTIFY "DEFENSIVE MEDICINE"		p. 124	
6. CONDUCT A STUDY ON OUTCOMES RESEARCH TO DETERMINE PRACTICE STANDARDS		p. 125	
7. STRESS EFFECTIVE PATIENT COMMUNICATION IN HEALTH PROVIDER EDUCATION		p. 125	
★ *OTHER MALPRACTICE ISSUES*		*p. 126*	

THE RECOMMENDATIONS	PROBLEM SECTION	RECOMMENDATION SECTION	APPENDIX
SUGGESTION			
★ *Consider the **TEXAS HEALTH PLAN (THP)** as the optimal long-term direction for the future of health care in Texas and initiate a study to compare the financial benefits of the THP with our current health system.*	***pp. 19-67***	***pp. 127-133***	***A-5 (p. 130)***
RECOMMENDATION #3			
★ *Compare the financial benefits of the THP with our current system.*		p. 128	
BENEFITS		pp. 131-133	
★ There would be guaranteed, universal access and coverage.			
★ Greater utilization of providers would be achieved.			
★ There would be a coordinated infrastructure.			
★ Cost escalation could be brought under control.			
★ The THP would provide a responsible system of finance for Texas health care.			

ENDNOTES

1.Blue Cross and Blue Shield of Texas, Inc., single page graph detailing type of health care coverage/non-coverage of population of Texas, December, 1990.
2.Begley, C. E., and J. Guidry, "Health Expenditures in Texas, 1988," June, 1991, p. 12.
3.Ibid., extrapolated to develop conservative estimates of growth in medical/health expenditures during the period between 1988-1992.
4.Ibid., extrapolated to develop a conservative projection of growth in medical/health expenditures during the period 1992-1993.
5.Coombes, P., M. Mendez-Lewis, P. Berger, et al, "Critical Condition, Soaring Health Care Costs Plague Texas Businesses," Texas Comptroller of Public Accounts John Sharp, Austin: March, 1992, p. 5.
6.Blue Cross and Blue Shield of Texas, Inc., op. cit.
7.Fein, R., "Prescription for Change," Modern Maturity, August-September, 1992, Vol. 35, no. 4, p. 34.
8.Dunkelberg, Anne., "Health Insurance: Rising Costs and Declining Access," Texas Research League, Austin: 1990, p. 43.
9.Stutz, Terrence, "Health-Care Reform Urged," The Dallas Morning News, Feb. 17, 1992.
10.U.S. Bureau of the Census, Statistical Abstract of the United States: 1991, p. xii.
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ACRONYMS

ADR	Alternative Dispute Resolution	MEWA	Multiple Employer Welfare Association
AFDC	Aid to Families with Dependent Children	NAIC	National Association of Insurance Commissioners
ANP	Advanced Nurse Practitioner		
CNM	Certified Nurse Midwife	OTA	U.S. Office of Technology Assessment
CON	Certificate of Need	PA	Physician's Assistant
CPR	Cardiopulmonary Resuscitation	PPO	Preferred Provider Organization
CRNA	Certified Registered Nurse Anesthetist	PRO	Peer Review Organization
DOL	U. S. Department of Labor	RN	Registered Nurse
DTPA	Deceptive Trade Practices Act	TCHP	Texas Children's Health Plan
EMS	Emergency Medical Service	TDPH	Texas Department of Public Health*
EPSDT	Early Periodic Screening, Diagnoses and Treatment	TDHS	Texas Department of Human Services
ER	Emergency Room	TDI	Texas Department of Insurance
ERISA	Employee Retirement Income Security Act	THFC	Texas Health Facilities Commission
GAO	U. S. General Accounting Office	THP	Texas Health Plan
HMO	Health Maintenance Organization	TSBME	Texas State Board of Medical Examiners

* (As of September 1, 1992, the Texas Department of Health was renamed the Texas Department of Public Health)

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Owner of a gas marketing company, active with Texas Oil Marketers Association, worked with Food Bank of Rio Grande Valley, experience as small business owner providing health insurance for employees.

THE HONORABLE PEGGY ROSSON, SENATE, El Paso
Chairs the Subcommittee on Regulatory Agencies; Serves on Senate committees on Economic Development, Natural Resources and State Affairs and Subcommittees on Water and Congressional Redistricting; Concentrates on utilities and consumer affairs issues; Former chair of Texas Public Utility Commission and of Public Utility Regulation Board in El Paso; Homemaker and former paralegal and business woman.

MARY ELLEN SCHATTMAN, Fort Worth
Director of Governmental Relations for Tarrant County Hospital District; Former employee of Tarrant County Red Cross; Experience with Tarrant County Crime Commission, Mayor's Committee on Status of Women and Adult Girl Scout Network.

THE HONORABLE DAVID SIBLEY, D.D.S., M.S.D., J.D., SENATE, Waco
Serves on Senate committees on Criminal Justice, Intergovermental Relations, Natural Resources and Congressional Redistricting; Former Mayor; Active in war on crime, police support, property tax reductions and term limitations; Former oral and maxillofacial surgeon; Attorney.

PEGGY SMITH, Ph. D., Houston
Professor and Director of Teen Health Clinic; Member of faculty at University of Texas Health Science Center-Houston and Baylor College of Medicine; Chairperson of Children's Trust Fund; Reviewing Editor for Journal of Developmental and Behavioral Pediatrics.

BRYAN SPERRY, M.A., Austin
Deputy Commissioner of the Health and Human Services Commission; Former Executive Director of Center for Rural Health Initiatives; Former Administrative Assistant for Health and Human Services for Lt. Governor during passage of the Anti-Crime Plan of 1989 and major legislation on AIDS, maternal and child health and rural health legislation; Former Executive Director for Texas Task Force on Indigent Health Care; Former Administrator of Health and Human Services Program at Texas Department of Human Services.

THE HONORABLE JIM TALLAS, HOUSE OF REPRESENTATIVES, Sugar Land
Chairs the House Committee on Financial Institutions; Serves on Criminal Jurisprudence; Former Chairman of Budget and Oversight for Financial Institutions and Member of Calendars and Appropriations; First term in 1984; Concentrates on issues relating to financial institutions; Current State Chairman of American Legislative Exchange Council; Insurance businessman.

THE HONORABLE ROBERT TURNER, HOUSE OF REPRESENTATIVES, Voss
Serves on House Committees on Cultural and Historical Resources and Science and Technology; Elected to House in special election in 1991; Serves as Chairman of National Rural Health Committee, Member of Texas Rural Coalition; Occupations as retail merchant, farmer and rancher; Retired Lt. Col.,U.S. Army Reserve.

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