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Texas Health Policy Task Force Votes On Final Recommendations

The Texas Health Policy Task Force adopted over 50 recommendations at final meetings in September. Though the group lacked the consensus to back a specific plan to cover all Texans, they did make a bold proposal to establish a program to guarantee health coverage for every child in Texas, and to guarantee maternity coverage for all women (see inside -- Texas Children's Health Plan); in addition, major changes in health insurance regulation were recommended.

Real effective change that makes health care available to all Americans at a price that does not result in a grossly lopsided concentration of GNP in health care will require concessions from every sector. Not just the health care providers and insurers, but also individual consumer-taxpayers as well as businesses must be prepared to accept changes in the *status quo*.

This article is limited to a discussion of health financing recommendations of the Task Force. It is hoped that by looking at the problems involved in trying to improve access to payment for health care, some of the dilemmas and painful tradeoffs inherent in health reform will become apparent. Examination of health financing proposals also leads to the inevitable question of how to control costs; therein lie some of the most difficult choices of all.

About This Issue

The Texas Health Policy Task Force wrapped up a year of proceedings with a final September meeting at which final recommendations were adopted. A final Task Force report is to be released by November of this year. This issue of *Analysis* looks at selected Task Force recommendations related to how Texans pay for health care: a proposed program to cover children and maternity care, and a variety of proposals for health insurance regulatory reform. Some possible implications for different sectors of the business community are also addressed.

About the Task Force

The Texas Health Policy Task Force was created by executive order in November 1991. According to the Order, the Task Force was "to propose a comprehensive health plan to ensure that all Texans have access to appropriate and affordable health services." The group consists of 13 public members from a broad spectrum of backgrounds; 12 members of the Texas Legislature; the agency board chairs from the Departments of Health, Human Services and Insurance; and the state's director for Rural Health Policy. The Task Force's final report is to be delivered to state officials by November 1, 1992.

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TEXAS CHILDREN'S HEALTH PLAN

The most sweeping proposal from the Task Force calls for the creation of a statewide health program -- the Texas Children's Health Plan (TCHP) -- that would eventually be available to all children and to all pregnant women. The only charges to enrollees would be limited co-payments for persons over the poverty level. All enrollees would be free to choose their own doctor, and enrollment in TCHP would be completely voluntary. If -- and this is a big "if" -- TCHP coverage was accepted by most health care providers and consumers as comparable or superior to private coverage, the program could, in theory, become the number-one payer for children's health services and maternity care in the state. Employers and employees could eliminate what they now spend on health benefits for children, and women's insurance premiums could be lowered to exclude maternity coverage.

Medicaid Financing. The TCHP concept was inspired by, and depends on, a fairly new provision of federal law that, simply put, allows states to deem children and pregnant women to be Medicaid-eligible up to any income level the state chooses. This means that the state could get 65% federal matching dollars for TCHP, but it also means that the state would have to come up with its own 35% share. To get an idea of the magnitude of such a program, first look at the current Medicaid program. **In 1992, there are about 5.4 million Texans under age 18; an astounding 27% of them are already covered by Medicaid. An estimated 325,000 babies will have been born in Texas by year-end, and about 122,000 of those deliveries (38%) will have been Medicaid-funded.** Under current law, about $1.44 billion ($516 million of which is the state share) will be spent by Medicaid on health services for this group (mothers and children) in 1992.

Cost Estimates. The Texas Department of Human Services (TDHS) provided the Task Force with rough preliminary estimates of the 1992-1995 costs of TCHP if it covered all kids and pregnant women up to 250% of the federal poverty level (an upper income limit of about $17,000 a year for an individual, $29,000 for a family of three, would include about 48% of expectant mothers and about 62% of Texas' children), and if it covered all Texas children and pregnant women. As shown in Table 1, the latter would cost about $3.3 billion **above and beyond current Medicaid spending** in 1992, $1.2 billion of which would be state funds. Assuming full participation by women and children, a 10% annual increase in cost-per-recipient, based on **current** Medicaid reimbursement rates with an additional 10% increase in physician fees in 1993-5, TDHS projects that by 1995 a program covering all kids and pregnant women would require an additional $4.6 billion **above the level of currently mandated Medicaid spending**, with the state responsible for $1.7 billion of that total.

In one sense, these estimates represent a worst-case scenario, because they assume immediate enrollment of all eligible women and children, when in practice any program this ambitious certainly would be phased in over a period of several years. Enrollment would probably build slowly, taking a number of years to reach high participation rates. Since enrollment in the proposed program would be

TABLE 1
Texas Children's Health Plan
1992 Enrollees and Projected Costs
($millions)

	Enrollees	Total Cost	State Share	Federal Share
Current Medicaid*				
Children (0-18)	1,491,000	$1,224	$ 438	$ 786
Pregnant Women	122,000	$ 215	$ 77	$ 138
Subtotal	1,613,000	$1,439	$ 516	$ 924
Add up to 250% Poverty				
Children (0-18)	1,863,000	$1,388	$ 497	$ 891
Pregnant Women	35,625	$ 63	$ 23	$ 40
Subtotal	1,898,625	$1,451	$ 520	$ 931
Add Remaining Group				
Children (0-18)	2,064,000	$1,538	$ 551	$ 987
Pregnant Women	167,375	$ 295	$ 105	$ 190
Subtotal	2,231,375	$1,833	$ 656	$1,177
Total NEW Coverage				
Children (0-18)	3,927,000	$2,926	$1,048	$1,878
Pregnant Women	203,000	$ 358	$ 128	$ 230
Subtotal	4,130,000	$3,284	$1,176	$2,108
GRAND TOTAL	5,743,000	$4,723	$1,692	$3,031

Source: Texas Department of Human Services estimates provided to Texas Health Policy Task Force.
*Includes children and pregnant women only; excludes aged, blind, disabled, and caretaker enrollees.

voluntary, many parents who currently purchase coverage for their children (and many health plans that now cover maternity care) would no doubt maintain that coverage until they were satisfied that TCHP could deliver coverage of comparable quality.

Rate Increase Component. From another perspective, however, the estimates above may understate the true costs of a fully-implemented program with full enrollment and provider participation. Most observers agree that significant increases in Medicaid payment rates -- beyond the 10% in the Task Force model -- would be needed to entice a majority of health care providers to accept the program.

The Texas Medicaid program adopted a new fee schedule for doctors in April 1992 that significantly improved payments for office visits, while reducing fees for many surgeries and other procedures. While not budget-neutral, published estimates of increased spending on physician services due to the new fees are in the neighborhood of 5%.

The new fee schedule has increased fees for some basic health care services from about half of what private insurance paid up to around 70-75% of private rates. Still, there is reason to believe that more than an additional 10% increase in rates may be needed to make TCHP acceptable to doctors who deliver babies. For example, fees for prenatal care visits were increased substantially; a doctor can now get paid about $975 for prenatal care and delivery (assuming early diagnosis -- 10 prenatal visits). However, private charges for prenatal care and delivery are now in the $1,500-$1,800 range (add another $400 or $500 for cesarean section), so at best, Medicaid is paying 65% of "retail;" for more expensive c-section deliveries, the payment is less than 45% of charges. Though TCHP (Medicaid) payments would not necessarily need to be equal to 100% of billed charges ("retail"), the size of the increase that would be required to bring doctors on board is a complex question, and getting the answer right is critical to whether a TCHP could really work.

Is This A Good Deal? One of the Task Force's selling points for TCHP is the reduction of employers' health benefit costs, since maternity benefits and coverage for children would be available from TCHP. Of course, Texas would have to fund its share of TCHP somehow, but the Task Force did not recommend a specific method for raising the new revenues needed to support TCHP. The Task Force received estimates of the revenue-generating power of various types of taxes; among these were estimated revenues from payroll taxes. A payroll tax of 1% was projected to yield $1.75 billion -- about one and one-half times the estimated state's share for TCHP in 1992.

Several Task Force members calculated their own firms' current expenditures on dependent child health care and maternity benefits, and found that they ranged from 3% to 4.5% of total payroll. The smallest of these firms employs about 200 workers, about half of whom are enrolled in the health plan. Thus, most large firms could, in theory at least, see reduced costs under TCHP.

But for small businesses, the picture is very different. Obviously, small firms that now provide no health benefits would face completely new costs under a business-tax-supported health program. Even the small employers that do currently fund a health plan may not see the kinds of potential savings the Task Force members projected. Many small firms fund benefits for workers only (no savings). For small firms that now pay for dependent coverage, those with high proportions of dependent children enrolled might save, while those with few children covered might lose.

Who Will Buy? Clearly, if this program is to be sold even to the most receptive Texas businesses it must cost less, and deliver equally good or better care than the status quo. Proponents will need to develop credible cost estimates based on realistic rates for doctors and other providers. Even if those conditions are met, there is bound to be resistance to a state-sponsored program from Texans, both in and out of the business community, who would prefer a program that contracts with the insurance/HMO industry to provide coverage.

HEALTH INSURANCE REFORMS

Market Reform. A number of recommendations are directed at the private health insurance and

HMO marketplace. Under the subheading of "Access to Coverage," the Task Force encourages the state to;

- allow small employer groups to form large pools to purchase and administer health coverage;
- require health plans to accept all groups and individuals (a six-month waiting period may be required);
- create a reinsurance pool to protect insurers who enroll high proportions of high-risk individuals or groups;
- set the maximum waiting period for coverage of a pre-existing condition at six months;
- forbid permanent exclusion of coverage for any condition;
- ensure that persons who change health plans with no significant uninsured period need not undergo repeated waiting periods;
- restrict annual premium increases to an inflation factor;
- allow premiums to vary only by age, industry, and gender (but no pregnancy-related variation allowed);
- prohibit rate variation based on health status or claims history;
- require all small group carriers to offer a standard benefit package to permit comparison shopping;
- direct the Texas Department of Insurance (TDI) to study the proportion of premium costs that are spent on administrative, marketing, and other costs rather than health care services; and
- direct TDI to use this information to develop standards to limit the amount of premiums that may be spent on non-health costs.

Many of these recommendations are similar to components of model laws for small group health insurance market reform developed by the National Association of Insurance Commissioners (NAIC); these have provided the basis for small group reform laws adopted in about 30 states. However, while the NAIC models apply reforms exclusively to the small group market, only two components (group pooling and standard benefit package) of the Task Force package are explicitly directed to small groups. Also, the term "small group," which in state and federal laws usually refers to groups ranging in size from 25 to 50 employees, is undefined here.

Reforming What? No state has yet attempted to apply insurance market reforms to all commercial health coverage carriers, largely because coverage for groups of 50 and larger is relatively stable and accessible. If applied to all commercial health coverage, certain market reforms would probably raise the average cost of coverage in the private marketplace, because they would allow less healthy and/or high-risk groups that are now excluded from coverage to join the pool. Larger firms might then be motivated to leave the private market and turn to self-insurance for health benefits (55-60% of all covered workers are now employed by self-insuring firms). Federal law (ERISA) exempts single-employer, self-insured health plans from state insurance laws, and the federal government (thus far) exercises little oversight over these plans.

It is likely that any insurance reform bills filed in the upcoming legislative session will be limited to the small group (50 or fewer employees) market. The NAIC model laws are attractive as a jumping-off point for small group reform, in large part because they were developed with extensive input from large health insurers and HMOs, and are thus acceptable to many of the largest players in the small group market (they are not acceptable to all small health insurers). Ultimately, however, analysts agree that the effect of small group reforms that guarantee that all groups can purchase coverage (with upper and lower limits on the variation in rates charged for identical coverage) will be to narrow the range of rate variations, lowering rates for some and raising them for others. Truly abusive rating practices could be eliminated. **Small group reforms alone can have no impact whatsoever on the enormous annual medical care inflation rate**; they will end triple-digit annual premium rate increases now

Health Care Reform: Why There Is No One "Business Position"

Texas Research League work often strives to build bridges between the business community and the world of public policy, and to analyze the impact of public policy on business. There has been an explosion in health costs in the U.S., evidenced by a medical care consumer price index that grew 630% from 1960-1990, while overall CPI growth was 342%. Businesses, of course, have not been insulated from these trends. Average employer spending on health benefits as a percent of total compensation went from 2% to 7% between 1965-1989. At the beginning of that period the amount employers spent on health benefits was only about 15% of average after-tax profits, but by 1989 health benefit costs were actually equal to after-tax profits.

The multitude of conflicting interests in, and positions on, health policy reform within the business community, and even within certain industries, has been a striking feature of the testimony presented to the Texas Health Policy Task Force. The encroachment of health costs on profitability has engendered a new willingness by business to consider health reform, in strong contrast to the hands-off attitude of even a decade ago. But the approaches to reform supported by medium-to-large firms differ markedly from those of small firms. This is mostly due to the fact that all but 8% of the larger firms now provide health benefits, while one-third of small employers have no health plan. Over 90% of large employers have converted to self-insurance, and have discovered first-hand that they lack the market power to slow the annual increase in per capita health costs. Small firms must purchase coverage in a market based on risk avoidance, and must pay overhead costs many times those of large employers. In a recent Louis Harris Poll, 35% of senior executives of large firms preferred mandating employer provision of health benefits over both the current system or a single-payer, national health insurance plan. In contrast, 49% of small business leaders picked the single-payer approach, and just 15% supported an employer mandate.

Of course, within the business community are health care and health insurance related firms whose interests and positions are quite varied. Among insurers there is a rift between the large carriers (many of which are also in the business of administering self-insured plans), and small group and individual coverage carriers. While large insurers generally support market reforms designed to make coverage more accessible, many small carriers (of which Texas has a high proportion) are vehemently opposed to such changes.

Neither is solidarity to be found among health care providers. Among doctors, for example, division of opinion occurs between "generalists" and "specialists." The American Medical Association has endorsed an employer mandate coupled with Medicaid expansion to improve access to financing health care; the proposal makes no recommendations aimed at slowing the growth in health care spending. The American Academy of Family Physicians and the American College of Physicians (internists) have separately endorsed plans that also recommend an employer mandate "pay-or-play" system. However, the family doctors and the internists support national global budgets for health care spending, including uniform negotiated rates for all doctors -- a stand that has been criticized by AMA leadership. Among hospitals, too, there is no unanimity of interests; public, private, and private tax-exempt hospitals all have different tolerances for reforms that may limit their autonomy or profitability.

It is worth noting in this election season that there is a fair amount of bipartisan common ground at the national level in the area of health insurance reforms. Several proposals are found in bills filed by both the Republican and the Democrat leadership. These include small group health insurance market reforms, development of centralized electronic health billing and claims networks, regulation of patient referral practices, and health service price information for consumers -- all of which are recommended in some form by the Texas Health Policy Task Force.

experienced by some groups, but they cannot prevent the double-digit rate increases for all groups that reflect medical care prices that grow twice as fast as wages.

Mandated Benefit Laws. About 20 states have passed laws in recent years that allow health insurers to market, exclusively to small groups, health plans that are exempted (to varying degrees) from state laws requiring the coverage of specific benefits in health policies ("mandated benefits"). It was hoped that the elimination of some benefits (mental health, chemical dependency, and chiropractic coverage were often targeted) might bring health premiums down to a level small businesses could afford.

Limited Impact of Mandate Exemptions. These laws have failed so far to produce significant new coverage of small firms, mostly because the absolute maximum premium reduction to be expected from elimination of mandated benefits (i.e., in states with the highest numbers of mandated benefits) is only about 20%. But annual premium increases of 20% or more have been common for small groups in recent years; thus the reduction attributable to mandate exemption would essentially be a one-time-only savings. Moreover, surveys of small employers who do not provide health benefits indicate that only if premiums are reduced by 50% or more would significant numbers of firms (36-46% of firms) be likely to offer health benefits.

The actual experience of pilot programs using limited benefits to promote small employer health coverage -- most of which use substantial premium subsidies and/or tightly limited health provider networks to further reduce premiums -- has been a maximum market penetration in the most successful project of 17% of previously-uninsured small employers. Because of the limited reductions attainable with mandate exemptions alone, **non**-subsidized small-group products have had to use other means to reduce premiums; these have included very high deductibles and co-insurance, strict limits on doctor visits or days of hospitalization, low dollar caps on annual benefits, and exclusions of pre-existing conditions. Because small employers (and their employees) want coverage that is comparable to that offered by larger firms, enrollment in these plans has been extremely limited.

New Mandates? The Task Force report states that the group could not recommend the deletion of any mandates. It was recommended that immunizations, pap tests, mammography, colo-rectal screening, prostate screening, and children's vision and hearing exams be provided with no deductibles under health plans in Texas. Since mammography is the only service on this list now mandated for inclusion in Texas health policies, the Task Force states that mandating coverage of these benefits "may be necessary."

The debate over the wisdom of mandating coverage of preventive health care services is worth an explanatory note. A number of relatively inexpensive health services (like the ones described above) have been demonstrated to effectively prevent costly future health conditions. **If an insurer were to cover an individual for life, it clearly would be to the insurer's financial advantage to pay up front for preventive services to avoid higher costs later.** In the U.S., however, people are not covered by a single plan for life, so the benefits of preventive services are not likely to accrue to the insurer who pays for them today. Thus, while paying for proven preventive care is the most cost-effective approach to limiting total health spending, the pressure to lower premiums in order to win business will always create a strong incentive for insurers to exclude coverage of those services.

Mental Illness Coverage. Also recommended was the extension to all health insurance of a mandate requiring coverage of treatments for "serious, biologically-based mental illness" (e.g., schizophrenia, bipolar disorder, clinical depression) **comparable to coverage of other major illness.** Under current law the mandate, added in the last legislative session, only applies to group coverage of state agency, state university and college, and local government employees. Such a mandate would certainly have an impact on health premiums, but there is no simple way to quantify that impact. A study by a national employee benefit consultant found that adding unlimited coverage of in- and outpatient mental health

services (from a starting point of no coverage) would add 9% to a typical health premium. The proposed mandate is somewhat less extensive, since it excludes many mental health diagnoses. While the included conditions are often associated with chronic, long-term -- and thus presumably costly -- illness, effective treatment with medication can prevent many hospitalizations. However, to the insurer trying to market an insurance product at the lowest possible price, these potential savings are of little benefit.

Standardized Health Coverage. Several other recommendations also call for reforms of the commercial health insurance marketplace. The first of these would require all health insurers to offer a maximum of five standard health benefits packages, to which other optional benefits could be added, with a 10-year phase-in to a single standard package. The aim of the Task Force is to make it possible for consumers and employers to compare bids from competing insurers on identical products; the current array of different combinations of benefits, co-payments, and deductibles is said to make comparison shopping impossible.

Standardization of health plans is a part of the NAIC small group reforms mentioned before; again, however, the Task Force did not limit its recommendation to small groups. The NAIC model encourages states to establish two baseline health plans, so that one plan can be a lower-cost option. Virtually all proposals for national health reform have also incorporated the standard benefit concept for all groups and individuals. In these, a "standard" plan functions as a lower limit for acceptable health coverage for the majority, but a lower-cost "basic" option is available to the smallest and least profitable employers.

So-called "standard form" health insurance is also promoted by health economists, on the grounds that the lack of standardization of health plans has been a major cause of the market segmentation that has eroded the small group insurance market. A group of economists known as the Jackson Hole Group have developed a "Managed Competition" reform proposal under which all kinds of health coverage could be marketed, but only a defined package of "uniform effective health benefits" would be exempt from taxable income for individuals or deductible as a business expense for employers. Such a change in tax incentives would certainly induce a high degree of uniformity in health benefits. This plan would maintain a private health coverage industry (strongly favoring "bigger players"), but price competition among players in that market would have to be achieved through efficient service, rather than by limiting or eliminating benefits. The uniform health benefits concept is incorporated in the Managed Competition Act of 1992, a health reform bill sponsored by the U. S. House Conservative Democratic Forum.

Electronic Claims and Billing. The Task Force recommends the creation of a central electronic clearinghouse system for health billing and claims, along the lines of the Federal Reserve Bank. A pilot clearinghouse program involving 19 hospitals with over 10,000 beds has been operating in Northeastern New York State since early 1992; doctors, clinics, and other providers will be brought into the project in the next two years. Participating hospitals already report major improvements in the speed with which they are paid, and have been able to make significant reductions (as much as 50%) in their billing staff. Both Democratic and Republican presidential candidates have supported the development of such systems in their respective health reform proposals. Supporters look to these electronic systems to simplify billing and claims and to reduce overall administrative costs for insurers and health providers alike.

FINAL NOTE: THE REST OF THE PACKAGE

The Task Force also recommended a number of changes aimed at health care delivery system development and at health care cost containment. Responsible proposals for increasing access to health care must include cost containment provisions; unfortunately, the problem of health costs has grown so serious in the U.S. that even if nothing were done to improve access, cost containment still would be of critical importance.

The manner in which health care is delivered and paid for in the U.S. is unavoidably bound for major change -- it can no longer support its own weight. However, as a well-known Yale health economist speaking to the Task Force pointed out, there can be no cost-containment in health care without conflict. Health care costs, he explained, are one and the same thing as health care incomes, so constraining health costs requires that someone's income be constrained. So far, few have volunteered to sacrifice potential income for the good of the system.

IN MEMORIAM

Berl E. Godfrey of Fort Worth, died in August. Mr. Godfrey was a League founder, former League Chairman and served on the League's executive committee for many years.

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