

NOVEMBER 2005

TEXAS MEDICAL ASSOCIATION'S  
**HEALTHY VISION**



*Diagnosis & Treatment*



PHYSICIANS CARING FOR TEXANS

©2005  
Texas Medical Association  
401 W. 15th St.  
Austin, Texas 78701  
(800) 880-1300  
[www.texmed.org](http://www.texmed.org)



**HEALTHY VISION | 2010**

November 2005

Dear Fellow Texans,

Ten months ago, the physicians of the Texas Medical Association published the first edition of *Healthy Vision 2010*. We put our stethoscopes to the heart of Texas' health care system, reached a diagnosis, and prescribed a rigorous course of treatment.

Our conclusion: This patient is sick, but not dying. Ten months later, the patient is even sicker, but still not terminal. We remain confident that our prescription for accountability, efficiency, and effectiveness will heal the patient. Our treatment will ensure that the Texas health care dollar is actually spent on health care ... not elsewhere.

We offer this second edition of *Texas Medical Association's Healthy Vision 2010* as the medicine Texas should take to return to physical and fiscal health. We cannot underestimate the stakes. Texans are growing older, fatter, poorer, and less well-educated. Unless we act now, chronic diseases and our unhealthy lifestyles will continue to eat away at our bodies while our desperately underfunded physicians' offices and hospitals crumble at our feet. The number of uninsured will continue to skyrocket, constantly robbing the system of its remaining vitality. The health plans will continue to bleed employers, employees, physicians, and hospitals to boost their profits. Taxpayers will decide they can't afford another dime to care for Texans who are poor or old or have disabilities.

That is not a healthy vision. That is a nightmare.

We can and we must begin the healing today. This will be a long and intensive course of treatment. The prognosis is good, but the patient needs extensive rehabilitation. We must enact changes in our private and government health care programs ... among individual Texans, health plans, employers, doctors, and hospitals ... in Austin and Washington.

The physicians of Texas invite our state's political and economic leaders to join us at the table as we search for the cure. We must be creative, brave, and innovative as we devise ways to make health care and health insurance affordable for Texas families, businesses, and taxpayers. We must encourage Texans to take better care of themselves – and take more responsibility for their health. We must improve patient safety, make life- and dollar-saving health care information technology readily available to physicians and patients, and bring some sense to the extraordinarily expensive and often very painful final days of our lives.

Early in 2006, the Texas Medical Association will convene a Texas health care summit. We'll bring together the thought leaders and the decision makers, all the stakeholders, to search for common ground. Surely, we won't agree on all of the solutions, on all of the treatments we recommend as part of *Healthy Vision*. But just as surely, we must all agree on the need to dismiss the status quo and move forward. We have no choice but to reject the nightmare scenario and embrace a healthy vision for the future.

We cannot underestimate the stakes. A healthy Texas depends on healthy Texans. A healthy Texas economy depends on a healthy Texas workforce. A healthy Texas tomorrow depends on healthy children today.

Healthy Texans depend on a robust health care system – healthy physician practices and hospitals. Healthy Texans depend on making healthy lifestyle choices and informed health care decisions.

The 41,000 physician and medical student members of the Texas Medical Association are dedicated to improving the health of all Texans. Since 1853, TMA has worked to advance professional standards, enhance the public health, and enable physicians to concentrate on applying the wondrous power of their healing hands.



**“We cannot underestimate the stakes. A healthy Texas depends on healthy Texans. A healthy Texas economy depends on a healthy Texas workforce. A healthy Texas tomorrow depends on healthy children today.”**

**Robert T. Gunby Jr., MD  
TMA President**

**HEALTHY VISION | 2010**

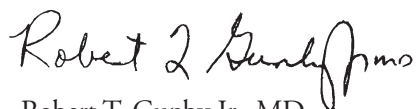
As physicians, our primary concern is promoting health. We stand for and support:

- What's good for the health of our patients,
- What's good for the physical and fiscal health of Texas, and
- What's good for the health of the health care system.

We encourage you to study this second edition of *Texas Medical Association's Healthy Vision 2010*. Read the details of our diagnosis and treatment plan. Discuss them with your doctor, your legislator, your friends and colleagues. Demand accountability, efficiency, and effectiveness.

Do not underestimate the stakes. A healthy Texas depends on healthy Texans.

Sincerely,



Robert T. Gunby Jr., MD  
President  
Texas Medical Association

P.S. I must express my sincere gratitude to the physician leaders and staff of the Texas Medical Association for the hours of research and analysis that went into this document. As physicians, we know the difficulty that often comes with accurately diagnosing disease and devising the appropriate treatment regimen. This "patient" deserves – and has received – our very best work. Thank you very much.

## Principles for Healthy Vision 2010

### **Rx Accountability**

**The Texas Medical Association supports:**

- The highest professional ethics in caring for patients.
- Empowering patients to take more responsibility for their health.
- Promoting continuous patient safety improvements.
- Assuring that physicians and their patients have the sole authority to make health care decisions.
- Promoting physician accountability and connectivity.

### **Rx Efficiency**

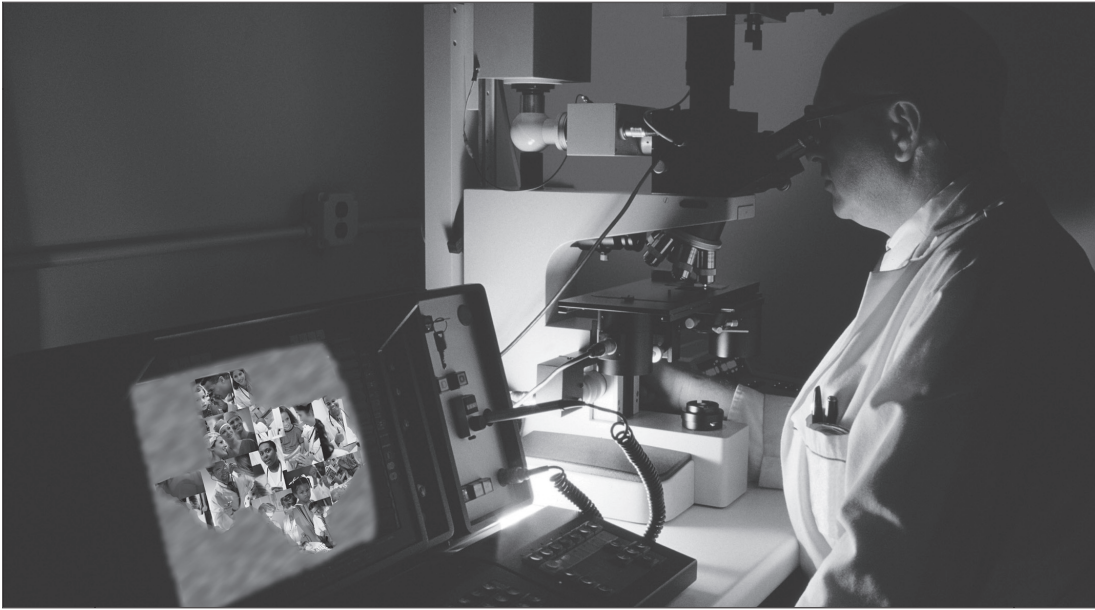
**The Texas Medical Association supports:**

- Making affordable health care available to all using multiple funding sources.
- Creating value in the health care of our patients.
- Eliminating excess administrative costs.
- Protecting the economic viability of physician practices.
- Using health care information technology to improve the quality of care.

### **Rx Effectiveness**

**The Texas Medical Association supports:**

- Investing in prevention.
- Providing an appropriate and enduring medical home for every patient.
- Providing portable and non-discriminatory basic health coverage for all Texans.
- Providing clinically appropriate medical care based on sound medical science.
- Promoting a team-based approach to safe and effective health care delivery.
- Investing in the public health infrastructure.



## THE DIAGNOSIS

### What Is Happening to Texans

Over the next 35 years, demographers project changes in our state's population that will significantly increase the demand for health care and strain our ability to pay for it:

- **Our population will grow rapidly.** In 2000, Texas was home to nearly 20.1 million residents. By 2010, that number is expected to reach 25.4 million; it could surpass 45 million by 2040.<sup>1</sup>
- **We are getting older.** In 2000, 9.9 percent of Texans were 65 and older; by 2040, 18 percent of the population will be that old. In 2000, 20.2 percent of the population was 45 to 64; by 2040, 23.6 percent of the population will be in that age range.<sup>2</sup>
- **We are putting on weight.** In 2000, 3.5 million Texas adults were obese; an additional 5.5 million were overweight. By 2010, those numbers are expected to rise to 5.1 million obese and 6.8 million more overweight. If that trend continues, almost three-fourths of the adult population could be overweight or obese by 2040.<sup>3</sup>
- **Our children are putting on weight.** Overall, some 35 percent of Texas school-

age children are obese or overweight, one of the highest rates in the nation. Among our fourth graders alone, more than one in five are overweight, a rate nearly 50 percent higher than the national average.<sup>4</sup>

- **We are growing poorer.** The U.S. Census Bureau ranks Texas seventh among all states in the percent of residents living in poverty. In 2000, the share of Texas households living in poverty was 14.4 percent. Forty years later, that figure will grow to 16.6 percent.<sup>5</sup> That 15-percent increase will further strain many Texans' already inadequate ability to pay for their health care.
- **We are becoming less well-educated.** An ever-growing share of Texas workers will lack high school and college degrees. Because education closely correlates with earnings and eligibility for employee benefits, more Texas households will live in poverty, without health insurance. Both the sheer number and the share of uninsured Texans will increase.

Medically, these demographics predict an onslaught of preventable disease, particularly diabetes, heart disease, and stroke; the first wave of this onslaught already has arrived.



In 2000, 15,000 of the 944,000 Texans with diabetes died of the disease. Texans as young as 6 years old are being diagnosed with Type II diabetes, a disease that used to be called “adult onset” diabetes.<sup>6</sup> Nationally, Type II diabetes accounts for approximately 45 percent of newly diagnosed cases in children, most of whom are obese.<sup>7</sup>

By 2025, as many as 47,000 Texas children may suffer from Type II diabetes. By 2040, the number of diabetic Texans is projected to exceed 2.4 million. In 2001, 43,192 Texans died of heart disease and another 10,612 died of stroke, both of which are, like diabetes, frequently related to obesity.

In Texas in 2001, the cost of all obesity-related illnesses exceeded \$10 billion. That included \$4.2 billion in direct health care costs and more than \$6.2 billion in lost productivity and wages due to illness and death. If current population growth trends continue through 2040, state health officials predict this cost will nearly quadruple to \$39 billion.<sup>8</sup>

## What Is Happening in Physician Practices

As physicians, we share the credo that the best, least-expensive, and most-effective response to illness is prevention. At the same time, we find ourselves trapped in a health care financing system driven primarily by the imperative of cutting expenditures today with little concern for the cuts’ impact on tomorrow. Virtually every private sector and governmental health program has contributed to this dilemma.

But the dominance of for-profit managed care (HMOs and PPOs) in the health insurance marketplace has generated major changes in medical practices. The primary drivers have been a steadily shrinking list of covered benefits and strict utilization controls. On the demand side, the aging of the population and expensive new technologies are geometrically increasing the costs of care – and will do so into the foreseeable future.

This deadly combination is rapidly driving up both the cost of medical coverage and the number of Americans without insurance.

## Summary

Preventable diseases will significantly increase morbidity and mortality for children and adults, and financial costs for all contributors to the health care system, over the next few decades.

- Texas is the uninsured capital of America. The uninsured pay the physical price; all of us pay the fiscal price. Roughly half the cost of caring for this huge portion of the population is borne by taxpayers, employers that offer health insurance benefits, and families that pay health insurance premiums.
- The constraints and demands of managed care have increased administrative expenses and paperwork that distract from patient care. Health plans’ payment practices and government budget constraints have reduced physicians’ revenue and damaged patients’ access to care.
- As Americans spend more and more on health insurance, the share of each dollar devoted to care decreases and the portion that goes into managed care’s pocket increases. Health insurance companies saw a 10.7-percent increase in profits in 2004, continuing a longstanding trend.



In 2000, 69 percent of all U.S. employers offered health coverage; in 2005, only 60 percent offered it. In 2005, the cost of employer-based health insurance for a family of four averaged \$10,880, more than the entire earnings of a full-time minimum wage worker (\$10,712).<sup>9</sup>

For physicians, managed care has resulted in increased administrative expenses, administrative requirements that distract and detract from patient care, and decreased revenue.

The administrative costs of running a practice have increased dramatically. On average, practices have twice the number of non-clinical staff members as they had in 1982. The primary reason for this growth is the increased difficulty of obtaining payment from managed care plans. While the rapid growth in nonclinical office staff has slowed since 2000, the Medical Group Management Association reports that physicians' overall operating expenses have continued to increase at almost twice the general inflation rate.

Physician reimbursement is deteriorating. Both public and private sector payers are reducing fees in inflation-adjusted dollars. In 2004, Medicare's 1.5-percent increase was less than the rate of inflation. Absent congressional action, physicians' Medicare fees are scheduled to fall by 4.4 percent in 2006 and a cumulative 26 percent over the next six years. In 2003, Texas reduced the size of its Children's Health Insurance Program (CHIP) and cut Medicaid fees. Medicaid and CHIP payments for Texas physicians now cover less than half the average cost of care. The average Texas family practice physician loses about \$50,000 per year in uncompensated care for Medicaid patients. For many other specialties, in rural Texas, and along the Texas-Mexico border, this figure is even higher. Workers' compensation fees were slashed by 17 to 41 percent for surgeons, radiologists, pathologists, internists, and physical medicine specialists who treat injured workers. The impact of Texas' 2005 workers' compensation system reconfiguration has yet to be determined.

Practice viability is in crisis. Managed care plans do not publicly announce their fee schedules, but all indications suggest that a downward trajectory continues in that arena.

- Despite the passage of prompt payment laws in 1999, 2001, and 2003, Texas physicians continue to struggle to get paid even deeply discounted fees for patient care. More than two-thirds of Texas physicians report slow payment and related cash-flow problems due to third-party payer policies. Nearly half of those doctors have had to draw on personal funds, or secure loans or lines of credit to cover practice expenses.
- Primary care practices have been particularly hard hit. Pediatricians, for example, have seen practice operating costs increase 74 percent since 1995, driving higher prices for patients, but revenues during that time period have increased by less than 50 percent.

The percentage of the insurance premium dollar devoted to health care continues to decline. While the rate of growth in per-capita health care spending has slowed in the past few years, bills for health insurance premiums continue to grow dramatically. The cost of employer-sponsored health insurance is forecast to increase by 9.9 percent in 2006, more than triple the general inflation rate. Employees' share of premiums and their out-of-pocket expenses will jump by about 11 percent.<sup>10</sup>

As Americans spend more and more on health insurance, the percentage of each dollar devoted to care decreases while the percentage of each dollar that goes into managed care's pocket increases.

- Private health insurance administrative costs have increased from \$85 per person covered in 1986 to \$421 in 2003. (See Figure 1.) From 1998 to 2003, health plans' administrative costs per enrollee nearly doubled.<sup>11</sup>
- The six largest health plans covering Americans have been steadily chipping away at





the percentage of premiums the plans actually spend on medical care: their commercial medical loss ratios. These plans reduced their medical loss ratios an average of more than 4 percentage points between 2001 and 2002.

- In total, 84.8 cents of every premium dollar paid for actual care in 2000. That declined to 81.5 cents in 2003.<sup>12</sup>
- Even these figures underestimate the true share of the premium dollar that is actually paying for patient care. The Texas Department of Insurance found that health plans frequently do not count as administrative costs such expense items as utilization review, internal and external appeals processes, records maintenance, supervisory and executive duties, and supplies and postage.
- The decline of the medical loss ratio raises questions about the rapid escalation of insurance premiums. Clearly, health plans have the power to raise their customers' premiums and reduce payments to those who actually provide medical services. The consolidation of the health insurance industry has increased the surviving plans' market power. By 2004, 26 health insur-

ance groups covered 1 million enrollees; they accounted for two-thirds of the total national health insurance rolls.<sup>13</sup>

Health insurance companies, meanwhile, are coming up with new and better ways to profit at physicians' and patients' expense.

- Many health plans do not create adequate provider networks, especially among hospital-based physicians such as emergency physicians, radiologists, anesthesiologists, and pathologists. This leaves enrollees stuck with both expensive insurance premiums and unexpected medical expenses for out-of-network services. At the same time, the insurance companies reap a profit from creating inadequate networks of care. They shift the financial risk of an inadequate network to patients. And they try to shift the "moral risk" to physicians, who are ethically and legally required to provide emergency care regardless of insurance coverage. The plans defend their inadequate networks by trying to prevent out-of-network physicians from billing their patients. They also try to pass laws

**Figure 1. Private Health Insurance Administrative-Related Cost Per Person Covered, 1986-2003**



establishing government-imposed price controls based on arbitrary reimbursement rates set solely by the plans.

- Several of the largest health plans in Texas are implementing tiered physician networks. Physicians are placed in a network tier based on how they rank against the insurers' evaluation scheme. Those who score high enough are placed in a preferred network tier that offers enrollees a lower copay. Those physicians scoring lower get shunted into a tier with higher copays. Most health plans claim that they create tiered networks by analyzing billing data and that they adjust that data to ensure cost-effective and efficient patient care. However, none of the adjustments in use capture quality of care; they are based solely on the cost of care. Low cost care is not necessarily effective care. Tiered networks may encourage underutilization and undertreatment. They often interfere with patients' ability to choose their physician and disrupt the patient-physician relationship. Patients and employers are left with the mistaken impression that tiers are created to regulate quality of care, but in actuality, they only lower the insurance plan's expense.

Physicians' long-time health care allies, the hospitals, also are caught in the financial vise between declining reimbursements and rising costs. Physicians, hospitals, and other entities have invested extensively in new lifesaving technologies and treatments, and in new settings in which patients receive health care. Studies demonstrate positive outcomes from and strong patient satisfaction with health care provided by physician-owned facilities. But rather than encourage what little remains of competition in the health care sector, many hospitals now actively oppose physicians' ability to refer patients to facilities where they have an ownership interest – regardless of medical necessity or patient convenience. Referrals to physician-owned entities or services must be based on the patient's medical needs, as determined by accepted utilization and quality-of-care standards. Physicians

must disclose to patients any relevant ownership interest and adhere to applicable ethical guidelines.

Over the years, government regulatory programs have steadily added to the cost of care. Physicians must submit electronically all Medicare claims on behalf of their patients. They must meet complex government standards to continue to provide many simple lab tests in their offices. They must appoint a fraud compliance officer and a privacy officer. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has required physicians to make expensive upgrades to their billing systems to continue transmitting their claims and insurance inquiries electronically.

In short, Texas physicians are caught between relentlessly increasing costs and steadily decreasing revenues. Unfortunately, this scenario discourages physicians and patients from taking the long view of their health. As employers shift from one insurance company to another every few years, patients tend to shift from one physician to another to stay within a network. This is a further impediment to developing strong patient-physician relationships.

## What Is Happening in the Health Care Financing Systems

### *The Uninsured*

In 2004, 56 percent of Texans 65 and younger had health insurance through their own or a family member's job, well below the U.S. average of 63 percent. Texas, sadly, now leads the nation in the percent of uninsured adults, number of uninsured working adults, percent of uninsured children, and number of uninsured children.<sup>14</sup>

The uninsured are up to four times less likely to have a regular source of health care and are more likely to die from health-related problems.<sup>15</sup> They are much less likely to receive



## What Health Care Means to Texas' Fiscal Health

Health care is a vital component of the Texas economy, generating tens of billions of dollars in revenue each year and providing hundreds of thousands of jobs. For example, the 42 hospitals and other institutions that compose the Texas Medical Center (TMC) in Houston have a combined annual operating budget of \$5.4 billion and employ more than 61,000 people.<sup>16</sup> Indirectly, TMC generates some \$13.5 billion for the Houston economy, according to the medical center's 2003 statistics.

Meanwhile, health care is one of Texas' largest employers. And it is one of the fastest growing. Employment in health services represents 6.9 percent of the job market and 7.2 percent of total worker earnings in Texas.<sup>17</sup> In 2005, hospitals, physicians' offices, medical and dental laboratories, home health care providers, and other health facilities provided some 866,900 jobs in Texas. The Texas Workforce Commission (TWC) says employment in the ambulatory care sector, which includes physician offices and other outpatient services, is growing the fastest, at 3.7 percent per year.<sup>18</sup> Private sector health care services employed more than 862,000 Texans in 2001, with a combined annual payroll exceeding \$32 billion. Texas state and local governments employed another 125,900 health and hospital workers, with an annual payroll of \$3.8 billion.

Allopathic and osteopathic physicians alone employed almost 133,000 people in 2000. That will grow by roughly one-third, to nearly 176,000 by 2010. TWC ranks offices and clinics of medical doctors, osteopathic physicians, and other health care practitioners as three of the 15 fastest-growing industries in the state.<sup>19</sup>

A healthy and viable medical system is vital for Texas' continued economic development. Without a healthy and educated workforce or ready access to high-quality medical care, the state cannot attract new industries and employers. Unfortunately, many areas of Texas suffer from a lack of health care professionals and health care infrastructure. And millions of our residents find accessing medical care a challenge because they are uninsured or underinsured.

Although health care collectively is big business, individual physician practices are small businesses – mostly very small and often struggling. About 40 percent of Texas physicians are solo practitioners; another 25 percent are in small groups of two to six physicians. These small practices each employ four to five additional workers per physician and have large overhead expenses. In recent surveys, two-thirds of Texas physicians report having trouble covering payroll and other practice expenses because of difficulties in collecting timely or adequate payment from insurers and government payers.

needed medical care, even for symptoms that can have serious health consequences if not treated.<sup>20</sup> About one in six Texans lives at or below the poverty level; for children, it is nearly one in four. Extending health coverage to the uninsured could improve their overall health by 7 to 8 percent.<sup>21</sup> Lack of insurance increases their dependence on Medicaid.

Lacking a medical home, uninsured people tend to look for health care in the emergency room, the most expensive setting they could possibly choose. Nationally, patients made 108 million emergency room visits in 2000, up 14 percent from 1997. The National Center for Health Statistics estimates that non-emergencies account for one in 10 of those emergency room visits.<sup>22</sup>

Using Medicaid payment rates and data on Medicaid patients' unnecessary emergency room visits, the Legislative Budget Board estimates that a condition that could be treated in a doctor's office for \$56.21 (including lab and x-ray) costs \$193.92 in the emergency room. (See Figure 2.) National studies back up that data, finding, for example, that the charge for treating an ear infection in the emergency room is \$170 versus \$55 in a family physician's office.<sup>23</sup>

While physicians' Medicaid reimbursement for even simple cases is far less than half the cost of providing care, they frequently treat uninsured patients for far less – even free. Texas Medical Association surveys show Texas physicians provide about \$1 billion in charity care each year.<sup>24</sup>

Taxpayers, Texans with insurance, and employers who offer health benefits also pay extra for caring for the uninsured. Families USA estimates the total cost for Texas in 2005 to be more than \$9.2 billion. Of that:

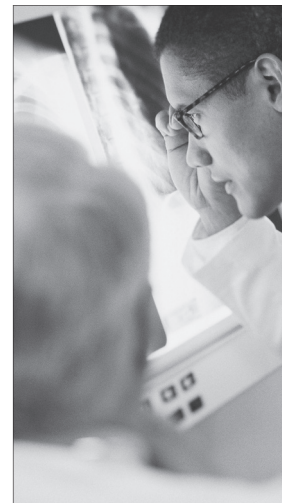
- The patients and their families pay about half (\$4.6 billion);
- Government health programs pay one-sixth (\$1.6 billion); and
- Those with private health insurance subsidize the remaining third (\$3 billion).<sup>25</sup>

In 2000, the 11 trauma centers in the Houston-Galveston area provided \$39 million in care to uninsured trauma patients. The hospitals lost more than \$2,500 for every trauma patient they admitted; losses on some patients exceeded \$200,000.<sup>26</sup> To cover these costs, hospitals charge insured patients higher prices, which in turn drives up insurance premiums. In what Families USA calls a “vicious cycle,” those increased costs are added to already-rising health insurance premiums, leading more employers to drop coverage, and leaving even more people without insurance. That further adds to premiums for the insured and further boosts the rolls of the uninsured.

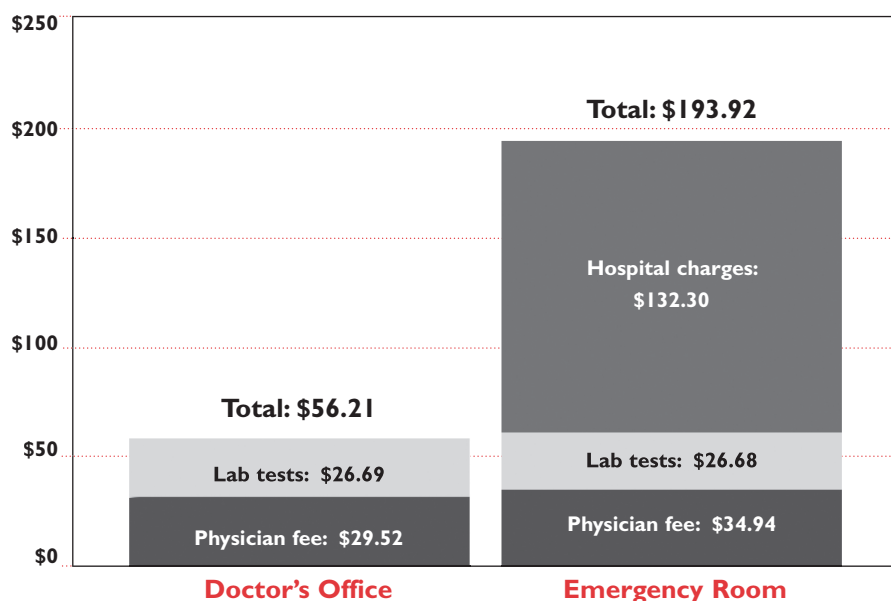
In 2005, typical premiums in the United States for family health insurance coverage provided by private employers include an extra \$922 due to the cost of care for the uninsured. In Texas, home of the greatest percentage of uninsured in America, that figure is \$1,551. By 2010, the national average will catch up to Texas’ current figure; by then, the annual cost per Texas family will soar to \$2,786.<sup>27</sup> Two-thirds of the uninsured

Texans of working age are employed. These employed but uninsured are particularly likely to work in small firms. Across the country, the percentage of firms with fewer than 200 employees providing health coverage to their workers decreased from 69 percent in 2000 to 60 percent in 2005.<sup>28</sup>

Smaller employers are the largest generators of new jobs today, and the Texas economy consists disproportionately of small companies. Therefore, these companies need access to reasonably priced health insurance for their employees if we are to reduce the state’s large uninsured population. Smaller employers have no leverage in the health insurance marketplace. They are more vulnerable to insurers who refuse to renew, or insist on huge premium increases because of one employee’s expensive illness. Even in small firms that offer insurance, the employer-paid subsidy may be too small to allow lower-paid workers to purchase coverage for themselves and their families. Resolving these problems will require some creative approaches to allow smaller employers more affordable access to insurance markets.



**Figure 2. The Excess Cost of Treating a Non-Emergency in the ER, Based on Medicaid Payments**



Source: Legislative Budget Board, 2005





### *The Private Sector*

The one essential fact of our current health care financing system is that every major stakeholder in the financing system is unhappy – except the for-profit managed care plans.

Why are these plans happy? In a word, profits. U.S. HMOs saw a 10.7-percent increase in profits in 2004, continuing a longstanding trend.<sup>29</sup> The nation's 17 largest health plans saw their average profits rise from \$193 million in 2000 to \$414 million in 2003. In the same period, they:

- Decreased their payments for health care services from 84.8 percent of every premium dollar to 81.5 percent,
- Increased their premiums by 60 percent, and
- Doubled their profit margins to 5 percent.<sup>30</sup>

Average pay for the five top executives at 16 of those insurers almost doubled, from \$1.6 million to \$3 million each. Stock options added millions more.

Just what value do Texans receive for the large rewards we have given these companies, their senior managers, and their stockholders? In aggregate, these 17 managed care companies' profits exceeded \$7 billion in 2003. Texans constitute roughly 8 percent of the U.S. population. If we allocate those profits proportionately, the plans have siphoned 560 million Texas dollars away from clinical care.

Moreover, the finances of for-profit managed care plans constitute only a partial portrait of the inefficiencies that the health plans foster in the delivery system. Medical practices have seen their administrative expenses grow to pay for employees added to navigate physicians' clinical and economic relationships with managed care plans. In 1982, before managed care became the dominant delivery system, practices had, on average, two nonclinical employees per physician; today, the average is four to five per physician. These are extra employees who deal with the hassle factors that come with managed care

contracts: long-unpaid claims, lost claims, inexplicable interpretations of the claims coding systems. Even today, these workers' job description includes begging the plans on behalf of patients for inpatient hospital stays and for other medical services the plans claim are overutilized. Hospitals, other institutions, and other health care practitioners tell much the same story about the parasitic, bureaucratic requirements that managed care organizations impose on them and their patients.

### *The Public Sector*

The two primary government health care financing programs, Medicare and Medicaid, face significant financial problems, although Medicaid's are much more immediate. Texas physicians realize Medicaid and CHIP must become more effective, efficient, and accountable, but not at the expense of the programs themselves. They are vital to the health and well-being of the state's poor and low-income families and to the economic vitality of the state and local governments.

Medicaid costs are growing more slowly than private health insurance, 6.9 percent versus 12.9 percent (Kaiser). But with 3 million Texans insured via the program, even modest cost growth is rightly worrisome to lawmakers. Medicaid costs are driven by the same factors as health care costs generally: an older, sicker population, and better and more expensive medical technology and pharmaceuticals. Growing caseloads and the expense of caring for the elderly and patients with disabilities also boost Medicaid's price tag.

With strong backing from organized medicine, the 2005 Texas Legislature restored needed Medicaid benefits and services that lawmakers cut in 2003. These included coverage for vision, mental health, and podiatric services for the elderly and adults with disabilities. The legislature did not reinstate funding cut from physician and provider reimbursements, Medicaid-funded graduate medical education, or the medically needy program.

## The Economy of Prevention

Employees' poor health takes an enormous toll on the fiscal health of American business. From spring 2004 to spring 2005, health insurance premiums rose an average of 9.2 percent for almost every market segment and company size, ranging from mom-and-pop businesses to corporate giants. Since 2000, premiums for family coverage have increased by 73 percent, compared with general inflation of 14 percent and wage growth of 15 percent.<sup>31</sup>

Well-designed and well-executed health promotion programs can pay for themselves by reducing health risk factors and improving health and productivity.<sup>32</sup> In 2002, Johnson and Johnson published the results of the first long-term evaluation of the financial and health impact of a large-scale corporate health and wellness program. Savings came from reductions in hospital admissions, mental health visits, and outpatient services. Savings grew over time, and most came in the third or fourth year after program inception. The bottom line: \$225 saved per employee per year.

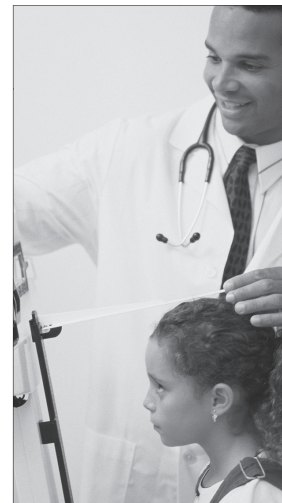
And the results are getting better. The average cost-benefit ratio has increased from 1:3 for earlier programs to 1:6 today.<sup>33</sup>

### *Tobacco and Obesity*

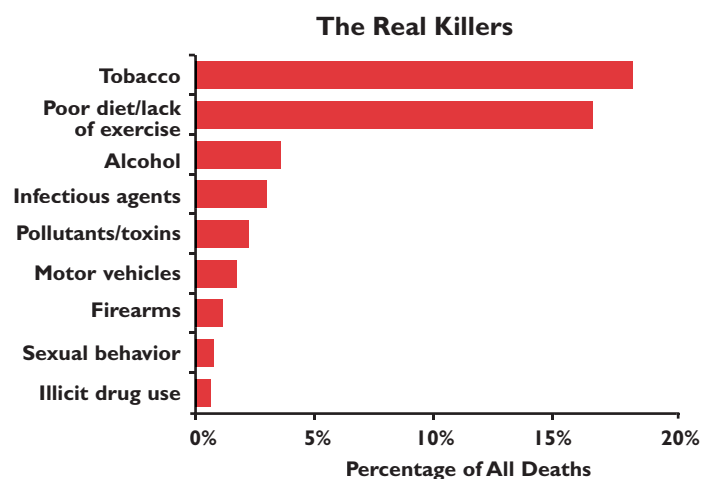
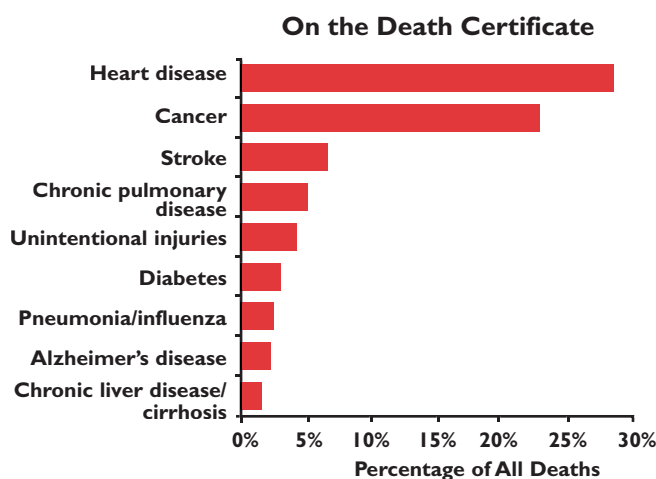
Heart disease, cancer, and stroke may be the most common causes listed on death certificates. The worst real killers, though, are tobacco, poor diet, and lack of exercise.<sup>34</sup> (See Figure 3.)

Tobacco use is the major cause of preventable death in Texas and the United States, with more than 400,000 related deaths each year.<sup>35</sup> Annual medical and economic costs attributable to active smoking in the United States are \$150 billion, according to the Centers for Disease Control and Prevention (2002). The annual costs of excess medical care, mortality, and morbidity caused by second-hand exposure to tobacco smoke exceed \$10 billion.<sup>36</sup>

More than 61 percent of Texas adults and 35 percent of Texas school-age children are considered overweight or obese.<sup>37</sup>



**Figure 3. Top Causes of Death**



Source: National Vital Statistics Reports, Vol. 53, No. 17, March 7, 2005. Accessed October 2005 at [http://www.cdc.gov/nchs/data/dvs/nvsr53\\_17tableE2002.pdf](http://www.cdc.gov/nchs/data/dvs/nvsr53_17tableE2002.pdf)

Source: Mokdad AH et al. Actual Causes of Death in the United States, 2000, JAMA, 2004;291:1238-45



The obesity epidemic hurts our schools and workplaces through absenteeism and lost productivity. An average-size school district could lose \$95,000 in state aid per year due to the rate of absenteeism among overweight students.<sup>38</sup> At least half of worksite health care costs are driven by lifestyle-related behaviors, such as smoking, poor diet, and lack of exercise.<sup>39</sup> In all, an estimated \$10 billion is spent annually on health care in Texas due to obesity; by 2040, that cost is projected to reach \$39 billion.<sup>40</sup>

### *Immunization*

Vaccines are among the greatest public health measures we have, particularly against life-threatening diseases in children. The direct and indirect savings of commonly used vaccines range from \$2 to \$24 per dollar invested, according to the National Immunization Program, Centers for Disease Control and Prevention (2004).

According to the Texas Department of State Health Services, pertussis (whooping cough) has killed more than 26 Texans since 1999, mostly infants too young to have received the vaccine; six of those were babies who died in the first nine months of 2005. The World Health Organization estimates that the annual cost of influenza epidemics to the U.S. economy is \$71 billion to \$167 billion.

Texas is currently 48th in the nation in childhood immunization rates.<sup>41</sup> Part of the reason for this dismal performance is that physicians and health officials have no way of knowing which children have been immunized. Additionally, recent media coverage questioning vaccine safety has made parents fearful of immunizing their children. Confusion resulting from changes in the recommended immunization schedule also has contributed. In recent years, sporadic vaccine shortages have compounded the problem.

Physicians face steep financial disincentives to provide immunizations. Reimbursement

is inadequate. The total cost of administering vaccines, per shot, is \$10.67 for pediatric practices and \$7.57 for family practices.<sup>42</sup> The current reimbursement rate in Texas for vaccine administration is \$5. Newly recommended vaccines have become increasingly expensive. Physicians must purchase those vaccines for people who do not qualify for the Vaccines for Children program and for those whose health plans do not cover the immunizations.

### *Mental Health and Alcohol and Substance Abuse*

According to the National Institute of Mental Health, untreated mental illness costs the United States \$300 billion each year; untreated depression alone is responsible for \$40 billion of that. The American Psychiatric Association (2005) asserts that mental health treatment can more than pay for itself in terms of increased worker productivity; untreated psychiatric illnesses exacerbate chronic conditions like arthritis, asthma, and diabetes, thus increasing potentially avoidable visits to primary care physicians.

Alcohol and substance abuse pour additional stress onto our already-burdened medical system in Texas. Most people with untreated alcoholism require more general health care, including treatment for illness and injury. Their health care costs are at least 100-percent higher than for people who do not have alcoholism. Untreated alcohol problems waste \$184.6 billion per year in health care, business, and criminal justice costs, and cause more than 100,000 deaths, according to the National Institute on Alcohol Abuse and Alcoholism (2000).

Underage drinking costs \$3.7 billion a year for medical costs due to traffic crashes, violent crime, suicide attempts, and other related consequences. The total annual cost of alcohol use by underage youth is \$52.8 billion.<sup>43</sup>

**Border Health Bordering on Disaster**

The U.S.-Mexico border region is an area of tremendous human interaction where two countries and two cultures meet and flow across a porous international boundary. The border stretches approximately 2,000 miles from the southern tip of Texas to California, and comprises six Mexican states as well as California, New Mexico, Arizona, and Texas. The U.S.-Mexico Border Health Commission reports that approximately 13 million people live along the border; by 2025, the population is expected to double. The region has experienced recent annual growth rates of 2 to 5 percent.

The border is a dynamic region whose population exhibits alarming adverse health and social conditions. (See Figure 4.) The border is medically underserved, its residents oftentimes uninsured. If it were to be made the 51st state, the U.S.-Mexico border region would rank:

- Last in per-capita income,
- Last in access to health care,
- Second in death rates due to hepatitis,
- Third in deaths related to diabetes,
- First in the number of schoolchildren living in poverty, and
- First in the number of children who are uninsured.<sup>44</sup>

The federal government classifies every county along the border (wholly or in part) as medically underserved. The number of primary care physicians there falls far short of meeting the needs of border patients. In the cities, the number of primary care physicians per 100,000 patients is about 12 percent lower along the border than in the rest of the state. In nonmetropolitan areas, the border is nearly 18 percent lower. And Texas as a whole trails the national average by more than 18 percent.<sup>45</sup>

Physicians practicing along the U.S.-Mexico border are besieged by a

“medical practice perfect storm.” Their practices depend disproportionately on government payers, with few privately insured patients to offset narrow margins. Their patients typically exhibit more severe and complex medical needs.

The general health of the border closely resembles that of an underdeveloped country in that the region is plagued with diseases affecting third-world nations. These are diseases that virtually have been eradicated in Europe and the vast majority of the United States.

The Texas-Mexico border is the gateway to our state. Not only does the border serve as a portal for the state's continued economic development and international commerce, it also provides an opening for the spread of deadly, contagious diseases such as tuberculosis, diphtheria, and hantavirus. Investment in the border health care delivery system is an investment that benefits all Texans.

**Figure 4. Eleven Texas Counties – Bordering on Disaster**

County	Population (2003)	Unemployment Rate (2003)	Poverty Rate (1999)	Uninsured Rate (2002)	Medicaid Enrollees (Sept. 2005)*	CHIP Enrollees (Sept. 2005)*
<b>Brewster</b>	9,058	2.4%	18.2%	30.6%	937	70
<b>Cameron</b>	358,644	11.8%	22.9%	32.6%	92,856	7,736
<b>Culberson</b>	3,094	9.1%	25.1%	34.3%	532	60
<b>El Paso</b>	714,326	10.2%	23.8%	32.1%	140,125	14,017
<b>Hidalgo</b>	619,383	15.5%	36.2%	33.3%	168,392	17,178
<b>Hudspeth</b>	3,483	9.0%	35.8%	37.2%	600	59
<b>Jeff Davis</b>	2,242	1.7%	15.0%	27.4%	231	26
<b>Presidio</b>	7,591	28.2%	36.4%	37.4%	1,992	101
<b>Starr</b>	57,257	22.0%	50.9%	36.7%	19,287	1,470
<b>Webb</b>	211,430	7.8%	31.2%	32.6%	50,426	5,326
<b>Willacy</b>	20,768	21.0%	29.9%	33.4%	5,780	438

Source: All figures U.S. Census Bureau, except: \* Health and Human Services Commission; Research and Forecasting. Accessed October 2005 at <http://www.hhsc.state.tx.us/research/dssi.htm#pov>

# HEALTHY VISION



## THE TREATMENT: ACCOUNTABILITY, EFFICIENCY, AND EFFECTIVENESS

Unless we act swiftly, the ailments plaguing our health care infrastructure today will overwhelm the delivery system tomorrow. The road ahead will be rocky and rutted. Some of our actions will not deliver on their promise for years to come; others are essential first steps along the path to health.

Our goal is simple to define: All Texans must have ready access to affordable, high-quality medical care. But a future of good health lies far in the distance. Many with vested interests in today's dysfunctional system will try to erect roadblocks and send us on detours. Most Texans are unaware of the danger we face; few can see clearly enough to take even the first step with confidence.

The physicians of Texas strongly believe that the intertwined triple guideposts of accountability, efficiency, and effectiveness will set us on the road to good health – and keep us moving in the right direction when we falter. *Texas Medical Association's Healthy Vision 2010* is our prescription for a state for which we care and a people to whom we have

devoted our lives and our careers. In the long run, this will cure what ails us.

**Accountability.** Physicians and our patients, hospitals and other health care practitioners, health plans and government agencies all play vital roles in maintaining and improving the health of the people of Texas. Accountability demands that we all take responsibility for those roles, reap the rewards when we fulfill them, and pay the price when we do not.

- Physicians must continue to develop and follow science-based care plans for our patients and for adhering to our professional ethics.
- Patients must understand the financial and medical consequences of their lifestyle choices and their health care decisions.
- Employers must recognize that short-term investments, such as workplace wellness plans, can become long-term benefits in their employees' health, productivity, and health care cost containment.
- Commercial health plans must stop short-changing the employers, employees, and taxpayers who purchase their products – as

well as the doctors and hospitals who provide critical professional services.

**Efficiency.** For two decades, miraculous new technologies and medicines – combined with our aging population's demand for more and better care – have pushed health care costs well ahead of the broader inflation rate. Frankly, health care is too precious, too extensive, and too vital for Texans to allow a single dollar to be wasted. We must devise and implement incentives to eliminate or streamline those activities that do not contribute to better health.

- As President George W. Bush and his team have noted, significant investment in new information technology is imperative. Electronic health records can improve the quality of care, enhance patient safety, streamline physician office operations, reduce redundant services, and save billions of dollars each year. These systems are extremely expensive, however, and physicians won't be able to implement them if they must bear the cost burden of these new technologies alone.
- We must allow those who buy health care services – either indirectly through insurers or directly from doctors and hospitals – to reap the benefits of the marketplace, constrained as it is. As mass purchasers, government and employers need the tools to better evaluate what they are buying and to demand a more valuable bang for the health care buck.
- We must minimize administrative burdens for the great majority of routine care and for physicians and providers who have proven they operate within acceptable parameters.
- We must develop a more sophisticated system of health care delivery that consistently dedicates adequate resources to the comprehensive care management of patients with chronic and complicated medical needs who need and use more health care services.

**Effectiveness.** From the individual patient's subjective notion of "feeling better" to broad reductions in disease prevalence among an entire population, the goal of health care

## Summary

All Texans must have ready access to affordable, high-quality medical care. But that picture of good health is distant and cloudy. The physicians of Texas strongly believe that the intertwined triple guideposts of accountability, efficiency, and effectiveness will set us on the road to good health.

### Goal #1: Accessible and Affordable Health Care for All Texans

- Texas' health professionals must collaborate with the business community, public and private payers, employers, and employees to devise and test initiatives that make health insurance companies offer coverage that is more broadly accessible, affordable, and portable.
- Texas must direct more of our precious health care dollars into direct patient care.
- Texas must build an adequate, home-grown supply of appropriately trained physicians.
- Texas must invest in the public health infrastructure needed to protect the public in response to natural disasters, epidemics, and bioterrorism.

### Goal #2: Increased Prevention and Personal Accountability

- Texans must take more individual responsibility for the financing of their employer-provided or individually owned health insurance products.

### Goal #3: Wise and Effective Use of Health Care Information Technology

- Texas must devise a plan to bring interoperable electronic health records (EHRs) to all physician practices to save lives and save money.

- Texas and the nation must encourage public/private sector collaboration on a plan that will make developing and using health information technology affordable for physicians, hospitals, and providers.

### Goal #4: Protect Patient Safety

- Texas health care professionals must support an environment conducive to reporting preventable errors and developing strategies to prevent and correct them.
- A strong and fair Texas Medical Board must protect the public safety while it brings new Texas physicians into clinics, exam rooms, and hospitals as quickly as possible.
- Limited-license health care practitioners must practice within the arena safely defined by their knowledge, skills, training, and experience.

### Goal #5: Humane and Cost-Effective End-of-Life Care

- Texans must ensure that our spending on health care resources during patients' final days, weeks, and months matches their individual desires.
- Texans must do everything possible to prevent needless pain.

is better health. An effective health care system simply delivers better health. Given the cost of care, effectiveness is inseparable from efficiency. Together, they lead us to the goal of cost-effective care.

- We must devise health care financing systems that reward the most cost-effective activity of all: prevention;
- We must train and disseminate enough doctors, nurses, and other health care professionals – with the correct knowledge and skills – to the parts of Texas where they are needed most;
- We must rely on proven, science-based clinical protocols that improve health outcomes and reduce costs without turning the art of medicine into an inflexible paint-by-number exercise; and
- We must provide physicians with access to valuable data that allow them to compare themselves with their peers and maintain continuous quality improvement.

## Goal #1: Accessible and Affordable Health Care for All Texans

Texas must provide access to affordable health care and an appropriate medical home to all of our residents. We must focus our efforts on working poor families – the uninsured and underinsured. This is the critical intervention, the lynchpin, of *TMA's Healthy Vision 2010*. We must reduce dramatically the mounting rolls of uninsured Texans and the unrelenting pressure they apply to government-financed health care programs, safety net hospitals and emergency rooms, private practice physicians, and employers and employees who buy health insurance. Without this crucial change, we are just tinkering at the edges. Without universal access to affordable care, none of our other treatment recommendations can achieve their true potential.

**R Texas' health professionals must collaborate with the business community, public and private payers, employers, and employees to devise and test initiatives that make health insurance companies offer coverage that is more broadly accessible, affordable, and portable.**

★ By and large, uninsured Texans are working Texans. Many of their employers – small and large businesses – can no longer afford to offer health insurance benefits. With no realistic alternatives available, the employers simply drop the benefit and leave the employees and their families to fend for themselves. Those families, likewise, have little choice but to “choose” to be uninsured.

TMA supports public policy initiatives that will expand employers' and employees' options. These include:

- Offering a supportive environment in which stakeholders feel free to develop and pilot-test basic benefit packages that can meet the health care needs of targeted employee populations. These could include combinations of health savings accounts, preventive care coverage, and catastrophic care coverage. We must test variations in premiums, copays, deductibles, and benefits to find the optimum configurations.
- Exploring variations on “3-share” programs such as that currently proposed for Galveston County, where The University of Texas Medical Branch is developing a health benefit program to provide coverage and improved access to care for the county's working uninsured. Like the name sounds, the 3-share plan divides the costs of care three ways: among the employer, the employee, and government funds. A 3-share plan is designed specifically for small businesses unable to purchase group insurance at affordable rates.
- Allowing Texas families who are ineligible for Medicaid or the Children's Health Insurance Program (CHIP) to buy in to those government-run programs. Another option is the TMA-supported legislation passed in



2003 that encourages blending Medicaid funds with employer subsidies to purchase affordable health insurance for uninsured workers. Texas should consider expanding this initiative and exploring other innovative options.

★ TMA also supports incentives for businesses to provide employee health insurance, including workers' compensation coverage, when the businesses contract with the state or receive state economic development funds. State government offers a variety of incentives, including hundreds of millions of dollars in grants, loans, and tax credits, for businesses to move to or grow in Texas. Local units of government also use property tax abatements to lure new businesses. State government itself awards contracts each year worth billions of dollars to various vendors. All these incentives and contracts include provisions with which the business or vendor must agree to comply. TMA recommends for consideration:

- Establishing tax incentives for businesses that contract with the state or receive state economic development funds to provide health insurance and workers' compensation coverage for their employees.
- Rewarding businesses that offer health insurance compensation coverage for their employees, and establishing tax incentives to encourage more businesses to do so.

★ For these public-private partnerships and innovations to work, Texas must impose no additional burdens on health care financing, including no new taxes on patient care. Taxing patient care is bad medicine. It will cost our state jobs in the health care sector and hurt our economy. Health care is a vital component of Texas' economy, generating tens of billions of dollars in revenue per year and providing hundreds of thousands of jobs. The cost of health care is high enough. New taxes on health care would drive those costs even higher or be an unrecoverable expense that would force more Texas doctors out of practice and worsen our state's access-to-care crisis.

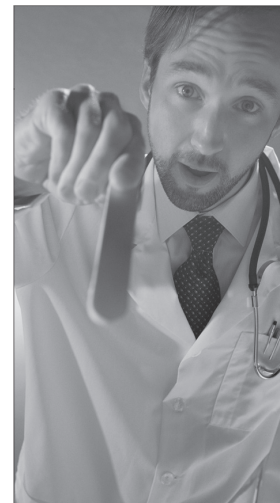
Moreover, a robust medical system is vital for continued economic development in our state. Without a healthy workforce or ready access to high-quality medical care, Texas cannot attract new industries and employers. TMA recognizes that a sound public school system is essential to developing the physicians of tomorrow and that a well-educated Texas is a healthier Texas. However, a healthy Texas requires healthy physician practices. Increasing expenses and falling reimbursements already threaten the viability of many medical practices.

Ethically and legally, physicians must provide emergency care without inquiring into the patient's ability to pay. Texas physicians already pay a \$1-billion-per-year hidden tax via unreimbursed charity care. This equates to a \$1 billion savings to Texas taxpayers. Medicaid and CHIP payments to Texas physicians cover less than half the cost of providing care. The average Texas family practice physician loses about \$50,000 per year in undercompensated care for Medicaid patients. For many specialists, in rural Texas and along the Texas-Mexico border, this figure is even higher.

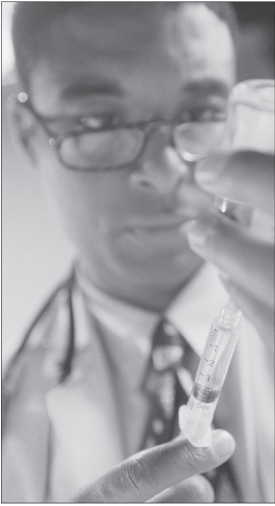
- TMA strongly opposes any new taxes on physicians or medical services.

**R Texas must direct more of our precious health care dollars into direct patient care.**

★ For much of the 1990s, managed care organizations and other insurers kept rates artificially low to attract new clients and members. The HMOs and PPOs obtained profits for their shareholders by severely limiting utilization and systematically ratcheting down reimbursements to physicians, hospitals, and health care providers. Once these tactics had been exhausted, health plans implemented double-digit premium increases so that premium inflation far outstripped the already soaring inflation rate for health care services.







The important measurement to focus on is the medical loss ratio. This is how the insurance industry defines the share of the premium dollar that actually goes for health care. In 2000, the national medical loss ratio was 84.8 percent: 84.8 cents of every premium dollar paid for actual care. That number declined to 81.5 cents by 2003. Unfortunately, the trend continues. United Healthcare, PacifiCare, WellChoice, and Coventry all recently reported continued “improvements” in their medical loss ratios – and their profits. Aetna stated a 78.6-percent commercial medical cost ratio for the third quarter of 2005.

In addition, the plans independently define what is included in their medical loss ratio. The industry has realized considerable success in convincing employers and major purchasers that many costs not directly involved with providing care still should be counted as such. The health plans argue that certain nonclinical expenses amounting to cost controls should be counted as the cost of patient care. Thus, they include in the medical loss ratio costs for such activities as maintaining records, supervisory and executive duties, and supplies and postage.

While the plans are spending a smaller share of the premium dollars they collect on actual patient care, they have become significantly more profitable. Collectively, the country's six largest health plans made nearly \$2.4 billion during the first half of 2002, far more than the \$1.8 billion they earned during all of 2001. In 2004, U.S. HMOs reported a 10.7-percent increase in profits.

Like all other HMOs operating in Texas, Medicaid HMOs pay the state a 1-percent premium tax. However, that tax is an allowable administrative cost for the Medicaid HMOs. The state actually pays them back for the premium tax.

To ensure that we spend more of the Texas health care dollar on health care, not elsewhere, TMA recommends:

- Requiring all managed care organizations to report and explain Texas medical loss ratios to purchasers and enrollees upon request.
- Establishing standard data elements for reporting medical loss ratios to allow for accurate comparisons among various health plans and workers' compensation carriers.
- Establishing reasonable medical loss ratios for Medicaid HMOs, which are paid using state tax dollars.
- Establishing reasonable medical loss ratios for workers' compensation carriers.
- Requiring the Texas Department of Insurance to regulate Medicaid HMOs as it does commercial HMOs.
- Protecting a patient's right to make treatment decisions in consultation with his or her physician.

★ On the public side of the equation, we need fair reimbursement rates to stop the exodus of physicians from Medicaid, CHIP, Medicare, and workers' compensation.

Medicaid and CHIP are essential elements of Texas' economic development. A 2003 study by Texas economist Ray Perryman, PhD, found that together, Medicaid and CHIP contribute nearly \$31 billion to the gross state product and produce almost 500,000 jobs.

Medicaid payments cover less than half the cost of providing services. Many physicians' practices, which are small businesses, cannot maintain their viability in the face of increasing expenses. (See Figure 5.)

Physician participation in Medicaid is dropping steadily and is perilously low in many parts of the state. Fewer than half of Texas physicians accept new Medicaid patients. The most severe shortages are among subspecialists, particularly those who treat children.

Patients' medical needs don't disappear just because the state cuts services and reimbursements. Local governments spend substantial tax dollars on health care for uninsured or underinsured patients. State Medicaid

cuts increase the burden on local taxpayers. For every \$1 Medicaid and CHIP cut, Dr. Perryman found, Texas loses \$19.14 in business activity, local taxes jump 51 cents, and insurance premiums rise by \$1.34.

Medicare payment increases for other providers have closely paralleled the Medicare Economic Index, which is Medicare's measure of the increasing costs of providing medical services. Physician fees, however, have fallen well behind the Medicare Economic Index and will trail the index further still in future years.

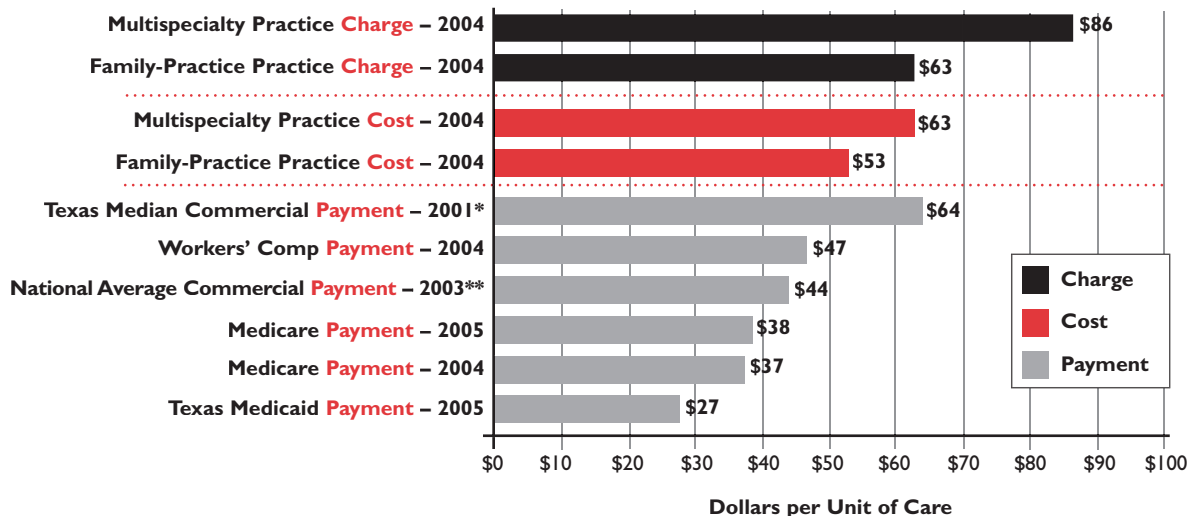
For the past 15 years, Medicare physician payment rates have fallen further and further behind the cost of running a medical practice. Today, Medicare reimburses a physician about two-thirds of what it costs to provide care to a patient. Every time Texas physicians see a Medicare patient, they actually lose money – an average of \$20 to \$35 on every typical office visit.

The problem is only going to get worse. The baby boomers, the biggest generation in American history, are about to enter retirement age. Millions of new Medicare patients will need medical care that Texas physicians very well may not be able to afford to provide.

Like any other business, a physician's practice cannot survive if costs exceed revenues, and Medicare payments are not adequate to cover average costs. Therefore, fees paid by private payers must be increased to cover physician losses on Medicare beneficiaries. When private payers are unwilling or unable to pay higher prices to cover these costs, physicians are forced to discontinue or drastically reduce their Medicare business, thus jeopardizing practice viability.

In the area of workers' compensation, costs, reimbursement rates, and access to care for injured workers have been flash points of debates among medicine, business, labor, and state government since 2001. Texas' cost-per-

**Figure 5. Physician's Office – Costs Versus Reimbursement**



\* Report from Milliman, USA, to the Texas Workers' Compensation Commission

\*\*Report to MEDPAC

Other Sources: MGMA Cost Survey (medians), Texas Workers' Compensation Commission, Centers for Medicare & Medicaid Services



injured-worker claim is higher than other states, primarily due to poor return-to-work patterns and a high frequency of medical service utilization by some providers. Average price-per-service for physician services was at or below the median in 1999, before the Texas Workers' Compensation Commission imposed fee schedule cuts. Price-per-service for chiropractors, physical and occupational therapists, and hospitals, however, was above the median.

Due to the high administrative burden and low reimbursement rate for workers' compensation, the number of physicians who accept new injured workers plummeted from 46 percent in 2002 to 23 percent in 2004.

TMA's primary goal for workers' compensation is access to quality care for injured workers. The 2005 Texas Legislature passed House Bill 7 to reform the workers' compensation system. The bill allows for managed care-style workers' compensation networks, where participating physicians may negotiate their fees; out-of-network services will remain at 125 percent of Medicare allowable. The bill also applies some prompt pay provisions similar to group health standards. The new law guarantees payment up to \$7,000 when compensability determination is challenged by a carrier. In the previous system, many physicians were left with no recourse when an injured employer claimed a work-related injury and the carrier later determined that the injury was not work-related.

Managed care networks are not a silver bullet that will fully reform the failed workers' compensation system in Texas. Under the new system, which is supposed to be based on market principles, physicians may negotiate fees with payers without regard to a fee schedule. The intended effect is for networks to attract quality physicians and to pay them appropriate fees for delivering quality services. There is growing concern, however, that insurance carriers will use this flexibility to push reimbursement even lower, further

threatening injured workers' access to quality health care.

TMA's recommendations for fair reimbursement rates include:

- Enacting competitive physician reimbursement rates for Medicaid and CHIP.
- Restoring Medicaid and CHIP services and eligibility to 2003 levels.
- Replacing Medicare's sustainable growth rate formula with the Medicare Economic Index, which would allow payment adequate to cover physician costs.
- Monitoring workers' compensation fees to ensure that they at least cover the cost of patient treatment and the unusually high administrative burdens inherent in the system.

★ As the 2005 legislature was convening, state Medicaid officials were ready to repeal the popular Primary Care Case Management model (PCCM) and expand STAR+PLUS Medicaid HMOs to serve the elderly and patients with disabilities living in and around the state's urban counties. Local counties were about to lose hundreds of millions of federal dollars. Harris County, where Texas piloted STAR+PLUS, lost some \$35 million as a result of the model and stood to lose another \$20 million. Other urban counties – Dallas, Bexar, El Paso, Lubbock, and Tarrant – would lose at least \$150 million collectively.

Faced with strong arguments that Medicaid HMOs are good for neither the health of patients nor the health of local economies or taxpayers, lawmakers decided to test an alternative. Integrated Care Management (ICM) is a noncapitated system of care that would achieve statewide savings and tax equity, maximize federal Medicaid matching dollars, provide high-quality and effective patient care, and simplify administration. The legislature required the use of ICM in Dallas and authorized it as an option in the other urban communities.

The state is moving ahead with plans to eliminate the PCCM model and use only HMOs to provide Medicaid services in and around most Texas urban areas. All patients who rely on Medicaid there – pregnant women, children, elderly men and women who don't live in nursing homes, and adult patients with disabilities – would have no choice but to seek care from HMOs.

PCCM and ICM are good values for the state. They put more money into direct patient care and spend less on paperwork and administration. PCCM receives very high marks from both patients and physicians.

To improve Medicaid care, TMA recommends:

- Directing the Texas Health and Human Services Commission to contract for an objective, third-party cost-benefit analysis of all Medicaid managed care delivery models, and require a legislative oversight panel to monitor the findings and their implementation. Any analysis of cost-effectiveness should include the impact on local taxpayers, hospital districts, and the health care safety net.
- Conditioning any further expansion of for-profit Medicaid HMOs on a clear expression of community need.
- Offering ICM – or another patient-centered, physician-directed model that relies on more efficient managed care principles to improve care coordination, assure appropriate utilization of services, and restrain costs – in all Medicaid service areas.
- Reenergizing physician participation in Medicaid by establishing a system that represents true collaboration between physicians and the state.

★ Transparency is a basic tenant of American business. “Let the buyer beware,” certainly. But the buyer must know what to be wary of. As health care transactions among patients, physicians, hospitals, employers, health plans, and others grow even more complex, the vari-

ous buyers and sellers of health care services must take extra pains not to mislead each other. Texas physicians call on all stakeholders to operate openly through appropriate disclosure, which (1) does not compromise the patient-physician relationship, (2) makes transactions more fully understandable at the point of service, and (3) facilitates communication among patients, physicians, other providers, purchasers, and plans.

To ensure that physicians' interests are always aligned with their patients', TMA continues to oppose any efforts to change Texas' longstanding prohibition against the corporate practice of medicine. Physician “employees” should not be held responsible for the bottom line of an organization managed or owned by nonphysicians.

To ensure transparency, TMA recommends:

- Requiring physicians to disclose to patients any ownership interest in a facility or service. TMA supports physician ownership in technology facilities, services, and equipment. Referrals to physician-owned entities or services must be based on the patient's medical needs, as determined by accepted utilization and quality-of-care standards.
- Requiring hospitals, health plans, and others to disclose to patients any ownership interest in a facility or service.
- Requiring health plans to provide employers, patients, and other purchasers with accurate, up-to-date lists of contracted physicians, hospitals, and other facilities. They must point out especially any contracted hospital for which the plan lacks adequate physician specialists, such as anesthesiologists, emergency medicine specialists, pathologists, and radiologists.
- Directing the Texas Department of Insurance to develop and enforce stricter rules requiring health plans to provide their members with adequate physician networks.
- Requiring health plans to use credible, reliable, understandable, and transparent evidence-based tools to measure quality, cost-effective care. They must share their







measurement criteria openly with physicians, patients, and purchasers.

- Prohibiting health plans from using costs – or tools that cannot measure quality of care – as factors when developing networks they promote as providing higher quality care.

**R Texas must build an adequate, home-grown supply of appropriately trained physicians.**

★ At 218 physicians per 100,000 population, Texas already trails the national average of 281 physicians per 100,000 by 22 percent. The federal government designates 132 of Texas' 254 counties – mostly in rural West Texas, along the border with Mexico, and in inner cities – as primary care Health Professional Shortage Areas. These counties are home to more than 5.4 million Texans. This diminished access to physician care will grow worse as Texans age and the population grows. While Texas State Demographer Steve Murdock predicts that the number of Texans will grow by almost 143 percent from 2000 to 2040, he likewise predicts that the number of physician contacts will increase by 170 percent.

Compared with the general population, Hispanic and African-American physicians are especially underrepresented. That discrepancy, too, will grow wider over the next quarter-century as Hispanics become the majority in Texas.

Each year, Texas' eight medical schools graduate about 1,300 new physicians. TMA strongly supports the schools' efforts to achieve more diverse student populations and to motivate and prepare students to practice in underserved areas of the state.

To help meet the demand for physician services, TMA recommends:

- Encouraging the state to partner with Texas medical schools to increase the

representation of Hispanic and African-American medical students toward the goal of reaching their proportion in the Texas population.

- Increasing state funding for medical education to provide incentives for medical schools to increase enrollment of underrepresented minorities.
- Increasing state funding to increase the number of medical schools in Texas and/or increase class size at our current schools.
- Expanding medical student clerkships in rural medicine and loan repayment/forgiveness programs for students who practice in underserved areas of the state.

★ Graduate medical education (GME) is the specialized training physicians receive after completing medical school. It is a lengthy period of time during which they immerse themselves in learning a specific field of medicine. GME programs play an important role in giving physicians the skills they need to become independent practitioners; in providing patient care, often to the most needy; and in improving the health of all Texans through medical research and innovations. An investment in GME is an investment in the health of Texans and our economy.

Teaching hospitals are concerned about their ability to sustain – let alone expand – GME programs due to narrow operating margins and low financial reserves. This is largely due to the recent whittling-away of GME funding sources. Medicare is the largest financier of GME. The number of Medicare-supported GME slots is generally frozen at 1996 levels. In Texas, most state GME funds are allocated by the Texas Higher Education Coordinating Board for primary care GME. In 2003, the legislature cut \$27 million of the Coordinating Board's \$51 million in GME funding. The 2005 legislature restored those funds but made none available to allow for needed growth. Medicaid's longstanding role in support of Texas GME was eliminated for 2004-05 – a loss of \$127 million in state and federal matching funds. Legislators in 2005 approved the first-ever state GME formula

funding process but were unwilling to finance Medicaid GME with general revenue funds. Instead, they established a funding system that is not expected to restore the lost funding.

To strengthen GME, TMA recommends:

- Funding the newly established state formulas for GME at adequate levels.
- Reinvesting state funds in Medicaid GME.

**R Texas must invest in the public health infrastructure needed to protect the public in response to natural disasters, epidemics, and bioterrorism.**

★ Texans discovered a whole new meaning of the word “homeless” when our state absorbed more than 300,000 evacuees from Hurricane Katrina. Although we welcomed our displaced neighbors from Louisiana and Mississippi, their rapid, unplanned arrival strained local and state health care resources. During Hurricane Katrina, emergency response, health care, and sheltering fell primarily on our large urban areas. These are highly populated cities with a large tax base and extensive health care facilities.

Much of the weight of responding to Hurricane Rita, however, fell on smaller, rural towns and counties in Texas that had never responded to a disaster of such magnitude. The deluge of evacuees, many of them individuals with special needs who were intentionally moved out of the storm’s path, initially overwhelmed local governments. While Texas responded with a well-defined plan, certain shortcomings became readily apparent. In many cases, the chain of command was not clear. Local government agencies weren’t certain of their responsibilities. Communication among those on the ground in East Texas, state and volunteer coordinating agencies, and medical volunteers was fractured and difficult. Local governments, hospitals, and health care workers could not keep up with the demands at special care shel-

ters. Those who wanted to volunteer found it difficult and sometimes impossible to get to the areas of greatest need.

To improve our ability to respond to the next disaster, TMA recommends:

- Studying and updating our state and local disaster response plans with special attention to improving communication among responders at all levels; providing public health surveillance in shelters; tracking specific populations (e.g., severely ill patients, individuals with disabilities, sex offenders, methadone patients) to improve their access to special services; and improving evacuation routes and plans.
- Ensuring that the Texas Department of State Health Services (DSHS) involves county medical societies in its disaster response plans.

★ Scientists, health care professionals, and federal and state governments have focused their recent attention on preparing for a possible influenza pandemic. On average, three influenza pandemics occur in a century; the most recent was in 1968. DSHS defines pandemics as “explosive global events in which most, if not all, people worldwide are at risk for infection and illness [from] a new strain of influenza against which there is little or no natural immunity.”<sup>46</sup>

The federal government’s pandemic response priorities include ways to increase vaccine production capacity and limit vaccine manufacturers’ liability. The Bush administration has asked state and local governments to develop plans for stockpiling and distributing vaccines and antiviral medicines, for tracking disease outbreaks, and for quarantining infected individuals in the event of an outbreak. DSHS has developed a draft state plan for pandemic influenza that addresses these issues and more.

To better prepare Texas for a pandemic, TMA recommends:





- Urging the Texas Department of State Health Services to complete and test its state plan for pandemic influenza.
- Appropriating sufficient funds to update the plan periodically and implement it rapidly in response to a flu pandemic.

## Goal #2: Increased Prevention and Personal Accountability

If an apple a day keeps the doctor away, so too does exercising regularly, quitting smoking, and obtaining a flu shot. The goal is to eliminate the preventable diseases that ravage our bodies and strain our health care finances. "At least 50 percent of health care expenditures are lifestyle-related," says Texas Commissioner of State Health Services Eduardo Sanchez, MD, MPH, "and therefore, potentially preventable." It is incumbent on individual Texans and their families, physicians and other health care professionals, employers, health plans, and the government to focus on wellness and prevention. We cannot afford, physically or fiscally, to do otherwise.

**R** **Texans must take more individual responsibility for the financing of their employer-provided or individually owned health insurance products.**

★ Patients who have a stake in the cost of their health care treatment decisions are more likely to make decisions that are cost-effective. TMA believes employers and health plans should aggressively pursue innovations in health insurance benefit design to encourage affordability, accessibility, disease prevention, health promotion, and individual enrollee participation in health care financing.

Consumer-directed health care plans offer a promising option for improving efficiency and increasing personal responsibility by excluding the insurance company from

financing a large portion of routine primary care services. Under these plans, businesses establish high-deductible insurance plans for their employees, coupled with accounts that employees can use to cover their family's routine medical expenses with pre-tax dollars.

This approach improves efficiency if these plans bypass the usual process of submitting formal medical claims to insurance companies and waiting for lengthy review and payment. It strengthens the practices of primary care physicians who are particularly overburdened by the demands of health plans to have every small service pass through their scrutiny. To the employer, the employee, and the physician, the value of consumer-directed health plans lies in their simplicity.

To be successful, high-deductible health plans must not just shift more costs to workers who may not be able to afford the higher costs and may thus decline coverage. These accounts should be seeded with initial funds and allowed to grow with tax-free employee savings that roll over from year to year. Benefits should promote employees' use of preventive health care services, such as cancer screenings, immunizations, and prenatal care. Administrative overhead must be minimized through the use of debit cards or other methods that limit transaction costs for all parties.

To promote individual responsibility, TMA recommends:

- Enacting tax breaks or other incentives for employers who offer appropriately structured, consumer-directed health plans to their workers.
- Directing the Employees Retirement System of Texas to devise innovative and affordable ways to offer appropriately structured, consumer-directed health plans to state workers.
- Encouraging employers and health plans to engage in educational efforts to make employees better-informed health care consumers.

★ The obesity epidemic threatens Texas' physical and fiscal health. Demand for treatment for obesity-related conditions is beginning to overburden the health care system. Obesity is responsible for 27 percent of the growth in health care spending. Treating obese patients costs 37 percent more than treating normal-weight patients.

Research shows that increased fitness levels correlate positively with student academic performance and test scores. A child who is overweight at age 12 has a 75-percent chance of being overweight as an adult. The 2001 Texas Legislature passed Senate Bill 19 (expanded by Senate Bill 1357 in 2003), requiring daily physical activity for all children in kindergarten through grade 6. There still are many questions about whether schools are implementing this law, and if so, how.

Vending machines provide additional revenue for schools. However, most serve primarily low-nutritional value food and drinks that only exacerbate the obesity problems among schoolchildren.

To combat this epidemic, TMA recommends:

- Providing state employees or their family members incentives – for example, reduced health insurance cost-sharing – for making healthy lifestyle choices, such as maintaining a healthy weight, quitting smoking, or keeping their children immunized. The state should test effectiveness of similar incentives for Medicaid and CHIP.
- Reinstating the smoking cessation benefit for CHIP and testing the effectiveness of including weight loss and smoking cessation programs as covered benefits under Medicaid and CHIP.
- Assuring full compliance with Senate Bills 19 and 1357, including an appropriate means of reporting daily physical activity and expanding daily physical activity requirements to all grade levels.

- Improving school nutrition by (1) codifying the public school nutrition policy developed by the Texas Department of Agriculture, and (2) evaluating compliance and accountability concerning the new requirements to replace food and drinks of low nutritional value with those of documented value.

★ Immunization is one of the safest and most cost-effective ways of protecting young children. However, a close look at the poor reimbursement levels for providing and administering vaccines explains one of the barriers to vaccine administration in the physician's office. As these costs are 50 to 100 percent greater than the doctor's reimbursement for giving the shot, many physicians find it cost-prohibitive to provide immunizations to their patients. This obliges more-motivated parents to take their children to publicly funded clinics. Others skip the vaccines altogether until public school requirements force the issue. With the advent of Texas' conscientious objector law, even that hammer has lost some of its impact.

The destruction of medical records and mass migration of Gulf Coast residents that accompanied Hurricane Katrina brought to light a new problem related to immunizations. States and parents are responsible for maintaining vaccination records. When the parents' paper records are lost and the state's computers are down or inaccessible, physicians in shelters and clinics or in the hurricane victims' newly adopted hometowns don't know the children's vaccination status. Adults' immunization records, even for those who have never moved or weathered a hurricane, are even more difficult to find. When seeing a patient with an unknown immunization history, physicians will err on the side of caution and administer the shots they think the patient needs. This wastes precious health care dollars, time, and resources. A national immunization registry, especially for children, would integrate data from the 50 state-level registries.

To promote immunizations, TMA recommends:

- Supporting the Texas Department of State Health Services' request for increased appropriations to enhance vaccine services through the Texas Vaccines for Children Program.
- Opposing any expansion of the conscientious objector law.
- Increasing funding for education and practitioner vaccine administration reimbursement fees.
- Strengthening Texas' ImmTrac immunization registry.
- Establishing a national immunization registry based on state-level data.

★ Mental illnesses account for more than one in every 10 days lost to illness. That's second only to heart disease, and closing fast. Untreated mental illness costs the United States \$300 billion each year. The *Wall Street Journal* has estimated that depression alone costs American companies \$70 billion annually in absenteeism, lost productivity, and direct medical costs. Untreated mental illnesses also can cause what's been termed "presenteeism," when employees show up but are not able to work to the best of their abilities due to their psychiatric symptoms. A recent Rand Corporation study showed that an annual investment of \$500 per employee in mental health more than pays for itself in increased worker productivity.<sup>47</sup>

Suicide is the eighth leading cause of death in the United States. About 20 percent of the 2 million people in American prisons suffer from severe mental illnesses. Mental illness contributes to dropout rates, special education placements, and grade retention in our schools. It is associated with teenage pregnancy, drug and alcohol abuse, and unemployment.<sup>48</sup>

These diseases touch a fifth of all Americans and are the second-leading cause of disability in the United States. However, we spend only 7 percent of our health care dollars to treat

them. There's less health care coverage for behavioral issues, higher costs to consumers, and lower reimbursement rates for providers. In addition, there is a dearth of mental health professionals to deal with the magnitude of the problem, particularly for children and persons living in rural areas.<sup>49</sup>

To strengthen our mental health system, TMA recommends:

- Encouraging employers to include mental health components in their workplace wellness programs and strong mental illness coverage in their health insurance benefit plans.
- Requiring mental health equitable treatment (parity) of health insurance coverage for psychiatric brain disease and malfunction (mental illness including substance abuse/chemical dependency) equal to that for other medical conditions.
- Increasing funding for mental health research and graduate medical education programs in psychiatry, child psychiatry, and family practice.
- Funding core mental health services and support to those persons with severe and persistent mental illness who are most in need, indigent, and have no third-party coverage.

### Goal #3: Wise and Effective Use of Health Care Information Technology

As in nearly every other sphere of modern life, technology has delivered enormous improvements in medicine. Once unimaginable diagnostic tools and treatment modalities are now commonplace; they also can be quite expensive. Health care information technology – among physicians, hospitals, other health care professionals, and patients – has not kept pace. We must move Texas physicians' offices from the days of stand-alone, paper-based medical records and transactions into an era of shared health information technology in which physicians can easily access their practices' clinical information,

find the treatment protocols that help them make evidence-based decisions on patient care, and participate in data-based quality improvement activities in their own practices.

**R Texas must devise a plan to bring interoperable electronic health records to all physicians' practices to save lives and save money.**

Widespread adoption of electronic health records (EHRs) and other health care information technology (HIT) in U.S. hospitals and doctors' offices will be expensive. Very expensive. Estimates range from \$7.6 billion per year over 15 years<sup>50</sup> to install EHRs in all hospitals and physicians' offices, to \$31 billion a year over five years<sup>51</sup> to build a national health information network.

The potential savings – in human terms and financial terms – make the expenditure worthwhile.

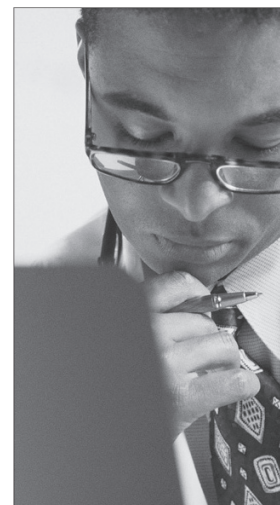
- The Rand Corporation estimates that EHRs can save “several tens of billions of dollars per year” by keeping patients with high-cost, chronic diseases such as asthma, congestive heart failure, and diabetes out of the hospital and the emergency room. Such systems will save more money and more lives by increasing the timely use of screening exams, recommended immunizations, and other preventive measures.
- Rand also estimates that EHRs can save nearly \$5 billion a year by eliminating more than 2 million adverse drug events (ADEs) annually. Systems that warn doctors about possible drug interactions or suggest alternative courses of treatment could prevent up to half of the estimated 8 million ADEs that happen each year in physician's offices and outpatient clinics. Each ADE avoided saves \$1,000 to \$2,000 in health care expenditures, improves patient care, and prevents unnecessary patient suffering.
- Empirical evidence from physician practices that have installed effective EHRs shows that the systems make physicians and office

staff more efficient and productive, allowing them to see more patients by “eliminating time lost waiting for charts, lab results, and other paper-based data.” They also reduce the time patients waste in the waiting room.<sup>52</sup>

More broadly, David Brailer, MD, PhD, national coordinator for health information technology at the U.S. Department of Health and Human Services, sees technology as a driving force for all participants in the health care system:

Health IT will transform the way Americans regard their health and the way they participate in healthcare. The important aspect of health IT is not software and computers – it is physicians making better treatment decisions, nurses and pharmacists delivering safer care, and consumers making better choices among treatment options. It is the way people connect across a fragmented delivery system – from physician offices to hospitals to skilled nursing facilities and even to the consumer's home. It is putting consumers in control of their health status and customizing care delivery to meet their needs.<sup>53</sup>

The global vision of health information technology breaks down into nine inter-related tools that put computer networking at the center of information management.<sup>54</sup> Taken together, these tools provide complete, updated, accurate information at the point of care. An interoperative EHR not only includes input from a single practice, but it also integrates medical information from any treating clinician who has network access to the patient's record. An electronically entered prescription will appear in the EHR regardless of whether the physician was in the office while writing it. Test and imaging study results reach the ordering physician rapidly, and automatically become a part of the EHR. As a clinician enters a prescription order, warnings appear on the screen of any allergy problems or interactions with the patient's other prescriptions.<sup>55</sup>







The Houston/Harris County Public Health Task Force envisions a “community health information network” that would link the region’s vast public health safety net with individual physicians’ offices and clinics. The network would prevent the all-too-common instance in which physicians and emergency room personnel must repeat a patient’s expensive tests and treatments because they have no accurate record of what happened the last time the patient visited a different clinic or hospital.<sup>56</sup>

Despite the many benefits that HIT brings to medical practices, its adoption in physician offices has been low. In a 2003 survey of office physicians, routine use of HIT tools was the exception rather than the rule, particularly in smaller practices. It found:

- Only 18 percent routinely used electronic health records;
- 17 percent routinely used electronic ordering of tests, procedures, and drugs; and
- 37 percent routinely accessed patients’ test results electronically.<sup>57</sup>

In the long term, HIT strengthens the health care system by making medical practices both producers and users of data. Physician office data will greatly enlarge the ambulatory care databases of developing regional health information organizations (RHIOs) and other locally based health data warehouses. Quality assurance in the medical office will move from a laborious, one-by-one review of medical records to an automated process in which information is continuously analyzed. Finally, the vision of networked medical communities also has great potential to meet the severe public health problems that plague Texas, including low immunization rates and the growing prevalence of obesity, tuberculosis, and diabetes.

In November 2005, the TMA Special Funds Foundation received a \$1 million grant to improve patient safety by increasing Texas physicians’ understanding, adoption, and

appropriate utilization of vital information technologies. The foundation’s three-pronged plan is to educate physicians about the value of health information technology for better patient care; teach physicians how to acquire and implement the technology; and help physicians use the newly created data to improve patient care in their offices and through confidential, regional data warehouses. That \$1 million, obviously, is only a fraction of what is needed to achieve this enormous transformation. TMA hopes, however, that this investment will help jump-start the process, especially in light of the mounting national political and economic momentum for HIT.

To spur physicians’ use of HIT, TMA recommends:

- Educating physicians, hospital executives, and political and business leaders on the value of EHRs and other HIT, especially its return on investment in both financial and human terms.
- Encouraging all physicians’ offices, hospitals, clinics, and other health care facilities to acquire interoperable EHRs as quickly as they can afford it.
- Promoting health care data sharing to enhance efficiency and effectiveness while maintaining patient privacy and physician ownership of business operations records. This will not only enhance the efficiency of health care safety net facilities, but also give physicians access to valuable data that allow them to compare themselves with their peers and adopt continuous quality improvement.
- Promoting the use of patient-owned, electronic personal health records.

**R Texas and the nation must encourage public/private sector collaboration on a plan that will make developing and using health information technology affordable for physicians, hospitals, and providers.**

As it currently stands, those who must pay for EHRs and other HIT tools are not those

most likely to benefit from their widespread adoption. “Barriers to wider adoption of HIT include ... payment systems that result in most HIT-enabled savings going to insurers and patients, while most adoption and care improvement costs are borne by providers,” the Rand Corporation reports. Rand also lists as barriers high costs, uncertain financial payoffs, and the disruptions that accompany any new technology.

In a 2003 survey of office-based physicians, the four most frequently cited barriers to acquiring HIT were startup costs (56 percent), lack of uniform standards (44 percent), lack of time (39 percent), and maintenance costs (37 percent).<sup>58</sup>

Given the technologies’ multibillion-dollar price tag, these are strong disincentives to keep physicians and hospitals from moving forward.

On the other hand, we have good reason to share those costs across the entire system: A January 2005 study found that a well-designed system linking patient records among physicians, hospitals, health plans, and others “could yield \$77.8 billion annually, or approximately 5 percent of the projected \$1.661 trillion spent on U.S. health care in 2003.”<sup>59</sup>

To help bring these valuable technologies to patient care rapidly, TMA recommends:

- Developing government grant and loan programs for physicians to purchase EHRs, install them in their offices and clinics, and train themselves and their staff on how to make best use of them.
- Investing taxpayer money in creating regional health information organizations.
- Ensuring health plans and government health programs adopt policy initiatives that accelerate market forces and provide physicians with incentives to invest in HIT.
- Urging the federal government to continue to develop uniform standards for electronic health care data collection and sharing.

- Encouraging health plans, Medicare, Medicaid, and other health care purchasers to include in their reimbursement systems provisions that reflect physicians’ HIT-related costs.

## Goal #4: Protect Patient Safety

All physicians pledge to “do no harm” and are dedicated to the proposition that even one medical error is one too many. A commitment to a culture of patient safety involves all members of the health care team: physicians, hospitals, nurses, other practitioners, even patients themselves and their families. Health care today involves so many interdependent, moving parts, especially for the sickest and most severely injured patients. We must continue to devise systems that prevent small, unintentional mistakes from quietly and rapidly turning into irreversible, destructive forces. We must ensure that all members of the team possess the knowledge, skills, training, and experience to carry out their assigned tasks. We must do all we can to ensure that our patients, whenever possible, leave the health care system healthier than when they came in.

**R Texas health care professionals must support an environment conducive to reporting preventable errors and developing strategies to prevent and correct them.**

There is, and always has existed, a strong consensus in the medical community on how to continuously minimize the potential for human error in our vast and complex medical delivery systems. The rigors of the scientific method hold the key to identifying and correcting the circumstances that erode patient safety. All members of the numerous interdisciplinary health care teams – physicians, nurses, hospital administrators, and other professionals – must collaborate in this process.



### **Tort Reform: A Victory for Patient Access**

Physicians' liability insurance premiums have continued to drop since the passage of Proposition 12 and the state's landmark 2003 health care liability reforms. In the first nine months of 2005 alone, all five of Texas' largest physician insurers announced rate cuts; together, they will produce roughly \$48.6 million in annualized savings for Texas physicians and greater access to care for Texas patients. Since the passage of Proposition 12, five carriers have announced double-digit rate reductions. For the first time in years, Texas physicians can competitively shop their policies. Meanwhile, lawsuit filings in most Texas counties have been cut in half since the passage of the 2003 reforms.

As a result of these improvements, patients' access to physician services is growing.

- Texas physicians have definitely slowed the reduction in services that had been spurred by the lawsuit abuse crisis. Some have begun to reinstate critical services.
- Before the reforms passed, the ranks of Texas internists, emergency care physicians, and orthopedic and neurosurgeons were flat or on the decline. From May 2003 through July 2005, however,

more than 3,000 new doctors established practice in Texas, many of them serving in those high-risk specialties and in medically underserved regions of the state.

- Some cities are experiencing unprecedented success in physician recruitment. In the year after reforms were passed, Corpus Christi added 47 new physicians. That is a stark contrast to the 40 physicians the city lost in the five previous years. Similarly, Beaumont saw a net loss of 12 doctors in the 18 months prior to the passage of lawsuit reform. In the following 18 months, the community gained 21 physicians, including five anesthesiologists and 15 emergency medicine specialists.<sup>60</sup>

#### **TMA recommends:**

- Protecting the 2003 tort reforms and ensuring no new causes of action are created for physicians and other health care professionals.
- Revisiting some of TMA's important health care liability reforms the Texas Legislature did not pass in 2003.
- Subjecting physician testimony in health care liability cases to Texas Medical Board scrutiny because that testimony constitutes the practice of medicine.

Media coverage of the 1999 Institute of Medicine (IOM) report, "To Err is Human: Building a Safer Health System" implied that patient safety is not a priority concern of physicians and other health care professionals and that the report raised new issues for the medical profession. Despite the report's methodological flaws, medicine can be thankful that it brought new resources to the battle. Physicians and hospitals have been addressing this challenge for decades and have made tremendous progress in improving patient safety. It is remarkable that they have been able to reduce medical errors at all of late, in the face of the cost-cutting onslaught of government and managed care.

Modeled after the aviation industry's non-punitive reporting of error, physician-led teams have systematically identified the root causes of unintentional errors, devised and implemented system changes that correct these problems, and shared their results with their peers. All of this has taken place, and must take place, in a no-fault environment in which the goal is to fix the problem, not fix the blame. Confidentiality protections for patients, health care professionals, and health care organizations are essential if we are to learn about errors and effect change. Information developed in connection with reporting systems should be privileged for purposes of federal and state civil matters and administrative proceedings.

Errors of omission – such as not prescribing certain medications for patients with certain conditions – are less visible, easier to correct, and have a greater long-term impact on patients' health than errors of commission – such as operating on the wrong limb. The most important work for physicians lies in developing and promoting evidence-based guidelines for patient care and discouraging their colleagues from using those practices that do not comply with these guidelines.

TMA President Robert T. Gunby Jr., MD, appointed a Select Committee on Patient Safety to develop recommendations regarding

patient safety legislation and to lead TMA's participation in the Institute of Health Care Improvement's 100,000 Lives Campaign. The select committee is focusing on concrete ideas to reduce adverse outcomes and decrease risks to patients. These include efforts to reduce surgical infections and adverse drug reactions, and to improve the use of proven practices, such as administering aspirin and beta blockers to heart attack patients. Best practices need to be disseminated among physicians and other health providers.

Since 2003, hospitals, ambulatory surgical centers, and mental hospitals in Texas have been required to report certain "sentinel events" to the Texas Department of State Health Services (DSHS) annually. The agency is responsible for aggregating data for public release, but the hospital names remain confidential. Facilities must perform a root cause analysis and develop a corrective action plan within 45 days of any event.

A new federal law, Patient Safety and Quality Improvement Act of 2005, has created a voluntary and confidential system for medical error reporting and is a major step forward in improving patient care. TMA is evaluating whether additions or changes at the state level would allow information to be gathered without the threat of liability so that systemic patient safety problems can be identified and corrected.

To enhance efforts to improve safety, TMA recommends:

- Encouraging all Texas hospitals, physicians, health care facilities, and other practitioners to endorse the principles of the Institute of Health Care Improvement's 100,000 Lives Campaign and to implement them wherever possible.
- Creating patient safety organizations under the Patient Safety and Quality Improvement Act of 2005 to collect voluntarily reported medical errors, incidents of "near misses," and enhanced health care quality practices.

- Developing a non-punitive, confidential culture for reporting health care errors that focuses on preventing and correcting systems failures and not on individual or organization culpability.
- Enhancing patient safety education in medical school and residency training.

**R** A strong and fair Texas Medical Board must protect the public safety while it brings new Texas physicians into clinics, exam rooms, and hospitals as quickly as possible. Limited-license health care practitioners must practice within the arena safely defined by their knowledge, skills, training, and experience.

★ The Texas Medical Board (TMB) continues to expand and improve its operations after the 2005 sunset review and the extensive changes to the Medical Practice Act the legislature adopted with TMA's strong support in 2003. Those changes further protect the public health from physicians who practice below the standard of care, and provide due process protections for physicians under investigation. The board received new legal tools and additional financing to hire more and better staff. The legislature must continue to monitor how well the board has instituted those changes.

All Texans must be confident that their physicians are qualified, competent, and uphold the highest ethical and professional standards. All Texas physicians must be confident that their fellow physicians are qualified, competent, and uphold the highest ethical and professional standards.

To protect the public safety, TMA recommends:

- Ensuring a strong and well-funded TMB and extensive evaluation of the physician disciplinary process. This includes expeditiously and accurately processing licensure applications as well as affording due process to both complainants and physicians.





- Subjecting physician testimony in health care liability cases to TMB scrutiny because that testimony constitutes the practice of medicine.

★ The scope of practice of health care professionals must be limited by their education, training, and skills. This is a patient safety issue. In virtually every legislative session, one or more groups of nonphysician health care professionals seek to expand their scope of practice, oftentimes under the guise of increasing access to care. Nonphysician health practitioners are highly valued by the medical profession; physicians and allied practitioners care for patients on a daily basis working as a team. However, only physicians should exercise independent medical judgment, serving as the trusted leader of the health care team.

To protect patients, TMA recommends:

- Stopping any efforts to expand scope of practice beyond that safely permitted by an allied health practitioner's education, training, and skills.

## Goal #5: Humane and Cost-Effective End-of-Life Care

Eventually, no matter how much prevention and treatment of illness we practice, everyone will die. Expensive technologies that may save lives and restore health in other circumstances frequently increase suffering and prolong our final days. As a society, we expend huge sums of money that do not improve care or quality of life but that frequently cause greater suffering for patients and their families. Physicians, especially those who treat the terminally ill, must discuss these sometimes-painful issues with patients and their families, develop a plan together, then follow the patients' wishes as the end comes.

**R** **Texans must ensure that our spending on health care resources during patients' final days, weeks, and months matches their individual desires.**

As our population ages, so too does the number of individuals with chronic illness. Approximately 132 million Americans today live with chronic illness. That number should jump to more than 170 million in the next 25 years. Since nearly all patients die during the course of a chronic illness, death rarely takes us by surprise and preparation is possible.

Until the turn of the 20th century, almost all Americans died at home. Today, 98 percent of Medicare patients spend at least some time in a hospital during the last year of life, and 75 percent die in a hospital or nursing home. But about 70 percent of patients say they wish to die – like their great-great-grandparents – at home. We have an immense gap between patient preferences and reality.

There is significant data showing that improving care at the end of life is quite possible and decreases costs. Of the \$247 billion Medicare spent in 2002, more than one-quarter – \$64 billion – came during the last 12 months of patients' lives. More than half of that amount – \$35 billion – came during the final two months. Counting all funding sources, we spend about 22 percent of our health care dollars in the final year of life; that's a total of \$330 billion for the 2.4 million Americans who died in 2002.

The medical literature is not conclusive as to the potential for significant cost savings at the end of life. Studies do show three- to six-fold variations in spending among the best hospitals in the country in the last six months of life, independent of severity of illness or outcome. And we know, conclusively, that it costs significantly less to die with appropriate hospice care at home, in a nursing home, or in a standard hospital bed than in the intensive care unit.

It is a Texas physician's responsibility to consult an ethics committee if a patient or family member asks for life-sustaining treatment that the physician does not believe will medically benefit the patient. In some cases, even if the ethics committee agrees with the physician that the requested care is futile, state law requires the physician and hospital to provide care for 10 days while attempting to find another physician or institution that will provide the treatment requested. It is undoubtedly in everyone's best interests to avoid such painful conflicts.

To improve the quality of Texans' final days, TMA recommends:

- Improving communications about the goals and likely outcomes of medical care. Building off of the success of the Texas Advance Directives Act, we should insist that physicians, patients, and their families incorporate advance care plans into standard chronic patient care and acute crisis care. Physicians, patients, and their families should discuss an advance care plan every time a patient is admitted to an intensive care unit by choice, i.e., after major surgery.
- Requiring medical schools, with appropriate funding from the legislature, to increase training in clinical ethics, palliative care, and cultural diversity. Dying is a universal human process, but we do not effectively train our future doctors how to deal with death.
- Collecting better outcome and discharge data from the intensive care unit, hospital, and nursing home. The state and our academic medical centers should collect this comprehensive data across Texas so that we can better understand the unique circumstances in which our physicians provide end-of-life care to their patients.
- Creating a flexible regulatory environment that facilitates creativity and cooperation in end-of-life care services across diverse communities. We should develop palliative care consultation services across Texas and provide financial support where needed – such as in rural communities or those with high numbers of medically indigent persons.

### **R** **Texans must do everything possible to prevent needless pain.**

Studies show that many terminally ill patients suffer moderate to severe pain in the final week or two of hospitalization and most have serious pain in the last three days of life. Surveys of those who know they are about to die show that their top request is to spend their final days with their families with their pain and other symptoms under control.

Better clinical ethics, palliative care, and hospice can reduce pain, help families, and relieve human suffering.

To reduce suffering, TMA recommends:

- Removing legal barriers to ethical, effective pain management at the end of life. TMA opposes any move that would endanger or prevent appropriate and aggressive pain management practices.



1. Murdock SH. Institute for Demographic and Socioeconomic Research, College of Business, The University of Texas at San Antonio. The Population of Texas: Historical Patterns and Future Trends Affecting Health Care; Sept. 17, 2005. Accessed October 2005 at [http://www.txsc.utsa.edu/download/pdf/presentations/2005\\_09\\_17\\_Tx\\_Medical\\_Assoc\\_Austin.pdf](http://www.txsc.utsa.edu/download/pdf/presentations/2005_09_17_Tx_Medical_Assoc_Austin.pdf).
2. Ibid.
3. Ibid.
4. Texas Department of Health. Strategic Plan for the Prevention of Obesity in Texas; February 2003. Accessed October 2005 at <http://www.dshs.state.tx.us/phn/pdf/obesity-plan.pdf>.
5. Murdock.
6. Texas Diabetes Council. 2004-2005 State Plan.
7. American Diabetes Association. Type 2 Diabetes in Children. *Diabetes Care* 2000. 23:381-9.
8. Texas Department of Health. The Burden of Overweight and Obesity in Texas 2000-2040; June 2004. Accessed November 2005 at [http://www.dshs.state.tx.us/phn/pdf/Cost\\_Obesity\\_Report.pdf](http://www.dshs.state.tx.us/phn/pdf/Cost_Obesity_Report.pdf).
9. Kaiser Family Foundation. 2005 Employer Health Benefits Survey. Accessed October 2005 at <http://www.kff.org/insurance/7315/sections/upload/7316.pdf>.
10. Hewitt Associates. News Release; Oct. 10, 2005.
11. Dor A, Sudano J, Baker DW. The Effects of Private Insurance on Measures of Health: Evidence From the Health and Retirement Study. NBER Working Paper, No. 9774; 2003.
12. Britt R. Insurers Get Bigger Health Dollar Cut, Profits Up, Premiums Up, But Medical Spending Lags. CBS.MarketWatch.com; Oct. 15, 2004.
13. Weiss Ratings, Inc. Nation's HMO Profits Increase 10.7% in 2004; Aug. 8, 2005.
14. U.S. Census August 2005, Robert Wood Johnson Foundation. Characteristics of the Uninsured: A View from the States; April 2005. Accessed October 2005 at <http://www.rwjf.org/research/researchdetail.jsp?id=1882&ia=132>.
15. Federal Reserve Bank of Dallas. Southwest Economy; November/December 2004.
16. 2006 City of Houston Budget Plan.
17. Temple L, Hughes M. Texas Workforce Commission. Jobs in the 21st Century; December 2003.
18. Texas Workforce Commission. Texas Labor Market Review; September 2005.
19. Temple.
20. Hadley J, Cunningham PJ. Center for Studying Health System Change. Perception, Reality and Health Insurance: Uninsured as Likely as Insured to Perceive Need for Care But Half as Likely to Get Care. Issue Brief No. 100; October 2005.
21. Dor.
22. National Center for Health Statistics. National Hospital Ambulatory Medical Survey: 2000; April 2002.
23. Factors Associated With Emergency Department Utilization for Nonurgent Pediatric Problems. *Arch Fam Med*. 2000; 9:1086-1092, p. 1088.
24. Center for Public Policy Priorities and Methodist Healthcare Ministries. The Texas Health Care Primer; November 2003.
25. Families USA. Paying a Premium: The Increased Cost of Care for the Uninsured; June 2005. Accessed October 2005 at [http://www.familiesusa.org/assets/pdfs/Paying\\_a\\_Premium\\_rev\\_July\\_13731e.pdf](http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf).
26. Clifton GL, MD. The Implosion of Emergency Services in the Texas Gulf Coast. Save Our ERs. Accessed Oct. 17, 2005, at <http://www.saveourers.org/crisis.html>.
27. Families USA.
28. Kaiser Family Foundation.
29. Weiss Ratings, Inc. News Release; Aug. 8, 2005.
30. Britt.
31. Kaiser Family Foundation.
32. [www.davidhunnicut.com/pdf/MAY\\_JUN\\_04\\_AA.pdf](http://www.davidhunnicut.com/pdf/MAY_JUN_04_AA.pdf).
33. Texas Department of State Health Services. Worksite Wellness – Reap the Benefits of Health; 2005.
34. Mokdad AH et al. Actual Causes of Death in the United States, 2000. *JAMA* 2004;291:1238-45.
35. U.S. Department of Health and Human Services. The 2004 Surgeon General's Report.
36. Behan DF, Eriksen MP, Yijia L. Economic Effects of Environmental Tobacco Smoke; March 31, 2005.
37. Texas Department of Health. Strategic Plan for the Prevention of Obesity in Texas.
38. Action for Healthy Kids Alliance. The Learning Connection: The Value of Improving Nutrition and Physical Activity in Our Schools; 2004.
39. Texas Department of State Health Services.



40. Texas Department of Health. The Burden of Overweight and Obesity in Texas 2000-2040.
41. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months - United States, 2004. MMWR; July 29, 2005 / 54(29);717-721. Accessed October 2005 at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5429a1.htm>.
42. Glazner JE et al. The Cost of Giving Childhood Vaccinations: Differences Among Provider Types. Pediatrics, Vol. 1333, No. 6; June 2004, 1582-7.
43. Levy DT, PhD; Miller TR, PhD; Cox KC. Costs of Underage Drinking. Calverton, MD: Prepared by Pacific Institute for Research and Evaluation for the Office of Juvenile Justice and Delinquency Prevention; 1999. Accessed October 2005 at <http://www.lhc.ca.gov/lhcdir/drug/CostsOfUnderageDrinkingMosherSep26.pdf>.
44. Texas Comptroller of Public Accounts. Bordering the Future; 1998 (Updated 2001).
45. Texas Department of State Health Services. Supply Trends Among Licensed Health Professions, Texas, 1980-2004. Second Edition; March 2005.
46. Texas Department of State Health Services. DSHS Plans for Pandemic Influenza. Accessed October 2005 at [http://www.dshs.state.tx.us/idcu/disease/influenza/pandemic/Pandemic\\_Influenza\\_briefing.pdf](http://www.dshs.state.tx.us/idcu/disease/influenza/pandemic/Pandemic_Influenza_briefing.pdf).
47. Karel RB. Another Study Confirms Parity Is Affordable. Psychiatric News; 2005. Accessed November 2005 at <http://www.psych.org/pnews/97-12-19/parity.html>.
48. Kennedy PJ. Mental Health Policy in the 21st Century. Presentation at The University of Texas Southwestern Medical Center, Department of Psychiatry; Jan. 28, 2002.
49. Ibid.
50. Rand Corporation. Health Affairs; Sept./Oct. 2005.
51. Commonwealth Fund. Annals of Internal Medicine; Aug. 2, 2005.
52. Health Data Management; October 2005.
53. Brailer, D, MD, PhD. Remarks made at the Healthcare Information and Management Systems Society; 2005. Accessed October 2005 at [www.os.dhhs.gov/healthit/BrailerSpch05.html](http://www.os.dhhs.gov/healthit/BrailerSpch05.html).
54. Audet AM et al. Information Technologies: When Will They Make It Into Physicians' Black Bags? 2004. Available at [www.medscape.com/viewarticle/493210](http://www.medscape.com/viewarticle/493210).
55. Garg AX et al. Effects of Computerized Clinical Decision Support Systems on Practitioner Performance and Patient Outcomes: A Systematic Review. JAMA, 2005; 293 1223-38.
56. Greater Houston Partnership. Public Health Task Force Report. Accessed October 2005 at <http://www.houston.org/pdfs/PHTF/Summary.pdf>.
57. Audet et al.
58. Ibid.
59. Walker J, Pan E, Johnston D, Alder-Milstein J, Bates DW, Middleton B. The Value of Health Care Information Exchange and Interoperability. Health Affairs; Jan. 19, 2005. Accessed October 2005 at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1>.
60. Texas Alliance for Patient Access. Early Texas Tort Reform Benefits; July 2005.