



The Primary Solution
Mending Texas' Fractured Health Care System

THE PRIMARY CARE COALITION



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In 2006, the Texas Primary Care Coalition published “Fractured: The State of Health Care in Texas,” the second in a series of reports detailing the failings of the state’s expensive and inefficient health care delivery system.

The Texas Legislature responded by strengthening public health care programs and working to empower patients as health care consumers. By raising physician payment in Medicaid and setting the framework for several innovative reforms in the program, and by removing many of the barriers to enrollment in the Children’s Health Insurance Program, legislators took bold steps toward protecting some of the state’s most vulnerable populations.

Despite these efforts, many of the dire circumstances described in “Fractured” still persist, threatening to drown the state’s economy in a flood of debt and disease. Past reforms have sought to treat symptoms of what is essentially a broken system, while the central problems have only worsened. To mend the state’s fractured health care delivery system, state leaders must consider reforms from the exam room up, and not the boardroom down.

The Primary Care Coalition has researched the causes of the health care crisis facing Texas and has developed recommendations to lay the foundation for an efficient, high-quality health care delivery system. We trust our comments will serve to stir and awaken readers to the need to confront the health care challenges facing our state and its citizens.

The Primary Care Coalition is comprised of physicians who serve their communities by providing direct patient care and who serve as the first point of contact for patients entering the health care delivery system. These physicians form the frontline of our health care system, providing both preventive and curative care in a coordinated and continuous manner. The Primary Care Coalition members are:

THE TEXAS ACADEMY OF FAMILY PHYSICIANS

5,500 members

Mission: The Texas Academy of Family Physicians is the premier membership organization dedicated to uniting the family doctors of Texas through advocacy, education and member services, and empowering them to provide a medical home for patients of all ages.

THE TEXAS CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS SERVICES

6,250 members

Mission: The mission of the Texas Chapter of the American College of Physicians is to promote quality health care for all Texans by strengthening the practice of internal medicine.

THE TEXAS PEDIATRIC SOCIETY

3,400 members

Mission: To focus its talent and resources to ensure that the children in Texas are safe and healthy, that its members are well informed and supported, and that the practice of pediatrics in Texas is both fulfilling and economically viable. The Texas Pediatric Society is the Texas chapter of the American Academy of Pediatrics.



The Problem: Texas' Health Care System is Broken

In the absence of a health care delivery system that supports cost-effective, coordinated, high-quality care for patients, a fractured system has evolved that provides inefficient and expensive care to those who can afford it and allows those less fortunate to fall through the cracks.

- The cost of health care continues to outpace inflation, putting needed care out of reach for many Texans.
- Double-digit increases in insurance premiums drive a growing percentage of employers to shift health care costs to their employees, to limit options or to stop providing health insurance altogether. Yet the insurance market fails to provide accessible or affordable coverage for those in need.
- Texas currently faces a severe shortage of primary care physicians, which will only worsen as the population swells in coming years. However, the number of students choosing to specialize in primary care has fallen dramatically over the last decade.
- Patients without access to basic primary care fall victim to a fragmented system that doesn't provide preventive, ongoing management of their health in a cost-effective and efficient manner. These patients tend to see multiple specialists for different problems, few of whom are aware of the full range of treatments their patients are receiving. This fragmentation leads to increased hospitalizations, poor-quality care and increased expense.

Past legislative action has addressed symptoms of the disease, but Texas as well as the nation needs a remedy that cures the disease itself. System-wide reform is the only option that offers a real solution. The Texas Legislature cannot cure this disease by itself, but if Texas doesn't begin to build the foundation for an efficient, high-quality health care system, health care costs will continue to consume a growing portion of the state's economy while the health of Texans suffers.

“Higher state health care costs mean worse coverage, and as costs increase, the rate of uninsured individuals also increases. There are several reasons for this relationship. First, higher health costs drive up insurance premiums, which may induce employers and the self-insured to eliminate coverage. Moreover, as workers are forced to assume a higher fraction of their premiums, more of them may not choose health insurance even when offered. In addition, higher health care costs drive up the cost of Medicaid and other need-based government health programs, inducing states to constrict eligibility requirements.”

– Ezekiel J. Emanuel, M.D., Ph.D.
from an editorial published in the
Journal of the American Medical Association, Feb. 27, 2008,
“The Cost Coverage Tradeoff.”

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A Crisis of Cost and Quality

The United States spends 16% of its gross domestic product on health care—\$7,600 a year for each person¹—yet nearly 47 million people are uninsured. Texas bears the dubious distinction of having the highest rate of uninsured citizens in the nation at 24.8%. That’s about 5.9 million people.²

- Spending on health care in the U.S. approached \$2.3 trillion in 2007, up from \$1.15 trillion in 1998.¹
- U.S. health spending is expected to top \$4.2 trillion by 2016.¹
- From 2000 to 2006, employer-sponsored insurance premiums across the nation rose almost 74%.³
- Medicaid spending in Texas climbed nearly 80% from 1996 to 2004.⁴
- Medicare spending in Texas increased by almost 58% from 1996 to 2004.⁵

For this ever-climbing expense, we suffer mediocre to poor-quality care.

- On average, Americans receive only 55% of recommended care for leading causes of death and disability.⁶
- Children receive only 47% of recommended care overall, and just 41% of the preventive services they need.⁷
- Texas ranked 49th out of the 50 states plus the District of Columbia in the Commonwealth Fund’s 2007 State Scorecard on Health System Performance.
 - » Only 34.9% of Texas adults age 50 and older received recommended screening and preventive care in 2004.⁸
 - » Only 34.5% of adult diabetics in Texas received recommended preventive care in 2004.⁸

The poor health of the Texas population underscores the lack of quality delivered by the Texas health care system and the need for system reform.

- In Texas, 64% of adults and 35% of children are overweight or obese.⁹
- The number of obese Texans has more than doubled from 12% in 1990 to 27% in 2005.⁹

- The Texas Department of State Health Services estimates that if nothing is done, the number of overweight or obese adult Texans will grow from 10 million today to 20 million, or 75% of the population, by 2040.⁹
- An estimated 1.4 million adults in Texas have been diagnosed with diabetes and experts believe another 400,000 have undiagnosed diabetes.¹⁰

For each 1% increase in primary care physicians, average-sized metropolitan areas experienced a decrease of 503 hospital admissions, 2,968 emergency room visits and 512 surgeries.¹⁸

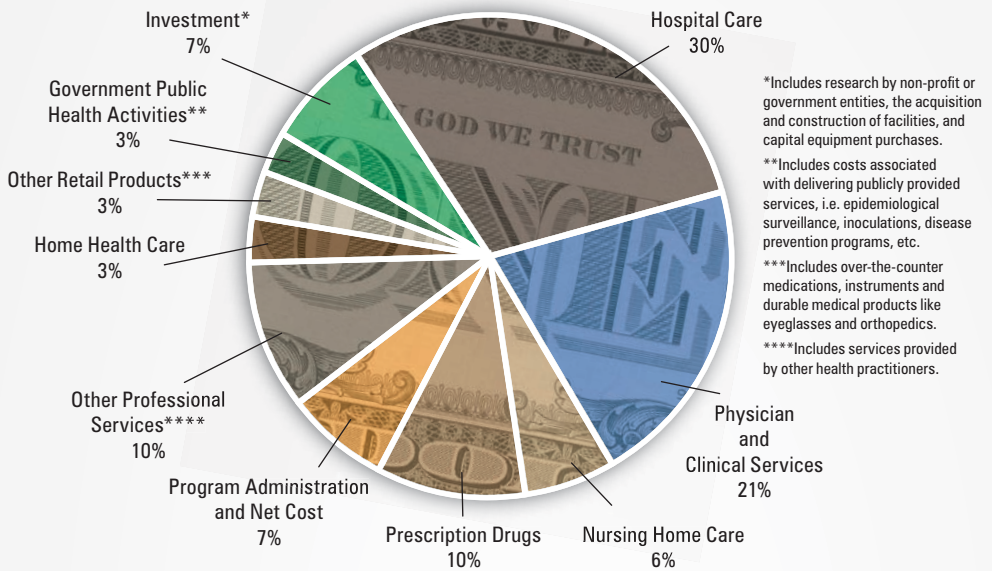
— Steven J. Kravet, M.D., et al., in a 2008 article published in the *American Journal of Medicine* called “Health Care Utilization and the Proportion of Primary Care Physicians”

Poor quality and inadequate management of care in the U.S. health system play major roles in the increasing prevalence of chronic disease among Americans, and chronic disease is responsible for the majority of U.S. health spending. The sickest population consumes the vast majority of health spending.

- 10% of the population account for 70% of health care expenditures.¹¹
- 1% of the population accounts for more than a quarter of health costs.¹¹
- The healthier 50% of the population consumes only 3% of health care expenditures.¹¹
- 95% of Medicare costs are spent on patients with two or more chronic illnesses.¹²
- Patients with chronic illness in their last two years of life account for about 32% of total Medicare expenditures.¹³
- 78% of national health care expenditures can be attributed to chronic illness. That’s almost \$1.8 trillion.¹²

DISTRIBUTION OF NATIONAL HEALTH CARE EXPENDITURES

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics for 2006



A 2008 study by the Commonwealth Fund Commission on a High Performance Health System identifies fragmented care at the national, state and community levels as the primary cause of the poor performance of the U.S. health care system. The report identifies the following characteristics of this fractured system.¹⁴

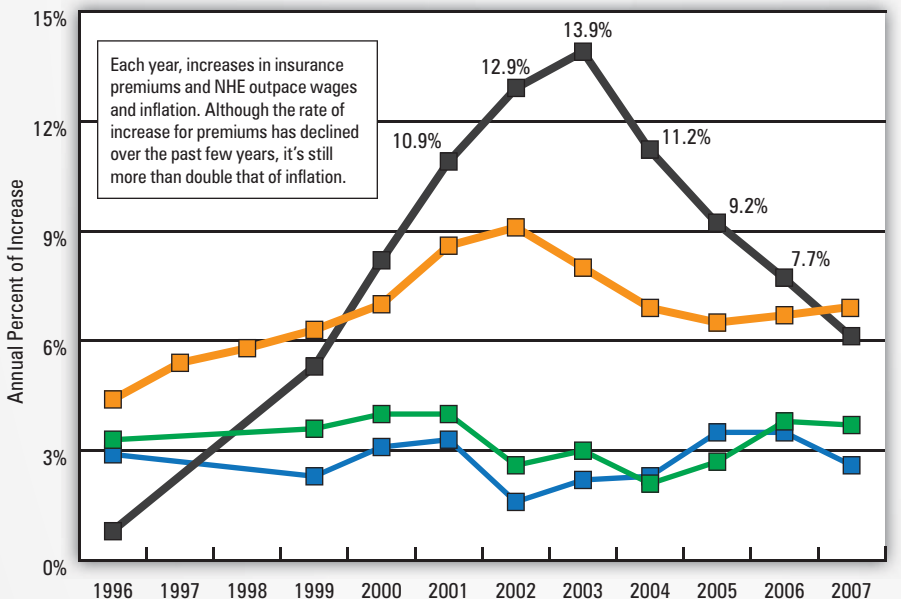
- Patients are forced to navigate the exceedingly complex system with little or no guidance, seeing multiple physicians and other health care providers in various settings.
- The lack of communication and coordination of the care they receive increases inefficiency and the chances of medical errors, waste and duplication of costly services.
- An absence of accountability, quality-improvement programs and clinical information systems leads to poor overall quality of care.
- An imbalance in compensation between high-cost procedures and primary care services devalues preventive medicine and the management of chronic illness.

How do we reform our health care system so that all patients have ready access to affordable, high-quality health care while stopping the persistent and unsustainable inflation in health costs?

To mend the fractured health care system, we must ensure that primary care physicians have the tools and support they need to provide the coordination and continuity of care required for patients to receive the right care at the right time at the right cost.

RATE OF INCREASE IN HEALTH INSURANCE PREMIUMS, NATIONAL HEALTH EXPENDITURES AND OTHER INDICATORS

Source: Claxton, Gary, et al. "Employer Health Benefits 2007 Annual Survey." The Henry J. Kaiser Family Foundation and Health Research and Educational Trust. 2007.

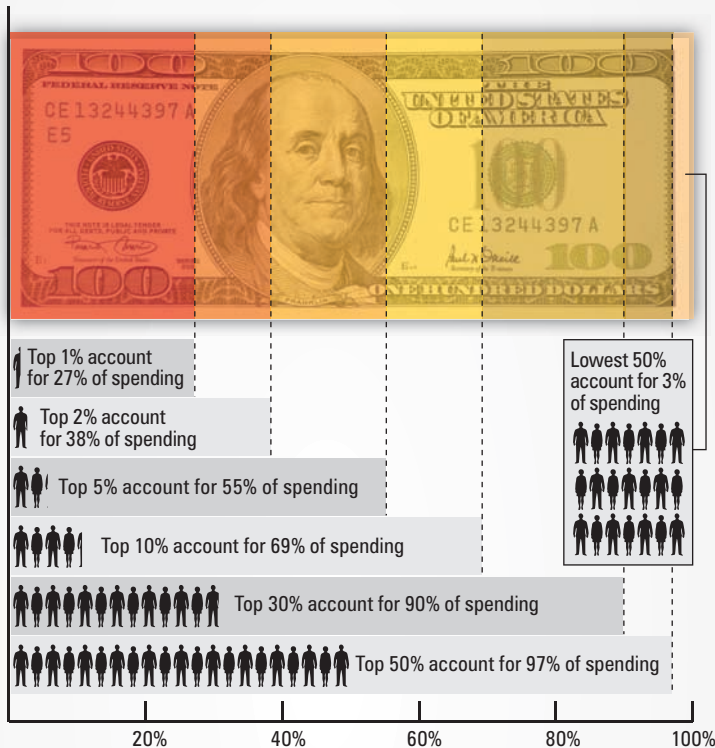


Year	1996	1999	2000	2001	2002	2003	2004	2005	2006	2007
National Health Expenditures	4.4	6.3	7.0	8.6	9.1	8.0	6.9	6.5	6.7	6.9
Health Insurance Premiums	0.8	5.3	8.2	10.9	12.9	13.9	11.2	9.2	7.7	6.1
Inflation	2.9	2.3	3.1	3.3	1.6	2.2	2.3	3.5	3.5	2.6
Workers' Earnings	3.3	3.6	4.0	4.0	2.6	3.0	2.1	2.7	3.8	3.7

CONCENTRATION OF HEALTH EXPENDITURES

A small percentage of high-cost patients account for a disproportionately large amount of health care spending

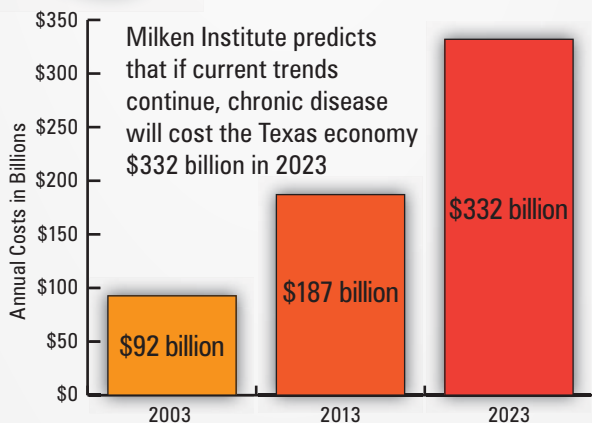
Source: Berk, Marc L, et al. "The Concentration of Health Care Expenditures, Revisited." Health Affairs 20.2 (2001): 9-18.



ECONOMIC IMPACT OF CHRONIC DISEASE ON TEXAS, 2003 AND FUTURE PROJECTIONS

Treatment expenses plus lost productivity equal tremendous costs

Source: An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007



The Primary Solution

Better quality at lower costs

Researchers have shown time and again that patients with ready access to primary care receive higher quality care with better health outcomes for less cost.

- The Dartmouth Institute for Health Policy and Clinical Practice has found that states relying more on primary care report better health outcomes, scoring higher on quality rankings and recording fewer ICU deaths.¹⁵
- They also have lower Medicare spending and lower health care utilization rates.¹⁵

Barbara Starfield, M.D., M.P.H., of Johns Hopkins University has published numerous studies showing that primary care is associated with lower health costs while achieving lower mortality and morbidity rates.¹⁶ Her research also suggests that a health system based on primary care reduces socioeconomic health disparities.

- Primary care medical homes can reduce or even eliminate racial and ethnic disparities in health care access and quality for people with health insurance.¹⁷
- Hospitalization rates and expenditures for ambulatory care-sensitive conditions like diabetes and congestive heart failure are higher in areas where there are fewer primary care physicians and where access to primary care is limited.¹²
- For each 1% increase in primary care physicians, average-sized metropolitan areas experienced a decrease of 503 hospital admissions, 2,968 emergency room visits and 512 surgeries.¹⁸

North Carolina officials launched a primary care network called Community Care of North Carolina (CCNC) designed to provide primary care medical homes and enhanced chronic care management for Medicaid patients. The network now serves more than 725,000 Medicaid patients.

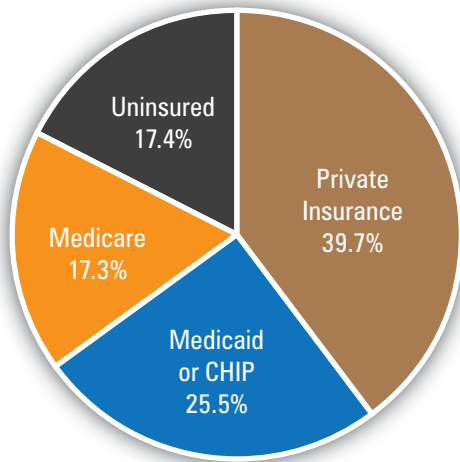
- CCNC saved North Carolina taxpayers between \$231 million and \$255 million in fiscal years 2005 and 2006.¹⁹

Geisinger Health System in Pennsylvania implemented the primary care medical home, complete with an integrated delivery system, EHR and other services for 2.5 million patients.

- Preliminary data show a 20% reduction in hospital admissions and a 7% savings in total medical costs.²⁰

EMERGENCY ROOM UTILIZATION BY EXPECTED FORM OF PAYMENT, 2006

The lack of access to primary care leads to increased use of Texas' emergency rooms



Source: National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary

When people are unable to access primary care, they seek care in our overburdened and expensive emergency departments where it is highly unlikely they will receive well-coordinated and efficient health care.

- Emergency room visits in Texas jumped from 5.5 million in 1992 to 8.6 million in 2003. Almost half of those visits could have been addressed for less cost in a primary care setting.²⁴
- From 1996 to 2006, ER visits in the U.S. increased more than 32% from 90.3 million to 119 million.²⁵
- While the proportion of those visits attributed to uninsured patients remained relatively flat between 1992 and 2005, the number of overall visits went up 28%.²⁵
- In an interesting trend, people earning more than 400% of the federal poverty level (about \$84,000 for a family of four) accounted for a growing portion of emergency room visits, while the number of ER visits by low wage earners showed no substantial increase.²⁵

The bottom line is this: By redesigning our health care system so all patients have access to a patient-centered primary care medical home where a team of qualified health providers is led by a primary care physician, we can ensure they will receive more preventive care, better management of their chronic illnesses and enjoy higher quality care with less medical intervention. ***And we'll save money.***

An established medical home empowers primary care physicians to use their expertise in the coordination and integration of care to ensure the kind of quality and savings these researchers and others have discovered. These trends hold true especially in the area of chronic disease management and long-term care, where the bulk of health care spending occurs.

But establishing a medical home depends on the support of a health care system dedicated to nurturing its success and providing an adequate supply of primary care physicians. In Texas' fractured health care system, that support doesn't exist.

The Primary Care Medical Home

How do we begin to build the medical home?

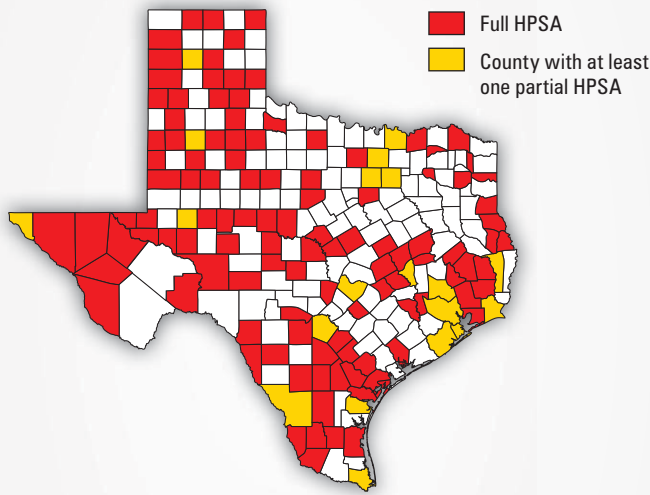
To make the primary care medical home a reality, we must overcome some formidable barriers.

- Texas faces a severe shortage of primary care doctors.
- To attract and produce those physicians and to support the work of coordinating patient care, we must restructure how we pay for primary care services.
- We have to usher medicine into the 21st century, giving physicians the tools they need to provide the high-quality, efficient care Texans need by investing in the health information technology infrastructure of Texas.
- We must make sure all Texans can access the health care system by ensuring a transparent, affordable private insurance market and through strengthened and streamlined public programs.

HEALTH PROFESSIONAL SHORTAGE AREAS

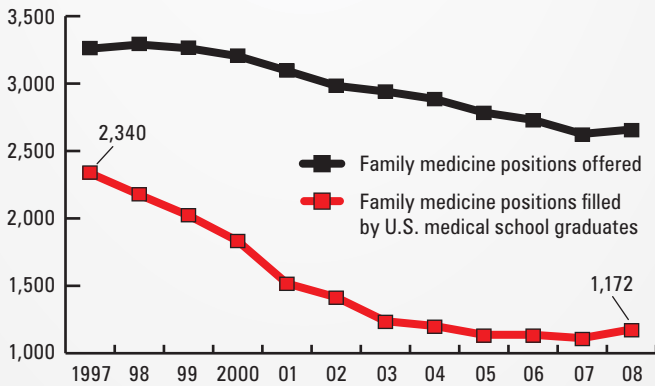
114 counties in Texas are classified as full HPSAs

Source: Texas Department of State Health Services Health Professions Resource Center



NUMBER OF FAMILY MEDICINE RESIDENCY POSITIONS FILLED BY U.S. MEDICAL GRADS

Source: National Resident Matching Program



A Dwindling Supply of Primary Care Physicians

Who'll be home in the medical home?

Texas, like the nation at large, doesn't have enough primary care physicians to care for its growing population, and the poor distribution of the physicians we have only worsens the problem. 56 million Americans do not have adequate access to primary health care because of local shortages of primary care physicians.²¹

- The national average for primary care physicians to every 100,000 people is 81. Texas averages 68 for every 100,000 people.²²
- 114 Texas counties are considered full primary care health professional shortage areas and the state has 47 partial HPSAs occurring in 17 counties.²³

- 19 Texas counties have just two physicians. 17 counties have one physician. 25 counties have no physicians at all.²³
- 5.1 million Texans—about 1 in 5—live in a full or partial HPSA,²¹ yet only 1 in 10 physicians practice in a non-metropolitan area.²⁴
- Federal government defines a HPSA as having less than 1 physician for each 3,500 people.
- Texas needs about 520 more primary care physicians to meet that ratio. If appropriately distributed to high-need areas, this increase would eliminate HPSAs in the state.²³
- By 2015, Texas will need more than 4,500 additional primary care physicians and other providers to care for the state's underserved population, predicted to be 5.3 million people.²¹

While the need for primary care physicians increases each year, the number of primary care residency positions offered today is basically the same as it was in 1998. Meanwhile, the number of U.S. medical school graduates entering primary care residencies has dropped dramatically.

- The number of U.S. medical school graduates choosing to enter family medicine has fallen by about 50% since 1998.²¹
- In 2008, there were 44 fewer family medicine residency programs and 780 fewer filled training positions than there were in 2000.²¹

Graduates leaving medical school carry considerably more than \$100,000 of debt, a figure that plays a significant role in their decision of whether to practice primary care or pursue more lucrative specialties.

- In 2007, medical school graduates incurred \$131,463 in debt on average.²⁷
- It takes more than a decade to prepare a primary care physician for practice. The time to invest in the future primary care workforce of Texas is now.

One of the most effective ways to increase the quantity of primary care physicians in Texas is to train them here. Most physicians choose to practice in the state where they trained as residents.

- Of primary care physicians completing residency in Texas from 1996-2001, 63% stayed in Texas.²⁸
- At 71%, family physicians were the most likely to stay in Texas.²⁸

- Almost 7% of primary care residents staying in Texas during those years practice in full HPSAs.²⁸

While it is imperative that we attract more medical students to primary care and support their residency training in Texas, we can't forget the wealth of experience that we have in our current primary care physician workforce.

A recent survey by Merritt Hawkins & Associates found that within the next one to three years, over half of physicians ages 50 to 65 plan to retire, seek non-clinical jobs or otherwise significantly reduce the number of patients they see.²⁹ We must work to keep our older physicians from leaving the practice of medicine when they are in the prime of their careers.

What is Primary Care Worth?

Change the incentives to get the care Texas needs

To make the medical home a reality for all Texans, we must reform the way our system pays for primary care. Adjusted for inflation, compensation for primary care physicians fell by more than 10% from 1995 to 2003.

Today, incentives in physician compensation work to encourage more high-priced procedures, discouraging physicians from spending time and energy coordinating and managing the health of their patients. One needs only to examine compensation trends for different medical specialties over the past decade to see that our current system places much greater value in high-priced, episodic specialty care than in primary care.

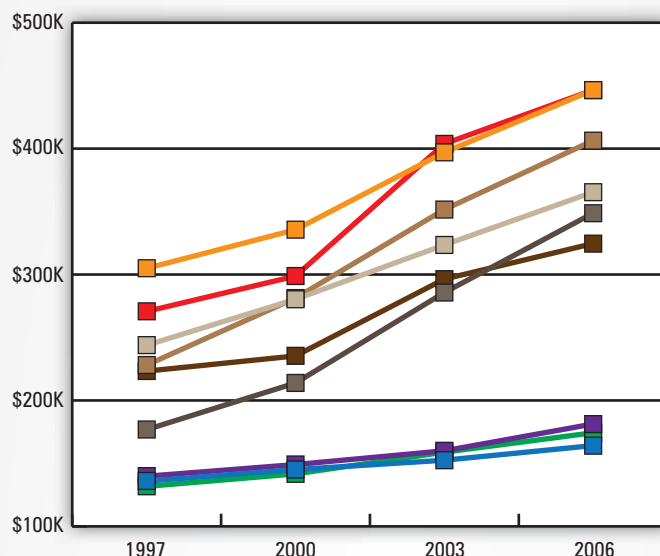
- In 1997, the average income for family medicine without obstetrics was \$132,002. The average income for dermatology was \$176,896 and for diagnostic radiology, \$270,796.³⁰
- By 2006, the average income for family medicine had increased by 20%, up to \$164,021.³⁰
- During the same period, compensation for dermatology jumped 97% to \$348,706, and diagnostic radiology increased by 70% to \$446,517.³⁰

By changing way we pay for primary care—by paying for better care rather than more care—we can attract more medical students to pursue careers in primary care and we can encourage primary care physicians to provide true medical homes for Texans.

COMPENSATION TRENDS AMONG MEDICAL SPECIALTIES, 1997 TO 2006

During a decade of increasing earnings for many specialists, primary care specialties have remained the lowest paid.

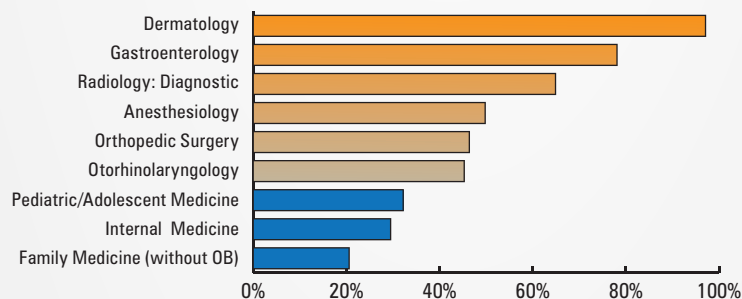
Source: Medical Group Management Association Physician Compensation and Production Survey Reports, Median Compensation for Selected Specialties, 1997-2006



	1997	2000	2003	2006	Percent of Increase
Dermatology	\$176,896	\$213,876	\$285,692	\$348,706	97.1%
Gastroenterology	\$228,122	\$281,308	\$351,614	\$406,345	78.1%
Radiology: Diagnostic	\$270,796	\$298,824	\$403,779	\$446,517	64.9%
Anesthesiology	\$243,937	\$280,353	\$323,491	\$365,409	49.8%
Orthopedic Surgery	\$305,000	\$335,646	\$397,059	\$446,517	46.4%
Otorhinolaryngology	\$223,366	\$235,415	\$296,338	\$324,529	45.3%
Pediatric/Adolescent Medicine	\$131,803	\$141,676	\$158,853	\$174,209	32.2%
Internal Medicine	\$139,879	\$149,104	\$159,978	\$181,187	29.5%
Family Medicine (without OB)	\$136,002	\$145,121	\$152,478	\$164,021	20.6%

PERCENT OF INCREASE IN COMPENSATION AMONG MEDICAL SPECIALTIES, 1997 TO 2006

Source: Medical Group Management Association Physician Compensation and Production Survey Reports, Median Compensation for Selected Specialties, 1997-2006



Texas Needs a 21st Century Health Care System

Building Texas' health information technology infrastructure

America boasts the most high-tech medical treatments and diagnostic measures in the world and we continue to develop more advanced procedures, pharmaceuticals and imaging technology. Yet Americans receive the recommended care for their illnesses only 55% of the time. In this era of technological supremacy, why do we get such poor care?

None of medicine's amazing technological advancements extend to the management of patient care. In fact, health care is the only major industry in America that still operates on a paper-based system. It's no wonder health care in America is fraught with error and duplication. If we are to experience the true benefits of the medical home, we must invest in a health information technology infrastructure for Texas.

- A study by the RAND Corporation estimates that if the United States were to experience broad adoption of interoperable electronic health records among physicians and hospitals, the country could save more than \$81 billion each year.³¹
- If those systems were connected through a national information network and the entire system were tooled to enable better quality and coordination of care, preventive care and chronic disease management, researchers estimate savings could be as much as \$142 billion to \$371 billion.³¹

Equipping residency programs and primary care clinics with health information technology is the first step to realizing these savings, but the cost of implementing these systems is prohibitive, especially in today's market where most primary care practices are struggling to make ends meet.

- One study of EHR implementation in small group practices showed that on average, the systems cost \$44,000 per full-time physician with annual maintenance costs of \$8,500 per provider.³²
- A large survey showed the average initial cost of EHR implementation is about \$33,000 per physician with maintenance costs of about \$1,500 per physician per month.³³
- For most practices, EHR implementation leads to a reduction in productivity for 10-15 months and a 10% cut in take-home pay for five years.³³

If we succeed in building an effective health information technology infrastructure resulting in increased efficiency, higher quality, better disease management and a healthier population, the lion's share of savings will go to insurers and the government. But the initial expense must be paid by individual physicians who probably won't realize any return on their investment for the first few years.

In the American health care industry, which thrives on new technology, it doesn't make sense that physicians rely on mid-20th century practices to manage their patients' care. If we expect to get better care for less money, we must give our physicians the decision-support tools of the 21st century. As Newt Gingrich says, far too often the doctor puts down the laptop and picks up the clipboard before walking into the exam room.³⁴ It's time for the state to invest in the health information technology infrastructure Texans deserve.

“The time has come to put the medical clipboard out of business and replace it with the computer. In doing so, we can transform our health care system so that we achieve fewer medical mistakes, lower costs, better care, and less hassle.”

– Mike Leavitt, Secretary, U.S. Department of Health and Human Services

Navigating the Maze of Private Health Insurance in Texas

The private health insurance market has failed Texas' citizens and its physicians. Unfettered consolidation of the managed care market has allowed multi-billion dollar insurers to run roughshod over solo and small group physicians and has placed patients in harm's way. Predatory managed care business practices have significantly increased the profitability of managed care plans while leaving patients with higher premiums, higher out-of-pocket costs, fewer benefits and less access to affordable insurance options.

- Family health insurance premiums for Texans in employer-sponsored plans rose 79.7% from 2000 to 2006, while median earnings for Texas workers increased only 10.8%.³⁵
- From 2001 to 2004, out-of-pocket spending for premiums and services for people enrolled in employer-sponsored plans jumped 21% to an average of \$3,211.³⁶

PREMIUMS VERSUS EARNINGS IN TEXAS

From 2000 to 2006, average premiums for employer-sponsored family coverage in Texas increased 79.7% while earnings increased 10.9%.

Source: Families USA—Premiums Versus Paychecks, A Growing Burden for Texas Workers

- 61% of small employers with 10 to 199 employees provided health insurance in 2007, down from 69% in 2001.³⁷
- 6.4 million fewer U.S. workers received employer-provided health insurance in 2006 than in 2000.³⁸

As employers are forced to shift costs to their employees, seek out limited-benefit health plans or drop health insurance altogether, people find themselves woefully underinsured or scrambling to find coverage in the deliberately labyrinthine individual insurance market.

- 75 million non-elderly adults were either uninsured or had inadequate insurance in 2007.³⁹
- An estimated 25 million adults were underinsured in 2007, a 60% increase over 2003.³⁹
- In 2007, 35% of adults insured for the entire year went without needed care because of high out-of-pocket costs.⁸

In a market where insurance premiums increase at such a rapid rate, we must ask whether the coverage and benefits we receive are worth the cost we pay. How much of the premiums insurers collect actually go to pay for health care services and how much goes to administrative costs, marketing and profits?

Unfortunately, Texans can't access the information they need to answer these questions because the Texas Department of Insurance doesn't have the proper tools to evaluate the rate-setting and underwriting practices of health insurance companies.

- Administrative costs for private insurance plans increased by 68%—from \$289 to \$485 per person—from 2000 to 2006.⁸
- About 7% of total U.S. health care spending goes to the administration of private insurance. That's \$161 billion.⁴⁰
- Only 2% of Medicare spending goes to administrative costs.⁸



With unchallenged market power, health insurers impose costly administrative burdens on physicians while constantly trying new ways to pay them less for services. Despite legislative efforts to inject fair market practices into managed care, physicians still must chase after payment from third-party payers, requiring costly administrative staff to handle billing problems, secure prior authorizations and untangle bundled and down-coded payments from health plans. They do not provide coverage information at the point of service so physicians and patients can have meaningful discussions about treatment options and what the patients' out-of-pocket responsibilities will be. Under the weight of this burden, physicians must endure growing administrative and practice costs.

Texas' Frayed Health Care Safety Net

Alongside the private health insurance market, Texas' public programs play a vital role in providing coverage to poor and low-income Texans. Investment in primary and preventive care through Medicaid and CHIP will lead to fewer costly hospital admissions and emergency room visits while returning federal tax dollars to our state and local economies.

- The federal government matches each dollar spent in the Medicaid program with \$1.54.
- For each dollar spent in the CHIP program, the state receives \$2.63.

The 80th Legislature enacted important reforms for both Medicaid and CHIP. Those reforms have significantly improved these programs, increasing coverage for some of Texas' most vulnerable populations. While the effort was laudable, many children still lack coverage.

- 850,000 uninsured children who are eligible for CHIP or children's Medicaid are not enrolled.⁴¹
- By improving enrollment in these programs, Texas can cut the number of uninsured children in half.⁴¹

Even though the Legislature increased payment rates for Medicaid and CHIP, those rates still lag far behind other payers.

- Medicaid pays physicians about 73% of what Medicare pays for the same service.

For many physicians working to keep their practices in the black, taking new Medicaid patients is simply a bad business decision. According to a 2008 survey by the Texas Medical Association, only 42% of physicians accept all new Medicaid patients. To ensure that our Medicaid beneficiaries can access primary care and preventive care today so they don't have to seek emergency care tomorrow, we have to bring Medicaid payments on par with Medicare.

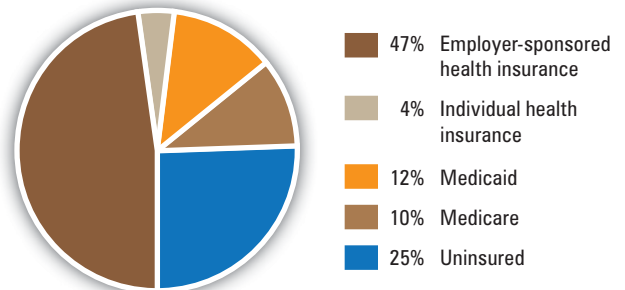
The Plight of the Uninsured

Perhaps the most damning indicator that the health care system and the private health insurance market in Texas have failed is the state's swelling ranks of uninsured citizens.

- One in four Texans is uninsured.² 79% of them work or have an immediate family member who works.⁴²
- 1.5 million children in Texas are uninsured.⁴¹

HEALTH COVERAGE IN TEXAS

Source : Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey



Uninsured patients rarely receive preventive, primary or continuous care. Their chronic conditions like hypertension and diabetes worsen as they go unmanaged and untreated until the patients wind up in the emergency room. They see multiple physicians and other health care providers during these episodes who have no record or patient history to rely on, increasing the likelihood that they receive duplicate and unnecessary diagnostic tests, lab work and screenings.

Uninsured patients are often left with mountains of medical debt, compounding whatever financial troubles rendered insurance unaffordable for them in the first place. It is a vicious circle, one experienced by more and more Texans every year.

The cost of uncompensated care provided to uninsured patients must be absorbed by the system, raising health-related costs for our counties, our hospital districts and our individual insurance premiums.

- Charges for uncompensated care rose from \$5.5 billion in 2001 to \$11.3 billion in 2006.⁴³
- The cost of that care is passed on to local and county budgets, driving up taxes and ultimately adding an extra \$1,500 to the average annual family health insurance premium for insured Texans.⁴⁴

For the sake of our citizens, our taxpayers and the children of Texas, we have to find innovative, market-based solutions to provide affordable, attractive and comprehensible insurance options to those who need coverage. We must give the Texas Department of Insurance the necessary tools to ensure the insurance market has consumer protections in place so that the promise of "low-cost coverage" doesn't turn out to be no coverage when it's needed most. And we must strengthen and secure our public health care safety net programs.

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Laying the Foundation for the Future of Health Care in Texas

The reality is that in Texas, far too many people are left stranded without access to primary health care, without a medical home, with serious and costly chronic illnesses, and no option but to seek emergency care and risk financial ruin. That's not a health care system that works for Texas.

The Texas Legislature cannot fix all that ails the state's fractured system. Ensuring that each Texan has a patient-centered primary care medical home will take strong leadership and dedicated effort at the federal level as well as the state and local levels of government. It will take broad acceptance of a new vision by physicians, health care providers and patients across the nation.

But the Texas Legislature can take bold steps toward a new health care system for our state. By working to provide an affordable and accessible insurance market for all Texans, by strengthening Medicaid and CHIP, by growing our primary care physician workforce and by investing in our health information technology infrastructure, the Texas Legislature can lay the foundation of a health care system that will benefit generations of Texans to come.

The Primary Care Coalition urges the following actions this legislative session:

1. Grow our primary care physician base.

- Create a consolidated loan repayment program for Texas' primary care physicians and other qualified health care professionals who agree to serve in medically underserved areas. The program would pay up to \$160,000 for medical school debt over four years, so that physicians would receive \$25,000 for their first year of service and increasing amounts in the following three years.
- Increase funding for family medicine residency programs and primary care residency programs, and reinstate Medicaid GME funding.
- Fully fund primary care preceptorship programs.

2. Invest in health information technology.

- Create a matching investment fund, modeled after the Telecommunications Infrastructure Fund, to provide HIT infrastructure for residency programs and primary care physician practices.

3. Ensure Texans have access to affordable health insurance options.

- Give the Texas Department of Insurance the statutory authority to review health insurance premiums to promote a fair, transparent health insurance market with adequate consumer protections, and enact legislation to simplify and streamline the rate-setting process for small employers and individuals to reduce premiums.
- Adopt a standardized managed care contract. Require TDI to establish a standard contract form between physicians and health plans that conforms to all state laws and regulations, and that clearly delineates any unique contract provisions. A standardized contract will reduce administrative costs for physicians and health plans and eliminate the need for extensive legal and administrative review of each and every contract.

4. Pursue innovative, market-based approaches to reduce the ranks of the uninsured.

- Build upon the reforms initiated by Senate Bill 10, which directs the Health and Human Services Commission to use Medicaid dollars as a financing tool to extend private coverage for low-income parents and adults.
- Support funding for local public-private collaborations such as the three-share model designed to extend affordable health care and coverage for the uninsured.

5. Reinvest in Medicaid and CHIP.

- Revitalize the Medicaid and CHIP physician network by supporting competitive physician reimbursement rates that keep pace with the amount it costs to provide the services, and include rewards for physicians who implement after-hours care, open-access scheduling and other features of the patient-centered medical home. To support access to care for all patients, the state should establish equivalent Medicaid payment rates for adult and children's services.
- Enact 12 months continuous coverage for children enrolled in Medicaid and CHIP. Texas should strengthen outreach initiatives with the goal of enrolling all children who are eligible but not enrolled in CHIP or Medicaid and support measures to improve the accuracy and timeliness of the eligibility process for patients.
- Reduce the Medicaid "hassle factor" to entice more physicians to participate, modernize outdated information technology, and support extended use of HIT such as electronic medical records and e-prescribing.

6. Support a patient-centered primary care medical home for all Texans.

- Assure that patients receive the right care at the right time, every time by supporting and nurturing the establishment of a medical home for every Texan.
- Provide incentives to physicians who adopt components of the medical home model into their practices such as after-hours care, open-access scheduling and health information technology to provide the best care at the lowest price for their patients.

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