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Significant Medicaid Savings Could Be in Jeopardy

A large chunk of approximately \$600 million in projected state savings for the 2012-2013 biennium could be in jeopardy if inpatient hospital services are excluded from the state's proposed strategy to better manage Medicaid costs through the expanded use of managed care.

The \$600 million in state savings and \$1.2 billion in All Funds are included in HB 1 and SB 1 and would result from the state's replacement of the fee-for-service and Primary Care Case Management (PCCM) models within the Medicaid program with an HMO model designed to control costs.

Also at risk are greater efficiencies within the program that could be realized as the state shifts from the fee-for-service system to a performance-based payment system as proposed in SB 7 by Senator Jane Nelson.

With hospitals accounting for 43 percent of all Medicaid costs, proponents of the state's cost containment strategies say that without the ability to manage inpatient hospital costs, a key cost driver for the Medicaid program is uncontrolled, significant savings would be lost and the state's budget certainty for the program will be gone. According to the executive commissioner of HHSC, such a loss in savings would need to be recaptured through further reductions in provider rates.

The state's investment in its STAR and STAR+PLUS managed care programs has resulted in national recognition for favorable outcomes, budget savings and accountability safeguards for taxpayers. The programs have been touted for their ability to reduce costs and improve care through the combined use of medical homes, innovative care delivery, disease management, prevention strategies and flexible incentives for physicians. STAR and STAR+PLUS managed care programs provide a long-term solution to controlling Medicaid costs. Other initiatives for savings such as provider rate reductions are one-time savings and do nothing to address the state's ability to bring Medicaid costs under control in subsequent years.

U.S. Supreme Court Says No on Expedited Review of Federal Health Care Reform Challenge

The U.S. Supreme Court's refusal to quickly rule on the legality of the federal health reform bill means the court will likely be considering the issue during the middle of the 2012 presidential campaign.

The court had been asked by Virginia's attorney general to consider the constitutionality of the Patient Protection and Affordable Care Act on an expedited basis; however, the Supreme Court rarely considers cases that have not been reviewed by appellate courts. With at least three challenges to the reform bill scheduled to be heard by appeals courts in May and June, the case could make its way back to the U.S. Supreme Court next year.

Several states, including Texas, have challenged the reform bill's mandate that all citizens not covered by an employer's insurance must purchase their own coverage. Legal challenges have been filed throughout the country with mixed results; some judges have ruled in favor of the individual mandate and some have ruled against it.

Meanwhile, built-in triggers in the reform means states that wait for a ruling from the Supreme Court could run out of time to take control of critical portions of the new health care system if the ruling goes against the states. The reform requires an American Health Benefit Exchange be established in every state. States that do not demonstrate by 2013 that they will have the structure in place to operate an Exchange will have their Exchange established and run by the federal government.

Birthdays

May

2 – Sen. Florence Shapiro

6 – Rep. Allan Ritter

8 – Rep. Barbara Mallory
Caraway

11 – Rep. John Kuempel

16 – Sen. Wendy Davis

18 – Rep. Sarah Davis

22 – Rep. Tan Parker

23 – Rep. Jose Lozano

29 – Rep. Charles Schwertner

30 – Rep. Charlie Howard

30 – Rep. Hubert Vo

Legislation Would Provide Employers New Tool to Manage Health Care Costs

HB 1772 by Rep. Larry Taylor would add an important new tool to Texas employers' ability to control health care costs and continue offering health coverage to their employees. The legislation, supported by the Texas Association of Business, Texas Association of Health Underwriters and the Texas Association of Health Plans, was approved on an 8-0 vote by the House Insurance Committee.

Rising medical costs are believed to be the primary driver causing many employers to eliminate health coverage for their employees. The most recent U.S. Census reports indicate the number of individuals receiving coverage from their employer dropped for the ninth consecutive year. The decline in employer coverage is a troubling sign for many families and individuals who may face financial difficulty as a result of being forced to purchase their own coverage or confront the risks of becoming uninsured.

In an attempt to better contain the underlying health costs that drive insurance premiums, employers are exploring new ways to manage medical expenses. Exclusive Provider Organizations (EPOs) are the latest approach they are utilizing in their quest to gain control of medical spending.

By striking a balance between the cost control measures of the traditional HMO model and the broad access offered by a Preferred Provider Organization (PPO), EPOs offer employers predictable, manageable and reasonable costs while retaining access to quality health care for their employees. Nationally, EPOs are widely utilized by businesses with self-funded health plans, but Texas law does not provide the state's employers the EPO option.

HB 1772 is currently pending in the House Calendars Committee.

Medical Errors: Are Hospitals Safe?

Recent studies show a hospital stay could cause more damage to health than previously believed.

One in three hospital patients suffers a hospital-related injury, with 7 percent either dying or suffering permanent harm, according to a recent study published in Health Affairs. According to the study, an estimated 400,000 "never events" — so called because medical professionals say they should never occur — were reported in the nation's Medicare system during 2008. Never events range from foreign objects left in the body, patient falls and traumatic injuries to infected catheter sites and serious pressure infections (bed sores).

Researchers from the actuarial firm Milliman report that medical errors cost the health care system \$17.1 billion a year, and that the cost of avoidable hospital readmissions adds another \$13 to \$18 billion a year.

Pressure ulcers were the most common measurable medical error found by the study, followed by postoperative infections and postlaminectomy syndrome, a condition characterized by persistent pain following back surgery. A total of 10 types of errors account for more than two-thirds of the total cost of errors.

Under new federal law, hospitals will be rewarded financially for quality outcomes and penalized for avoidable errors. Beginning in 2014, Medicare payments will be cut by 1 percent to hospitals with the highest rates of patient safety issues. Federal officials hope new initiatives will reduce preventable injuries in hospitals by 40 percent and cut preventable hospital readmissions by 20 percent.

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