

*Investing in Texas: Financing Health Coverage Expansion  
Conference Proceedings*

**Opportunities for Generating New Revenue**

**David Warner:** Next, we are going to look at some financing options, given that Senator Ellis has given us the backdrop within which we have to play. Basically, we are trying to look at this with regard to using no additional general revenue to pay for expansions. This panel is going to be moderated and added to by Kristie Kimbell. Kristie is a native of Waco, Texas, who received a bachelor's degree from Texas A&M University and a master's degree in social work from UT Arlington. She worked at Scott and White for several years before coming to the LBJ School, and is now in her second year at the school.

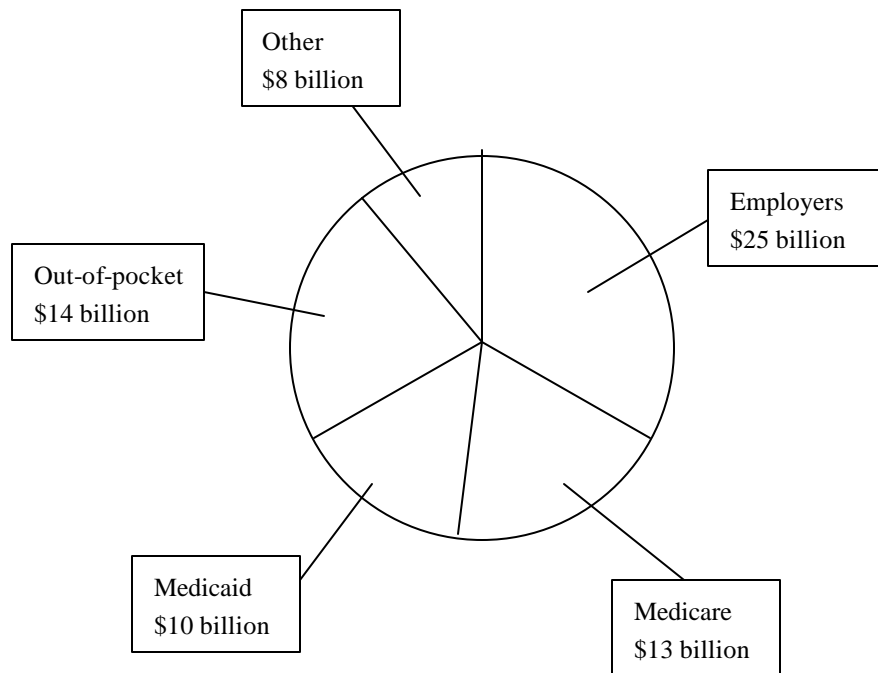
**Kristie Kimbell:** Thank you, Dr. Warner. Senator Ellis brilliantly described for us the fiscal landscape in Texas. Given that this less-than-rosy picture exists and provided that Texans are indeed interested in an effort to maximize our current health care expenditures, the next presentation will turn our focus to possible mechanisms for financing a health coverage expansion. I would first like to take just a moment to tell you about the research team behind this monumental task of discovering sources of funding from such an alleged dry well. This group has come to be known affectionately as the "show me the money" taskforce. This group has spent hours, days, weeks, and months undertaking the following research. The group conducted state-by-state research via the Internet, e-mail, and telephone. They conducted a statewide survey of county judges and program and hospital administrators to which 120 responses were returned. They conducted countless in person and telephone interviews with state agency experts, state elected officials, and stakeholder experts, and they poured over mounds of state agency reports, legislative committee reports, national expert reports, Texas Administrative Code, and various related house and senate bills.

I would like to introduce you to a group of individuals that I have an ever-growing admiration and respect for. A couple of them are sitting out here in the audience. I am going to ask them to stand: Kate Brodsky, former Senator Chet Brooks, Laura Koenig, Evan Christman, and Jamie Dudensing. Evan is one of several token East Coasters in our class. Evan has impressive experience as an analyst with the Congressional Budget Office in D.C. Jamie Dudensing is from Sweetwater, Texas, and as a registered nurse has had the unique distinction for about 6 or 7 months of being the nurse for the State Legislature, prior to coming to the LBJ School. Evan will begin our presentation this afternoon by briefly walking us through a description of the current spending structure for health care in Texas specifically for the uninsured. Evan will then present several alternative funding mechanisms, utilizing existing resources. Jamie will then present a variety of ever-popular options for new revenue generation and lastly, I will provide a brief wrap-up regarding expansion and funding. Evan...

**Evan Christman:** Thank you Kristie. As Kristie mentioned, I am going to be taking you through the way the health care system in Texas is currently funded, and there are three things I want to go through in order to do that. I am going to give you an overview of where the current money is spent. I want to give an introduction to how the two systems the state operates provide public assistance for the uninsured, and we are going to look at possible alternatives using the current funding that we have.

Now, this graph will probably be familiar to a lot of people (see Slide 1). It is based on the State Comptroller's study of health care spending in Texas in 1998. I just thought I would throw it up there to give everybody a big-picture look. There is a total of about \$70 billion there, and the three big payers are the ones you would expect: employers, Medicare, and the Texas Medicaid program. Then there are out-of-pocket expenses for \$14 billion and a countless number of other programs in the remaining \$8 billion. By comparison, the Comptroller estimated that in 1998, of the \$70 billion spread throughout all these payers, about \$5 billion in care for the uninsured was delivered in the state.

### Slide 1 Health Care Spending in Texas in Perspective, 1998



Texas could be said to operate two different systems of public assistance. The first one is the Medicaid system. In Texas, Medicaid primarily covers low-income children, TANF-eligible adults, the elderly, and the disabled, though a state-federal partnership. The state pays 40 cents of each dollar of Medicaid expenses. The second system is basically a

system that Texas counties are mandated by law to operate, and this a system that provides care for low-income uninsured people who are not eligible for other assistance, and in contrast to Medicaid, this system is primarily funded by county or hospital district revenue. Under the Indigent Care Act, there are three different ways counties can meet their indigent care requirement. First, they can set up a hospital district, a special revenue district that collects taxes and pays for the care. They can operate a public hospital, which they fund with general revenue, or they can operate a County Indigent Health Care Program, which they also fund with general revenue. These indigent programs cover non-Medicaid-eligible adults and children. Under current law, such programs must at a minimum serve persons whose incomes are below 21 percent of the federal poverty level, which comes out to about \$150 a month for a single adult or \$300 for a family of four, which gives you some idea of how much money there is in the system. The 138 counties that operate County Indigent Health Care Programs spent about \$60 million, and the hospital district tax expenditures—this is what they collected—came to about \$1.1 billion. That is a little bit misleading, as 90 percent of that money is in the nine large urban hospital districts.

Another important source of paying for the indigent care system is the state matching funds. Matching funds are important because they take some of the burden off local taxpayers. There are three principal sources that can provide matching funds to the indigent care entities. First is the Medicaid Disproportionate Share Hospital Program (DSH). These are federal funds that the state can draw down under the Medicaid program. In fiscal year 2000, about \$500 million in federal funds was paid to non-state hospitals. Under the 1997 Balanced Budget Act, the amount of these dollars that the state can pull down was capped, and the state is currently at its cap. The state funds the matching dollars required to draw down DSH federal funds for non-state-owned hospitals by collecting hospital district tax revenues from the nine large urban hospital districts. The districts receive back much more than they contribute and there are substantial funds then available to distribute to rural hospitals and other facilities.

Another source of matching funds for the local programs is state-appropriated funds; this is a reimbursement program only for the counties that operate a County Indigent Health Care Program. If those counties spend more than 8 percent of their general revenue tax levy on indigent care, the counties qualify for matching funds. At that point the state will pay them 90 cents on the dollar for every additional dollar of expense they incur, and the counties are only obligated after they pass the 8 percent threshold to operate their system for as long as the state can pay the matching funds. In 2001, when the state ran out of money for matching funds, seven counties were forced to close or curtail their programs. The legislature and the state have increased the amount of matching funds that are available in the next biennium to try to prevent such closures in the future.

A third source is funds from the tobacco lawsuit. The counties signed a settlement agreement with the tobacco companies and some of the funds that the tobacco companies agreed to pay the counties were put into a permanent trust settlement fund. This trust fund was invested in securities, and the interest from these securities is paid out to the counties on the basis of a formula. The counties have set a formula where each county

receives a pro rata share of its share of the total unreimbursed care provided by all counties. In 2001, this fund paid out about \$13 or \$14 million, and this year, because much of the money in the settlement fund was invested in stocks, the fund actually lost money so there were no gains to distribute. The board that governs the fund is going to meet soon and some sources say that the fund is going to find a way to pay a \$13-14 million amount similar to what they paid last year.

One of the things that we can gather from this is that the majority of local funds are unmatched. I will give you an example of a large urban hospital district. They collected \$939 million in fiscal year 2000. They put up about \$309 million to fund the Medicaid match DSH, which means they were left with about \$620 million in unmatched funds, and obviously, this does not do much for relieving the burden on local taxpayers.

So there are some possible alternative arrangements that we could think of, using the county funds or the hospital district funds, where we arrange for the populations that those county programs currently serve to be in the expanded Medicaid program, so that we can take the money from local entities and use it to fund an expansion. Now, there are two principal ways you could do this, if you look at it quickly. The first would be that we would have all local entities, the public hospitals, the county indigent programs, and the hospital districts that now pay for care, to contribute to a state-level program. The state would negotiate an agreement that relieves counties of the burden of indigent care in exchange for local entities sending their funds to the state. Another approach might be to rely on the large urban hospital districts, because they have such a large system of finance; you could use the hospital district funds to start a state-wide program. The hospital districts could put their funds up for the match, and use the federal matching dollars to fund the expansion in the hospital districts and the rest of the state. The matching funds would go back to the hospital districts, but a share would also be used to provide care in other parts of the state. The other counties could agree to make side payments to the hospital districts to ensure that they are paid back in full.

Other approaches could use the state funds and the health science centers and teaching hospitals funds that are used to care for the uninsured to provide further state match to the expanded Medicaid program. These organizations recognize the need for this kind of expansion. In fact, the Association of Academic Health Centers has launched an initiative called Academics for Access to Healthcare, which endorses coverage for more Americans. Another way to do it would be to set up a program that gets around the need for a series of intergovernmental transfers. In this approach, instead of a waiver, the state could use a Certification of Funds approach. In this way, the counties certify that they have spent funds on the Medicaid-eligible population, and these certifications can be presented to the federal government to draw down funds. It gets around the need to negotiate.

Each one of these has different advantages and disadvantages (see Slide 2). Obviously, if you rely on the urban hospital districts only, it concentrates the burden really on those tax bases, on those intergovernmental transfers. You have less participation from throughout the state. You do not have to build as broad a base of support for the program, which

could turn against you in some instances. Advantages are that these are tax funds committed to health care and not like a county's general revenue taxes, which will compete with things like education and criminal justice. It is also maximizing an existing funding stream, and I think, for both those reasons, you could argue it is an ideal pilot program. The nice thing about pulling in all the indigent care entities is that it spreads the burden around and gets more people involved. You achieve a broader buy-in, though it gets a lot more complicated. It requires the coordination of more entities and requires a number of diverse agendas to be reconciled.

## Slide 2 Advantages and Disadvantages

	Advantages	Disadvantages
Urban Hospital Districts Only	<ul style="list-style-type: none"> <li>• Tax funds are committed to health care</li> <li>• Maximizes an existing funding stream</li> <li>• Ideal pilot program</li> </ul>	<ul style="list-style-type: none"> <li>• Equity: concentrates the burden</li> <li>• Less participation</li> </ul>
All Indigent Care Entities	<ul style="list-style-type: none"> <li>• Spreads the burden more evenly</li> <li>• Achieves broader buy-in</li> </ul>	<ul style="list-style-type: none"> <li>• Requires coordination of more entities</li> <li>• Diverse agendas</li> </ul>

Another issue that Texas has to think about when comparing these two types of proposals is what kind of expansion do they really want to see? Do we want to see one where the hospital districts with their funds each pursue different programs, and you have an even broader range of benefits and coverages than the current patchwork of systems? There are some other issues that will have to be considered for funding expansion. The entities who fund a system will need to be guaranteed that there will be a return on their dollars, either in the form of additional insured people or additional funds to pay for care. Some counties have very strong indigent care programs and may be adverse to a waiver that disrupts or ends their local programs. Transitioning counties from a locally based state-regulated program to a state-operated federally regulated program would be a big change for everyone and would likely be challenging. For counties and hospital districts, this would have to be a part of the bargain, making this transition to get access to Medicaid matching funds. There may not be a way to get around a lot of these issues. The system would also need to consider how a new program would affect different parts of Texas. Rural areas looking for more funding for their providers could benefit. On the other hand, those hospital districts that have large numbers of beneficiaries could lose if these beneficiaries become entitled to benefits and they travel to other providers, but the hospital districts are still required to kick in a similar share.

Now that we have seen how the existing system is funded and could be altered, Jamie Dudensing will talk about potential sources of new revenue.

**Jamie Dudensing:** Thank you Evan. Now that we have heard an overview of the current safety net situation and alternative uses for existing funds, I am going to talk about generating new revenue. With the current fiscal stress facing the state and the amount of funds it takes to develop a significant expansion program, it is evident that the reallocation of existing funds that Evan just presented may not be adequate. In fact, new revenue may be required. One way to generate these additional funds is through the “popular” method of taxes and fees. To justify new taxes, we looked for areas in the health care industry that could benefit from the health care coverage expansion program and taxable items that have a connection to increased cost in health care. The three areas of taxation I will talk about today are health care-related taxes, the franchise tax, and excise taxes.

Hospitals and physicians spend a significant amount on uncompensated care. According to the Comptroller’s report on Texas health care spending, hospitals incurred costs of \$1.2 billion and physicians provided an estimated \$914 million in charity care in 1998. Hospitals and physicians are paying much of the cost for the uninsured in Texas, and instead of spending these dollars at the back end, they could be maximizing these funds by investing them in a Medicaid expansion program. A program like this would be able to draw down federal matching funds—remember that for each dollar the state would spend in a Medicaid expansion it would be able to draw matching funds of \$1.50. A program like this would benefit hospitals and physicians through a reduction in the number of uninsured, and in return, a decrease in uncompensated care, and at the same time it would provide individuals a more reliable way to receive health care services.

One method the state has to reallocate these funds for a Medicaid expansion program is through health-care-related taxes. Health-care-related taxes or provider taxes could be a valuable way to draw down federal funds. However, these taxes have come under some scrutiny in the last 10 years due to the tendency of states to use the funds obtained for uses other than health care. But if provider taxes are implemented correctly, they can be a valuable way for states to implement a Medicaid expansion program. There are just a few federal stipulations that must be followed. One of these is the use of provider donations. The ability for the states to use provider donations has been eliminated. This leaves taxes or fees the only method available to obtain these funds. Also, the tax burden established with the provider tax must be spread equally within a provider class. You can implement the tax on only one provider class, but it must be the same for that entire class, such as physicians. If we implemented the provider tax on two different types, say hospitals and physicians, the tax could be different between the two different industries. Also, if the provider tax is enacted, it cannot hold providers harmless of the tax burden. This is any kind of side payment or redistribution the state can make to alleviate this burden. However, it is still possible for the state to increase Medicaid reimbursement to relieve the tax burden. As I have mentioned before, hospitals and physicians are the two main areas of health care that would benefit from the expansion program that currently spend a significant amount on uncompensated care.

Provider taxes on these two groups can be levied in a variety of ways. One is through a total revenue tax. This is usually a 0.5 to 2 percent tax from the total revenue of physicians or hospitals. Another is through an admit fee. This is a fee that would be placed on patients each time someone is admitted to a hospital. Another is a bed fee—this is a fee that is paid for each occupied bed per day. There is also the possibility of an office visit fee, for example, each time a patient visits an office, they will pay a \$1 fee.

These are some examples of what these taxes would generate if levied. A 1 percent total revenue tax on hospitals would generate an estimated \$450 million dollars. A \$3 admit fee would generate an estimated \$87 million dollars. A \$3 bed fee would generate an estimated \$32 million dollars, and for physicians, a \$3 office visit fee would generate an estimated \$365 million dollars. This would be the state's portion of that revenue; there would still be the federal funds that would be brought in to match those, if they were invested in the Medicaid expansion program. One of the major implications to be considered if one or both of these taxes was to be implemented is the burden that will be felt by both providers and consumers. Many times these taxes get labeled "sick taxes" because of the appearance that the taxes will fall only on consumers. However, research indicates that the ability for providers to pass the tax on consumers depends a lot on market power. Market power depends on the nature of health care demand. Providers can only pass the cost of the tax to consumers when the market will permit it, so in most instances the tax falls on the providers as well.

There are some ways, however, to relieve the burden of the tax. One is by designing a structure to implement smaller taxes among a few providers rather than implementing one large tax on one provider. There are also some states who have initiated similar taxes to find ways to implement the tax among all health care participants including providers, consumers, and third-party payers. It is still often possible to increase Medicaid reimbursement to offset the burden of the tax. There are also a number of incentives for hospitals and physicians with the implementation of a provider tax. One is the new source of revenue that will be available for the Medicaid expansion program. Through an expansion program, the state can effectively decrease the number of uninsured and in return decrease the cost of uncompensated care for hospitals and physicians. With more individuals covered by insurance, hospitals and physicians will also have a more reliable source of funds. This new coverage also allows individuals to receive health care through office visits rather than through emergency rooms. This has the potential to free up space in emergency rooms for hospitals who currently have to sometimes send patients away.

Other health-care-related taxes that have the ability to generate revenue are taxes on pharmaceuticals and nursing home facilities. These taxes do not share the same benefit the hospitals and physicians would have from an expansion program. However, they can generate additional revenue that would allow an increase in Medicaid reimbursement to these particular providers while at the same time easing some of the fiscal stress the state is experiencing with the Medicaid program. Another possible source of newly generated funds is through the franchise tax. Currently, due to loopholes, the tax does not cover all businesses and current exemptions are costing the state revenue. The franchise tax

exemptions currently cost at least \$650 million dollars. Through a reworking of the franchise tax, the state could bring in a significant amount of additional funds from businesses that are exempt. This would have the potential to ease fiscal concerns the state is having while making the tax fair among businesses. With this new revenue available, it is possible that both the health care industry funds that are currently being brought in and the potential funds that could be brought in from the elimination of the exemptions could be used for health care purposes. Once again, one way to maximize these dollars is by investing them in a Medicaid expansion program. Currently, there is approximately \$36 million being paid by the health care industry into the franchise tax and about a 1,000 health care businesses that are currently exempt.

Excise taxes on items that have been linked to poor health and high health care costs are another way to obtain funds. Examples of this are taxes on items such as soft drinks, tobacco products, alcohol products, and snack foods. The two areas our research focused on were a tax on soft drinks and an increase in the cigarette tax. A soft drink tax is one excise tax that has been levied by other states for health care purposes. Research has indicated that the cost of obesity, a problem that could be linked to consumption of soft drinks, has been found to be more costly for the health care system than even smoking or drinking, and Texas currently addresses these two problems. There are taxes on tobacco and alcohol but those does not currently address the costly problem of obesity. One way to address this is through a soda tax. This tax can be levied at either the wholesale or retail level. At the retail level, a one-cent tax on every 12 ounces of soda could generate approximately \$118 million dollars a year for the State of Texas.

An additional source of revenue through excise taxes is to increase the cigarette tax. Currently, a significant number of states are working towards an increase in these taxes due to current budgetary problems. Cigarette taxes are also easily justified because of the link between smoking and poor health. A four-cent increase on cigarettes, which is less than a 2 percent increase in the total cost of a pack of cigarettes, would generate an estimated \$46 million dollars in Texas.

All three of these revenue expansion methods, the provider tax, franchise tax, and excise taxes, have the ability to help expand health coverage in the State of Texas. Through the investment of these funds into a Medicaid expansion program, the state can maximize these dollars by drawing down federal funds. However, if these dollars are used other than for the expansion or an increase in reimbursement, those contributing to the tax will see no benefit and the taxes would not receive the kind of support they need to succeed. Now, here is Kristie for a few closing remarks. Thank you.

***Kristie Kimbell:*** Thank you, Jamie. I would like to wrap up our presentation by making just a few summary statements. First, why should we expand? We need to expand because local entities are financially strapped. The cost of health care is skyrocketing and the number of uninsured is significant and growing. We expand because our emergency and trauma care systems are crippled due to the cost of uncompensated care. We expand because a healthier workforce is a more productive workforce and because an expansion bringing millions if not billions of federal dollars into the state facilitates

economic development and strengthens communities. What we learned by conducting our survey was this: local entities recognize their fiscal limitations to meeting the indigent care needs of their residents single-handedly. Many local entities are interested in an indigent health care system that builds upon our existing Medicaid structure. Some, in fact, have begun to express an interest in a local match arrangement.

We should fund an expansion by maximizing existing available federal dollars, and by building on our existing public health care system. We utilize first current expenditures on safety net care by local entities, state-owned teaching hospitals, and medical schools, and we focus on preventive and maintenance care versus emergent care services for the newly insured. Where we fall short, we generate additional revenue from providers that stand to benefit from an expanded pool of insured patients, i.e., physicians, hospitals, and nursing homes, or through taxes on potentially health-damaging products such as sodas and cigarettes.

In planning an expansion that utilizes local entity funding, there are important considerations to be addressed in the funding design. For instance, local entity differences in the areas of geography, taxing ability, mandate, number of uninsured, and percentage of population below a given federal poverty level should all be built into the structure to the extent possible. The degree of local control allowable should also be considered. In other words, can a local entity choose not to contribute, especially a county with a county indigent health care program, and do counties have the option to develop a locally controlled provider organization? Another very important design consideration, described earlier by Evan, is whether or not a local entity can simply certify a given level of expenditure versus actually transferring funds to the state. Consideration should also be given to whether or not there is any benefit to a phased-in funding system, beginning with large urban hospital districts, then medical schools, and then counties, for example.

To some extent through such efforts as Senate Bill 10, Senate Bill 1156, and Senate Bill 1246, Texas has already laid the legislative groundwork for a local contribution structure. These pieces of legislation have provoked much discussion and interest in local contribution efforts to pull federal dollars into the state. Several currently developing waivers grew out of these pieces of legislation. Specifically, the HIV/AIDS waiver, which was originally a part of Senate Bill 1156, involves a number of large urban hospital districts and the University of Texas Medical Branch. These entities are collaborating to pool resources to expand Medicaid coverage for this population. They are currently still working out the details but they plan to utilize a certification of funds financing structure. These projects can serve to instruct planners regarding implementation of a local funding contribution system.

The next step then is to continue the dialogue that has been heard here today, a dialogue that began sometime ago. The discussion should continue with all of the pieces of this funding and expansion puzzle in mind at one time, and with all interested parties around the table. Maximum buy-in by all stakeholders should be sought. A winning situation is possible for all concerned. While state and local funding constraints are a reality, so is

the growing number of uninsured in this state. It is indeed because local entities and the state are so fiscally strapped that the state needs to take action to utilize other potential funding sources to finance a health coverage expansion in Texas. Thank you, and we can take a few questions now.

***Sherri Greenberg:*** Did you, in looking at these financing alternatives, review the recent history in Texas with some attempts at these particular structures?

***Evan Christman:*** I think obvious one that everybody thinks of is Senate Bill 10 in the early '90s, with regard to using local funds and putting them into a Medicaid match waiver. One of the entertaining features of this course has been learning all of the subplots that surrounded SB 10 and its fiery demise. What has become clear is that the system of payments that was arranged in the waiver was certainly put on paper and sent to Washington but it seemed like many of the issues of sharing control and sharing funds had not been entirely hammered out, and it seems obviously that there would have to be a lot of work on that. Were you involved with that at all?

***Sherri Greenberg:*** Well, let me answer that, since I have ten years of battle scars. Of my years serving in the Texas House of Representatives, I spent four on the Appropriations Committee, and two as Chairman of the Pensions and Investments Committee. I worked on a lot of these issues, and was one of the people who actually supported Governor Bush's effort at tax reform in Texas.

My hypothesis is that you are not going to find the legislature willing to face the "alternative business tax" again this session. You will find that political bodies only have an appetite for a limited amount of tax debate. Due to redistricting, there will be a lot of turnover in the legislature, but many members will still be returning who were in office during the last round of tax debate. When you talk about equity, certainly it is a valid argument to make that we should have equity in taxation among businesses. Of course, those who currently are falling on the side of not paying the tax, and there are many of them with a powerful interest group, do not want to be included. The one that I will tell you from my experience that Texans seem to have a fairly unlimited capacity to absorb is what I call the "sin taxes," which are taxes on alcohol and cigarettes. In fact, in a recent poll giving Texans several alternatives for increasing or expanding taxes, the vast majority chose the sin taxes. I would keep these facts in mind, if part of your study is to have a strategy for implementing taxes during the next legislative session.

***Kristie Kimbell:*** Thank you. Our last session for the afternoon is one that many of us have been waiting a long time for. We are very pleased to have with us representatives from primary stakeholder groups—individuals who are involved in the difficult planning, decision-making, and service delivery of health care services. We have asked them to be here today to provide feedback and insight on what they have been hearing. We will see you back here after the break.