HOUSE
RESEARCH
ORGANIZATION
Texas House of Representatives

focus REPORT

February 23, 2001

2 Health-care cost squeeze

2 Current health plans

3 *Box: A Rural District's Health-Care Woes*

4 Funding issues

6 *Box: The CHIP Problem*

7 Financing proposals

10 *Box: Insurance and Equity*

Teacher Health Insurance: The Multibillion-Dollar Question

Health insurance for teachers will be one of the most expensive items on the table for the 77th Legislature in terms of new spending — in the range of several billion dollars per biennium. Now being considered by a House select committee, most proposals under consideration would cover not only active and retired school teachers but all public-school employees and their dependents.

Legislation to provide teacher health insurance has been introduced nearly every session since 1977. This session, however, volatility in the health-care market, inequality among local school districts' benefit plans, and the need to recruit and retain teachers for Texas' growing population of school-age children have put a spotlight on the issue. The problem of access to affordable insurance seems particularly acute in rural school districts.

Supporters of increasing the state's role in providing health insurance for teachers point to 41,400 public-school teaching vacancies. A recent survey by the Texas State Teachers Association and Stephen F. Austin State University found that 43 percent of Texas teachers are considering leaving the classroom because of low pay, poor benefits, and stress. Another survey by Texas A&M University ranked Texas last among all states and the District of Columbia in providing health benefits for teachers.

Last session, Texas lawmakers awarded a $3,000 salary increase to teachers, counselors, and librarians, but teacher advocates say that higher health-insurance premiums ate up much of the salary increase. This session, teachers are asking for state-funded health coverage comparable to that of state employees. However, budget constraints and the complexity of the issues will make such a program difficult to create and maintain.

Texas lawmakers face difficult budget constraints in considering ways to create a state-funded health insurance program for teachers.

Under current law, teachers are considered local employees of the school districts that hire them. School districts, like many

other large employers, bear full responsibility for insuring their employees. Opponents of a state-funded health plan say that school districts should retain the freedom and flexibility to hire, fire, and design benefit plans according to local needs and standards. However, because the state sets teachers' salary schedule and certification standards and requires many accountability measures and teaching standards, advocates argue that teachers should be treated like state employees when it comes to benefits.

Health-care cost squeeze

The rising cost of health care is a national issue. Both private- and public-sector employers are feeling the pinch. According to the Employees Retirement System (ERS), which administers the Texas state employees health plan, prescription drug costs alone have risen 20 percent in the past year. The Teacher Retirement System (TRS), which covers all retired public-school employees, estimates that fully one-third of their retirees' health-care costs are due to prescription drugs, which are not covered under the federally funded Medicare program.

The total per-capita cost of health care in most school districts rose more than 10 percent from the 1998-99 school year to 1999-2000, according to TRS. Representatives of rural school districts told the House Select Committee on Teacher Health Insurance that they have seen increases ranging from 20 to 400 percent. Like many employers, school districts have had to raise premiums and reduce benefits, leaving many teachers and other employees without affordable health-care coverage.

Demographic factors. Enrollment in Texas' public schools has risen from 3.3 million students in 1990 to nearly 4 million in 1999, increasing the demand for qualified teachers. Teacher shortages put school districts in direct competition for available teachers. Wealthy urban districts that can offer good health-benefit packages have a prime competitive advantage in filling teacher vacancies.

The aging of the population also increases demand for health insurance. Traditionally, the older a person is, the more health-care services he or she uses, and increased use drives up costs. TRS projects 211,000 retirees by fiscal 2004, including teachers and other education professionals, amounting to more than 1 percent of Texas' population. TRS-Care, the TRS health plan, is expected to require a $6.9 billion infusion in the coming decade to remain solvent.

Another demographic factor is the high proportion of women working in public education. Actuarial reports consistently rate females — especially young women of child-bearing age — as a higher insurance risk than males. ERS estimates that women's health-care costs average about 25 percent more than men's, making the potential cost of insuring public-school employees 10.5 percent higher than the cost of insuring the current pool of state employees.

Current health plans

School districts. This school year, Texas school districts are expected to spend $977 million on health insurance for their employees. Under the equalized school-finance system, for every penny of local property-tax effort, school districts receive state funds through equity formulas designed to equalize the tax effort of rich and poor districts.

On average, school districts now dedicate to health insurance about 10 cents per $100 of assessed value from their maintenance and operations (M&O) taxes, according to Texas Education Agency estimates. Many rural districts dedicate a much higher portion to health insurance — some more than 20 cents per $100. Prairiland ISD near Paris, a rural district forced to self-insure after being dropped by its insurance carrier, reports that it devotes 38 cents of its M&O rate to employee health insurance.

In 1991, the Legislature directed school districts to provide coverage comparable to the Uniform Group Insurance Program (UGIP), the health plan for state employees. (See Education Code, sec. 22.004.) As a compromise with school districts, who saw this directive as an unfunded mandate, the law was enacted with no enforcement mechanism. In 1997, HB 2644 by Telford et al. required TRS to certify the comparability of local coverage to UGIP in a biennial survey and report to the Legislature. Teacher advocates say that with no penalty for noncompliance, considerable disparities remain in both the cost and the quality of school districts' health coverage. Others say that overall coverage in most school districts still compares favorably with the benefits offered by many private-sector employers and that some school districts offer plans that are better than UGIP.

More than 1,200 school districts, education service centers, and charter schools in Texas offer about 2,600 health-insurance options. According to TRS, 54 percent

A Rural District's Health-Care Woes

Larger urban school districts are more likely than smaller districts to provide affordable health-care benefits to their employees. As more people enroll in a health-care plan, the more the risk is spread, thus dropping the cost per participant. Also, urban districts have greater access to a variety of health-care providers, enabling them to negotiate more competitive contracts and pass on the savings to their employees. Many rural districts lack the property-tax revenues, "pooling power," and access to providers to obtain affordable health insurance.

Data compiled by the Texas State Teachers Association reveal that of 82 school districts with the highest costs for employee/family coverage, 65 have fewer than 100 teachers and only three have more than 5,000 students enrolled. In 40 percent of those districts, insurance carriers charge more than $800 per month for employee/family coverage, and in five rural districts, the cost exceeds $1,000 per month.

The 428 employees of the Cleveland Independent School District in Liberty County, about 40 miles northeast of Houston, faced rate increases of almost 400 percent after district employees filed three catastrophic claims in one year. When rates for family coverage through the district's preferred provider organization (PPO) leaped from $470 to $1,833 per month, the school board had to cancel PPO coverage and obtain coverage from a health maintenance organization (HMO). The HMO's rates rose from $375 to $1,209 per month, of which employees must pay $709. As a result, many of the district's lower-income employees have had to drop their coverage or have quit their jobs altogether.

School administrators feel a "tremendous sense of urgency" to deal with this situation, said Terry Myers, Cleveland ISD superintendent. Myers said a faculty member approached him saying he was afraid to take his wife to the doctor because she had breast cancer, and the faculty member was afraid that his family would lose coverage because the breast cancer was a pre-existing condition. Also, Cleveland must compete for teaching personnel with much larger school districts in the Houston region. Four of Cleveland's teachers quit last year, and Myers fears that more will leave when their current contracts expire. "You can't ask a beginning teacher to spend 40 percent of her after-tax salary on health care," he said.

Cleveland ISD already dedicates 23 cents per $100 of assessed value in local property taxes (the statewide average is 10 cents) to pay for the district's $800,000 share of annual health-care costs. Since the district's maintenance and operations (M&O) tax rate already is at $1.375 per $100 and state law caps the M&O rate at $1.50, the district is "running out of choices," Myers said.

While not all small districts are in such dire shape, many are seeing double-digit increases in health-care costs each year. Even in Dallas ISD, where the district pays a large portion of the premium, teachers pay an average of $3,348 per year in out-of-pocket costs for employee and family coverage.

of Texas public schools offer their employees at least one health-insurance plan that is certified as comparable to state employee coverage. Eighty-five percent of school-district employees receive employee-only coverage at no out-of-pocket cost. However, 95 percent of districts pay nothing toward dependent/family coverage for their employees. As of the 1999-2000 school year, 17 districts offered no health plan at all, and one district offered only a medical savings account.

While the law requires that school-district benefits be comparable to UGIP in terms of benefits offered, they need not be comparable in price. According to a Texas State Teachers Association survey of 973 districts, the average monthly cost to most public-school employees for family coverage is $400. Thus, a starting teacher who makes $26,000 per year pays 18 percent of his or her gross salary for health insurance that is not necessarily comparable to state employees' coverage.

Supporters of a state-funded health plan note that the public sector already picks up the costs of uninsured public-school employees. In a big city, the uninsured often seek care at a public clinic or a county hospital emergency room, where the costs of charity care are shifted back to county taxpayers. An uninsured employee could run up bills with local hospitals and providers that are high enough to force the employee into personal bankruptcy. Some say the state ultimately would save on health-care costs by providing insurance to school employees in the first place.

ERS. UGIP, administered by ERS, currently provides an employee-only benefit package to all state employees at no cost to the employee. The state's cost for employee-only coverage ranges from about $170 per month for health maintenance organization (HMO) coverage to $250 per month for HealthSelect, a "point-of-service" plan offered by Blue Cross/Blue Shield of Texas. A point-of-service plan is the most generous form of coverage available in today's market, allowing participants to choose providers and services as long as they are willing to pay higher copayments for access to providers who do not have prenegotiated contracts with the network.

The total monthly premium for employee and family coverage under the state HealthSelect plan is about $725, of which the state pays $487 and the employee pays $238. HMO coverage is available to state employees and their families for as little as $514 per month, of which the state pays $346 and the employee pays $168.

HealthSelect, the benchmark plan used in most teacher health-insurance proposals, provides state employees a point-of-service plan at a maximum cost of $500 in out-of-pocket deductibles, a $15 copay for doctors, a $5 copay for generic drugs, and a $20 copay for preferred brand drugs. State employees using HealthSelect also may go "out-of-network" for a 70/30 copay and a maximum of $1,500 in out-of-pocket coinsurance.

In addition to HealthSelect, state employees may choose from among several other plans, such as an HMO or preferred provider organization (PPO), both of which require a primary-care "gatekeeper" to manage care and contain costs. As with HealthSelect, the state pays 100 percent of the cost for employee-only coverage and 50 percent of the cost for dependent coverage for HMO or PPO care. The advantage to employees of choosing an HMO or PPO is the lower cost of coinsurance for spouse and/or dependent coverage.

TRS. The state covers 127,000 retired public-school employees and their dependents under TRS-Care, a plan begun in 1985 and financed primarily by retirees' premiums and active employees' payroll deductions. Like many school districts, TRS-Care does not provide benefits comparable to UGIP.

Although the state contributes only 26 percent to total costs, merely keeping TRS solvent by maintaining the status quo for retired public-school employees (no new benefits or beneficiaries) is expected to cost the state more than $654 million in fiscal 2002-03. TRS-Care was not designed to be a long-term, self-sustaining program, and according to agency spokesmen, it cannot continue to sustain itself on the current revenue stream. Upgrading health benefits for TRS retirees so that they compare to UGIP benefits would cost an additional $1.4 billion (not including start-up costs) in fiscal 2002-03.

The cost of a TRS-Care plan depends upon whether or not a retiree qualifies for Medicare. Many teachers retire at age 50, leaving 12 to 15 years before they qualify for Medicare. During these in-between years, the option of TRS-Care is crucial for many retirees. The out-of-pocket cost of TRS-Care for a retiree with Part A Medicare, which covers hospitalization, is $67 per month; without Part A, the cost is $167 per month. Retirees of Medicare age also pay an additional $50 per month for Part B, which covers other medical expenses, such as doctor's visits or tests. Because almost 60 percent of TRS retirees rely on Medicare in addition to TRS-Care for their health insurance, any tightening in Medicare coverage could have an immediate, negative impact on TRS-Care costs.

Funding issues

Although a consensus appears generally to favor some form of state-funded health insurance for teachers, much disagreement exists over how to structure the program and how to pay for it. Many say that budget constraints make either a scaled-back plan or creative financing a necessity.

Under all of the current proposals, TRS would administer the state-funded health plan because TRS already maintains a database and manages payroll deductions for all the targeted beneficiaries of the new system. The biennial costs of proposals on the table range from $400 million to $3.2 billion initially, depending on who is covered, what benefits are included, what

percentage the state pays, and whether participation is mandatory. Actuaries for TRS estimate a compound growth rate of 13 percent per year in health-plan expenses, which would result in a doubling of program costs in a little less than six years. Administrative start-up costs also would be high, as the state would have to hire 100 new people to administer the plan, according to TRS. Supporters point to uncalculated savings in administrative costs for 1,100 school districts, which no longer would have to negotiate and administer several thousand different health plans.

Who should be covered? Most teacher advocate groups support pooling retired and active teachers into a single state-funded health plan, as long as retiree benefits are not downgraded. These groups also support covering the entire public-school community, including teacher's aides, custodial and cafeteria staff, bus drivers, and other support staff.

Supporters argue that pooling active public-school employees with retirees not only would be the fair thing to do but also would help shore up TRS-Care's financial condition by creating a more actuarially sound risk pool. Also, because the proposed state budget for fiscal 2003 already contains $268 million to $350 million for medical payments for TRS-Care, pooling retirees and active employees into one plan would enable this money to be redirected to a broad-based teacher health-insurance plan.

The biennial costs of current proposals range from $400 million to $3.2 billion initially, depending on who is covered, what benefits are included, what share the state pays, and whether participation is voluntary or mandatory.

Adding 540,000 active public-school employees and their 250,000 dependents to the TRS system would increase the state's cost of providing health benefits to an estimated $3.2 billion for fiscal 2002-03, assuming that the state would pay 100 percent of employee-only coverage and 50 percent of dependent coverage, as it does for state employees. This estimate also factors in the costs of adding to the system 40,000 TRS retirees who now subscribe only to catastrophic coverage and another 16,000 TRS retirees who have waived coverage altogether.

A statewide program would average the cost of health benefits across all districts by pooling the risk. Opponents of pooling retirees with teachers say that local school districts should not be required to shoulder the burden of retirees' health care and that adding retirees to the mix would increase the average risk and therefore the costs of the entire group. However, this objection would apply only if local districts were sharing the cost with the state.

Some have suggested that retirees could be allowed to "buy into" an upgraded, statewide teacher health-insurance plan at an additional cost of 30 to 35 percent per year. However, financing the current shortfall in TRS-Care through retiree premiums alone would require a doubling of retirees' out-of-pocket expense. The average annual pension for TRS retirees is only $18,780, and advocates for retirees say that their expenses already have increased beyond a reasonable amount. Other approaches, such as 523 by Tillery and SB 178 by Armbrister, would phase in coverage for retirees based on years of service.

Of the 500,000 certified teachers in Texas, only 264,000 are teaching in the classroom. Many school districts are recruiting retired teachers back to the classroom to ease the current teacher shortage. However, some say that one reason districts are recruiting retirees may be to save on benefit costs, because retirees already are covered under TRS-Care and many are part-time employees for whom the districts are not obligated to pay for benefits. This raises the question of who should pay the health-insurance costs of a reactivated teacher: the employing school district or TRS? Supporters of pooling retirees with active teachers under a statewide health-insurance plan say that eliminating this distinction could help ease the teacher shortage by simplifying local districts' administrative issues and eliminating a barrier to full-time employment for retirees who wish to return to the classroom.

What should be covered? Most current proposals are based on providing all public-school employees with coverage comparable to UGIP. One proposal, HB 50 by Chavez, would leave benefit design entirely up to the local district. HB 1248 by Tillery would provide only a prescription drug benefit plan to be administered jointly by ERS and TRS, and HB 575 by Green would provide no direct health coverage but would offer access to a statewide risk pool.

Some opponents of a state-funded teacher health-insurance plan worry about what the benefit package

The CHIP Problem

Participating in a state-funded health plan could be a mixed blessing for low-income school employees such as teacher aides, custodians, and cafeteria workers. Currently, low-income families who do not have access to or cannot afford employer coverage can fall back on the state-federal Children's Health Insurance Program (CHIP), designed to insure the children of working families who make too much money to qualify for Medicaid yet cannot afford the coinsurance for their employer's plan. Even though the state now pays 50 percent of dependent coverage for all state employees, paying the other 50 percent can be a heavy burden for low-income workers.

The federal Health Care Financing Administration recently issued final rules that interpret eligibility guidelines for CHIP. The rules exclude from CHIP benefits not only state government employees but any public employee who has access to a state health-benefit plan, even if he or she waives coverage. The second test for exclusion from CHIP eligibility is whether a public agency (including the state or a public school district) that provides a state health-benefit plan makes more than a nominal contribution ($10 or more) toward dependent coverage on behalf of the employee. While many public-school employees' children are now eligible for CHIP, a 90-day waiting period with no coverage has discouraged some from applying.

If an employee's health plan is operated and organized at the state level and is available statewide (like the Employees Retirement System or the Teacher Retirement System), even if it is paid for completely with local dollars, the federal rules still deem that employee as having access to a state health plan, and his or her dependents are disqualified from CHIP coverage.

If school districts were to pay the state for dependent coverage, even if all the funds came out of local money, their employees' children would be disqualified from CHIP. Only if the school districts created, funded, and administered a separate insurance program for school employees' dependents, not funded or administered in any way by the state, would these children be eligible for CHIP.

Recognizing that federal guidelines excluded state employees from applying for CHIP, the 76th Legislature enacted SB 1351 by Barrientos, creating the State Kids Insurance Program (SKIP) specifically for the dependents of low-income state employees and some higher education employees. Rather than providing a separate health plan for these employees' children, SKIP subsidizes an additional 30 percent of premiums for dependent coverage under UGIP. Because public-school employees are not technically state employees, under current state law, they are not eligible for SKIP.

Under a state-sponsored health-insurance plan for teachers, the same federal CHIP regulations would apply to public-school employees with access to state benefits. Some caution that this exclusion would create a hidden cost for a state health plan for teachers because of the added expense of allowing low-income school employees to qualify for SKIP. Supporters of a state-sponsored solution point to what they call the greater good of providing affordable health insurance for many thousands of children who otherwise would not be covered.

might include. One concern is that it could create a state funding mechanism for public employees to obtain abortions or plastic surgery, procedures that are not covered by the current benefit package for state employees. Another concern is that once an expensive new benefit is provided, the state never will be able to scale it back or take it away, even in lean years.

Mandatory or voluntary? Most supporters of a state-funded plan maintain that it would be more cost-effective in the long run either to mandate participation by local school districts or to give them a strong incentive to participate so as to avoid "adverse selection," also known as "cherry picking." Adverse selection would result if high-risk districts with an expensive claims history opted

into the program while low-risk districts with a less expensive claims history opted out. This would leave the state paying the bill for only the high-risk participants, thus increasing overall risk and expenses. Participation would be mandatory under all proposals except SB 389 by Shapleigh, HB 326 by Gallego/SB 127 by Staples, and SB 473 by Bernsen.

Opponents of mandatory participation say that many school districts prefer to retain local control over the cost and design of their benefit packages for employees. Some districts that already provide attractive health-benefit packages want to preserve their competitive advantage in hiring and retaining teachers. Also, because a statewide plan would average the cost of health benefits across all districts, there is no guarantee that every district would experience lower costs than they now incur.

How much should the state contribute? Many teacher advocates support HB 12 by Ehrhardt/SB 135 by Carona, which would require the state to pay for 100 percent of employee-only coverage and 50 percent of dependent coverage for public-school employees, just as it does for state employees. Others say the state cannot afford to start the plan with this level of funding and that it would be necessary to "scale up" benefits over a number of years. The least expensive proposal on the table, HB 575 by Green, would allow school districts to buy into the statewide risk pool with no financial contribution by the state. HB 523 by Tillery would split the costs equally between the state and local school districts. Under HB 326 by Gallego/SB 127 by Staples, the state would pay 35 percent of the costs, leaving districts and their employees to split the remainder at the discretion of the districts.

The report of the House Select Interim Committee on Teacher Health Insurance recommended a 60/40 cost-sharing arrangement between the state and local school districts. Assuming full participation of all districts, this plan would cost the state approximately $12 million in start-up expenses in fiscal 2002 and $1.6 billion in fiscal 2003, the first full year of program operation. Advocates for this plan say that the state must contribute at least 60 percent to encourage local participation and prevent adverse selection. School districts are concerned that the Legislature might mandate a rich benefit package, equivalent to UGIP, while paying only a small portion of the costs, thus burdening local property taxpayers with an unfunded mandate.

Some advocate requiring all participants to pay a certain amount of coinsurance on the grounds that this would focus their attention on cost containment. They say that cost sharing is standard insurance policy among most major private employers and that the state benefit plan would be too high a standard to meet.

Another approach, HB 1513 by Delisi, would establish regional risk pools through which ERS could provide various options for employee health-care coverage. Choices could include HMOs, PPOs, medical savings accounts, fee-for-service plans, and dental and vision plans. Public-school employees and their dependents would receive a defined contribution from the state and from their school districts, with which they could buy any combination of coverage from the options offered. The intent would be to promote competition not only between regional risk pools but also among providers within the risk pools and to leave benefit-design decisions up to the individual.

Some have proposed excluding ancillary staff and providing state-funded health insurance only to teachers, just as the $3,000 pay raise was awarded only to teachers, counselors, and librarians for fiscal 2000-01. Others suggest that the state cover only public-school employees and not their dependents, or alternatively, cover only dependents and not employees. Still others propose that the state guarantee each school district a base amount of coverage, such as an HMO or PPO plan, then allow school districts to "buy up" into the HealthSelect plan for their employees. For example, HB 1189 by Telford would require the state to pay for catastrophic health coverage for active public-school employees and would allow districts to buy up to higher levels of care. HB 1248 by Tillery would require the state to provide only a prescription drug benefit. Other cost-saving suggestions include requiring the use of generic prescriptions when available or providing incentives for using mail-order prescription services for "maintenance" medications.

Financing proposals

Lawmakers are not likely to be able to rely on surplus funds in an already tight budget to finance a new teacher health-insurance program. Roughly half a dozen potential funding sources have been identified thus far.

Tobacco-settlement funds. The terms of the state's 1998 settlement with tobacco companies do not

restrict the use of settlement funds. To preserve the stability of the state's investments from tobacco-settlement proceeds, the 76th Legislature established 21 permanent trust funds and endowments. In so doing, it "locked in" the corpus and the earnings on those funds to support the programs for which they were established. The transfer and distribution of dedicated earnings on tobacco-settlement funds are governed by spending rules enacted by the 76th Legislature in HB 1676 and HB 1945, both by Junell. Changes in the distribution of these earnings would require legislative action.

The state will continue to receive new funds from the settlement each biennium over the next two decades. This session, the state could appropriate some of this new money, which goes into general revenue, toward a new trust fund for teacher health insurance, or it could use these funds to pay TRS for direct program costs such as premiums and medical payments. The size of the initial investment needed to support an insurance program for public-school employees would make interest earnings from a new trust fund an unlikely funding source. Some say that general revenue would provide the most flexibility to TRS and that tobacco-settlement proceeds are an unreliable source of income. Also, under SB 445 by Moncrief, enacted in 1999, the Children's Health Insurance Program (CHIP) receives first priority for these funds. Tobacco-settlement money also funds 100 percent of the State Kids Insurance Program (see box on page 6).

Many state leaders support using capital gains from the Permanent School Fund to pay for insurance for public-school employees.

The budget plan in SB 1 as introduced proposes to appropriate $587 million in tobacco-settlement funds for fiscal 2002-03. Approximately $340 million in additional payments (outlined in the 1998 court-ordered payment schedule) could become available during the biennium, subject to adjustments for domestic tobacco sales and net industry profits, among other factors. The final amount of the adjusted payment is under litigation.

Permanent School Fund (PSF) capital gains. Many state leaders have signed on to using up to $450 million per biennium in PSF capital gains to finance a health-insurance program for public-school employees, as proposed by HB 1020/HJR 54 by Junell et al. (SB 490/ SJR 19 by Ellis/Bivins) and SB 389/SJR 14 by Shapleigh. Supporters of this approach point to substantial increases in the fund's performance in recent years.

The PSF, primarily comprising stocks, bonds, and oil and gas royalties from state-owned lands, generates nearly $700 million per year in interest earnings that are distributed to all school districts on a per-student basis. Because PSF investments are managed for income (interest and dividends) rather than for total return (income plus capital gains), distributions to the Available School Fund (ASF) from the PSF have risen only 3 percent from 1990 to 2000. One reason for this slow growth is that under current spending rules, the primary way to increase income for the fund is to transfer assets from stocks to bonds. However, since 1990, realized capital gains on the PSF — the gains recorded when assets were sold — have increased 806 percent, while unrealized capital gains — the growth in value of assets held compared to their purchase value — have increased 221 percent. Supporters of using the fund's capital gains for teacher health insurance say that distributing 3.5 to 6.5 percent of capital gains annually could generate as much as $2.25 billion per biennium, while protecting the corpus of the fund.

Currently, the State Board of Education (SBOE) manages the PSF according to trust law principles, which require capital gains to be reinvested in the corpus of the fund. To redirect capital gains from the PSF, Texas voters would have to approve a constitutional amendment. Precedent exists for such a move in the form of Proposition 17, approved by voters in November 1999, which authorized the University of Texas System board of regents to reallocate up to 7 percent of Permanent University Fund investment assets for distribution to eligible institutions through the Available University Fund. Other protections preserve the corpus should assets fail to increase.

SBOE members and other opponents of redirecting capital gains from PSF investments say that this source of revenue would not be reliable and could be disrupted by a downturn in the stock market. In a bad year, they say, diverting capital gains could eat into the corpus, jeopardizing the fund's long-term growth potential and possibly forcing school districts to raise property taxes. Also, opponents note that the fund was created to benefit Texas school children and is a primary source of funding for school textbook purchases. They say that funding teacher health insurance would not necessarily provide a

direct benefit to children in the classroom. Opponents also say that drawing off capital gains is a short-term strategy that would not protect the corpus of the PSF to cover long-term enrollment growth in Texas public schools.

Supporters counter that the Junell proposal, as modified since filing, would give the majority of the benefits from PSF capital gains directly to Texas school children. They say that fully 80 percent of the estimated $2.25 billion in biennial revenue from capital gains would go to the ASF, while 20 percent would be earmarked for teacher health insurance. Supporters also say that because the capital-gains withdrawals would be calculated on the basis of a five-year average return on the fund rather than on the most recent year's return, and because withdrawals would be capped at 6.5 percent, the corpus of the fund would be protected from sudden upswings or downswings in the stock market. Also, they say, the legislation would build protections into the Constitution so that asset allocations would be determined not by the state's income demands but by what is the most prudent investment.

Pension fund surplus. Concerns over the looming insolvency of TRS-Care have focused attention on the $5.4 billion surplus in the TRS pension fund. SB 1128 by Armbrister, enacted in 1999, increased the multiplier for calculating retirement annuities from 2.0 percent to 2.2 percent, representing a 10 percent increase in pension payments to retirees. Some suggest that increasing the multiplier to 2.25 would increase pension payments further while leaving a $2 billion surplus and no unfunded liabilities. ERS uses a 2.25 multiplier for retired employees of state government.

As the TRS pension fund appears to be in excellent shape, some say the fund surplus would be a good source of revenue to shift to retirees' health insurance. Using the surplus this way, supporters say, would ensure that benefits continue to go to those who contributed to TRS and would save lawmakers from having to find a new source of revenue to cover the TRS-Care deficit expected in August 2001. Others say that by using the surplus to pay for expanded coverage for retirees, the state could avoid including higher-risk retirees in the statewide pool.

Another plan would allow school districts to dedicate the proceeds of a new optional property tax to teacher health insurance.

Opponents say that increasing pension payments only would cover the higher cost of health-care premiums for retirees and that recent increases in TRS-Care premiums already have offset the cost-of-living adjustment in the last biennium. They say that using the surplus to finance retirees' health insurance could threaten the actuarial soundness of TRS and endanger future pensions.

Education "settle-up" money. School districts will refund an estimated $2 billion to the state this year as a result of school districts' overestimates of their average attendance and underestimates of growth in local property-value appraisals. Advocates of state funding for teacher health insurance have targeted about one-third of this settle-up money. They say this would provide "seed money" to cover the start-up costs of an insurance program for public-school employees.

Opponents of this approach say the settle-up money varies greatly from year to year and would be an unreliable funding source. In some years, depending on changing property values and fluctuating attendance, the "settle-up" could be a negative balance, requiring money to flow from the state to local school districts. Others caution that this money already has been promised to local districts for other purposes.

Optional property tax. SB 389 by Shapleigh proposes a new optional property tax dedicated to teacher health insurance. Currently, state law caps school districts' M&O tax rates at $1.50 per $100 of assessed value. SB 389, as modified since filing, would allow local districts to shift some of their current M&O tax effort to the new health-insurance tax. Proponents say this would enable districts to leverage more state matching funds per penny of local effort than current equity formulas allow.

If a school district decided to participate in the state health-insurance plan, it could ask local voters to approve the financing mechanism. The uniform local tax rate, capped at a certain number of pennies per $100, would leverage different amounts of state benefits according to the value of the local tax base. To equalize the benefit among districts, this proposal would require that 100 percent of any savings created by the new health-insurance tax be returned to local taxpayers in the form of an M&O tax cut or to the state in the form of "recapture."

Insurance and Equity

Whenever a new public education issue arises, especially one that requires a great deal of money, the question of equity arises as well. Would proposals for a new teacher health-insurance plan benefit some school districts more than others?

Supporters of a state-funded health-insurance plan for public-school employees say that as long as all school districts received the same benefit, no equity issue would arise. In the context of school finance in Texas, equity is defined as requiring substantially equal access to similar revenue per student at similar levels of tax effort. School finance experts say that if teacher health insurance were financed entirely by the state, were not needs-based, and were available to districts in the form of a tangible benefit rather than cash, the legal equity principles applied to school-finance formulas would not be tested. If all districts received the same state benefit, whatever equity gap now exists among districts would remain the same. Simply put, if the state paid the employee premiums directly, there would be no equity issue; if the state paid the districts, which then paid employee premiums, there would be an equity issue.

Because state payments to local school districts are subject to many complex formulas to ensure equity, most health-insurance proposals now on the table would avoid the problem by giving benefits directly to teachers. Among current proposals, HB 50 by Chavez would tie the teacher health-insurance plan's financing to the equalized school finance system by giving an annual allotment to school districts based on weighted average daily attendance, a method of counting students for the purpose of allocating state aid. SB 389 by Shapleigh would give all districts the same state benefit on the basis of an equalized local tax effort.

Under most proposals, all public-school employees would get the same health plan, whether they worked in an urban or rural, wealthy or poor district. Opponents say this approach would create a greater gain for districts with higher ratios of workers per student, because the more people a school district employed, the more health benefits the district would receive. Other opponents say a "per-employee" state-financed health plan would create a greater benefit for districts that already provide competitive benefit packages, because these districts could redirect money freed up by a state-funded plan to other areas of the teacher compensation package, such as higher salaries or dental or vision plans. Supporters counter by arguing that the windfall of giving a fully state-financed plan to smaller rural districts that currently cannot afford coverage would trump any equity issue and could level the playing field by helping rural schools compete to fill teacher vacancies.

Depending on a district's current spending on health care, the net effect of using this new funding source could be a net increase or a decrease in local property-tax rates. According to a Legislative Budget Board analysis of the proposal, more than 800 school districts would see a net tax-rate decrease. Fewer than 200 would see a net increase, and more than half of those would see less than a 2-cent increase. No change in the tax rate would take effect unless local voters approved it.

Supporters of such a tax say it simply would redirect and maximize current monies that school districts already are spending to provide employee health insurance. They say that districts have a strong incentive to participate because their employees would retain more benefit per penny of local tax effort than under the current financing system, and because the new plan would provide needed breathing space under the $1.50 M&O cap.

Opponents of this approach say teachers still would not be guaranteed health insurance but would be subject to a lengthy process involving two layers of local approval. The local school board first would have to approve the decision to opt into the state health-insurance plan, then local voters would have to approve the new tax to fund the program. Another concern is that a uniform statewide

tax could violate the prohibition in Texas Constitution, Art. 8, sec. 1-e against a state property tax. Other opponents say that Texans already are subject to too many taxes and that lawmakers should find other ways to pay for teacher health insurance. Still others question how charter schools and regional service centers would benefit from this funding source, since neither have a local property-tax base. Finally, some are concerned that school districts would not reduce their tax rates to reflect M&O savings unless the law required them to do so.

Supporters counter that while some districts might see a net tax increase under this plan, others would see a net decrease because of the net effect on M&O rates. Supporters also say that the constitutional ban on a state property tax would not be an issue because local districts could choose not to participate in the program. They add that while charter schools and educational service centers have no local tax base, neither do retirees, yet all these groups would receive the plan benefits. Finally, if a district did not wish to submit a proposal for teacher health insurance to local voters, or if such a proposal failed at the polls, the district still could buy into the statewide risk pool for a lower level of health-care coverage by paying a premium.

Gasoline tax increase. HJR 46 by Alexander proposes a constitutional amendment to dedicate any additional revenue raised by an increase in the 20-cent-per-gallon state tax on gasoline directly to teacher health insurance. Currently, three-fourths of the revenue from this tax goes for highway spending, while the other one-fourth goes to the ASF. HJR 46 would not change the current distribution but would redirect any future increase above 20 cents to teacher health insurance. Each increase of one cent in the gasoline tax would generate $100 million to $110 million in annual revenue.

Supporters say this is a stable source of revenue that historically has grown at the same rate as the population, about 2 to 3 percent per year. Opponents point to many other competing uses for an increase in the gasoline tax, including highways, tourism, and state parks.

— by Dana Jepson

HOUSE RESEARCH ORGANIZATION

Steering Committee:

Peggy Hamric, *Chairman*
Roberto Gutierrez, *Vice Chairman*
Tom Craddick
Dianne White Delisi
Harold Dutton
Bob Hunter
Carl Isett
Mike Krusee
Brian McCall
Jim McReynolds
Elliott Naishtat
Joe Pickett
Robert Puente
Bob Turner
Steve Wolens

Capitol Extension
Room E2.180

P.O. Box 2910
Austin, Texas 78768-2910

(512) 463-0752
FAX (512) 463-1962

www.capitol.state.tx.us/hrofr/hrofr.htm

Staff:

Tom Whatley, *Director;* Greg Martin, *Editor;* Dana Jepson, *Associate Editor;* Rita Barr, *Office Manager;* Kellie Dworaczyk, Patrick K. Graves, *Research Analysts*