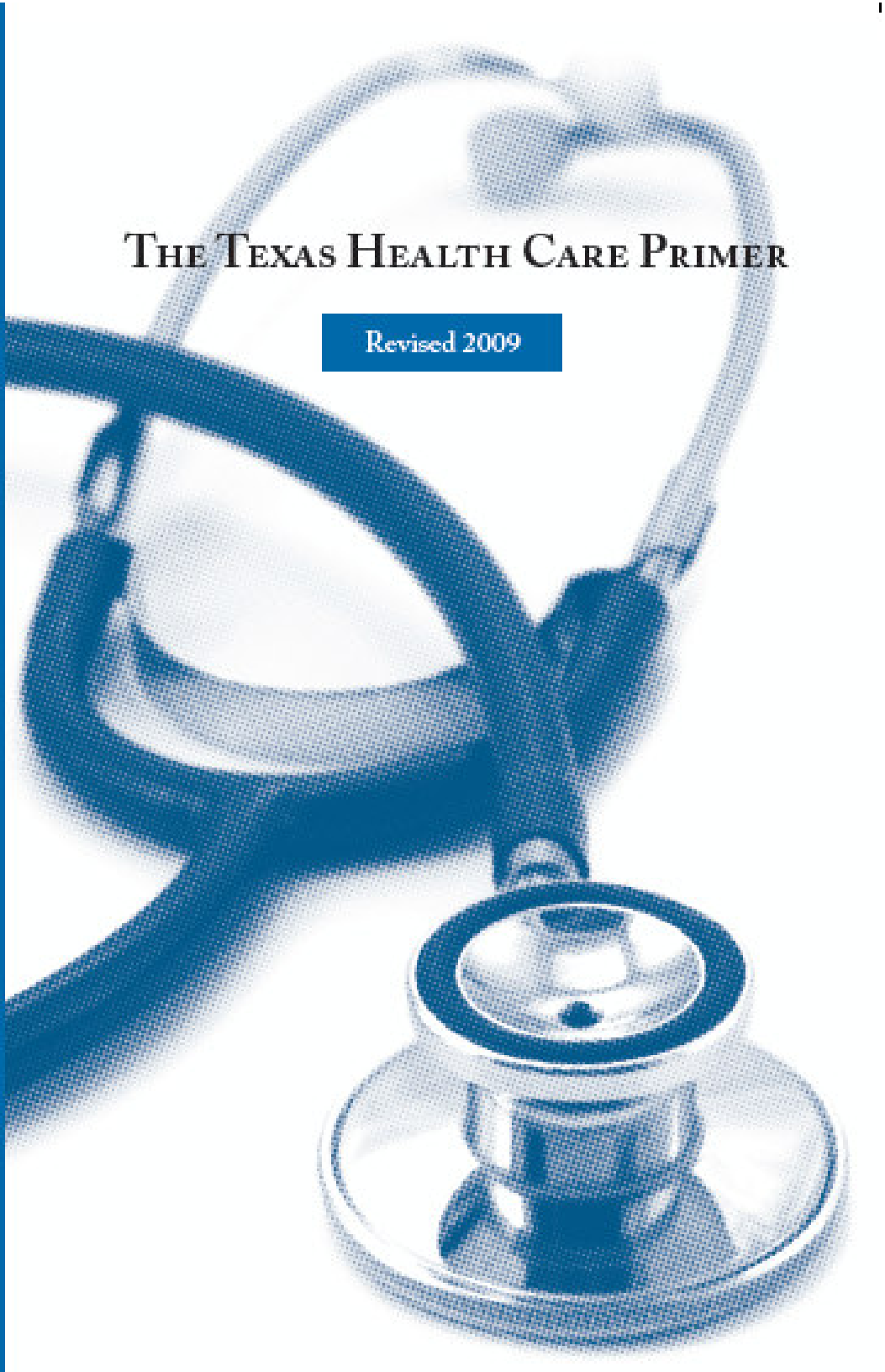

The Texas Health Care Primer

Revised 2009

CPPP Center *for* Public Policy Priorities

Methodist Healthcare Ministries of South Texas, Inc.

The Center for Public Policy Priorities is a 501(c)(3) nonpartisan, nonprofit policy institute committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. CPPP pursues its mission through independent research, policy analysis and development, public education, advocacy, coalition building, and technical assistance. CPPP's work is grounded in rigorous data analysis.

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Methodist Healthcare Ministries is a faith-based, 501(c)(3), not-for-profit organization founded in 1995, whose mission is "Serving Humanity to Honor God" by improving the physical, mental and spiritual health of those least served throughout South Texas. MHM's service area covers over 72 counties of South Texas, many among the poorest in our country, identified as the Southwest Texas Conference of The United Methodist Church. MHM is the largest non-public funding source for community health care services to those least served and uninsured in South Texas.

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The Texas Health Care Primer
Updated November 2009

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"Health care is a basic human right… It is unjust to construct or perpetuate barriers to physical wholeness…

"We also recognize the role of governments in ensuring that each individual has access to those elements necessary to good health."

The United Methodist Church
Social Principles

Foreword

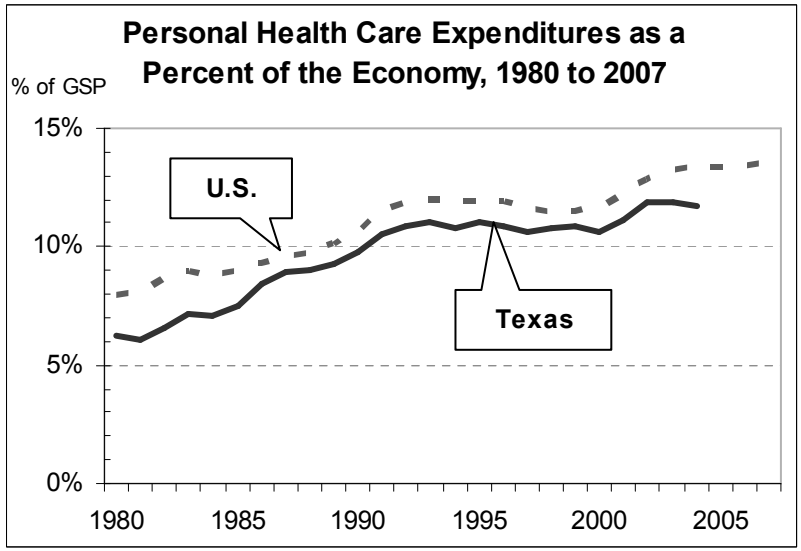
The Center for Public Policy Priorities (CPPP) and Methodist Healthcare Ministries (MHM) are pleased to release another update of the *Texas Health Care Primer*. The primer was first issued in 2003 and has been reprinted and distributed electronically to thousands of readers. Right now, national health care reform is being debated. If Congress makes significant changes, we will again update this primer.

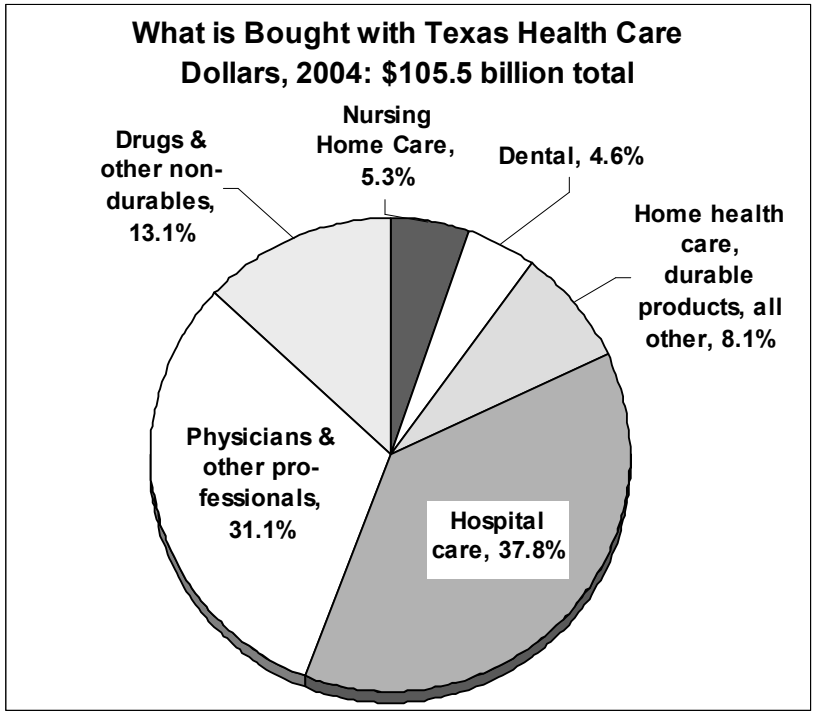
As two nonprofits working to improve life in Texas communities, our partnership is natural. CPPP researches and advocates ways to improve the economic and social conditions of low- and moderate-income Texans; MHM, through health services, programs, and public policy advocacy, directly touches the lives of those least served.

This primer is designed to give readers an introductory overview of factors shaping Texans' access to health care. We define "access" as the ability to obtain health services in a timely manner and to have an adequate infrastructure of health care professionals and facilities willing and able to serve those needing medical attention. Readers of this primer will be better able to contribute to federal, state, and local debates about how to improve that access.

Another goal of this primer is to paint a picture beyond the numbers and facts conveyed. Knowledge brings responsibility. We hope that the knowledge in this primer will prompt readers to reach into their hearts and not only find compassion, but ask: Is this the kind of society in which we want to live? Is it wise that many of the children on whom we will depend for our future state economic viability are without health care? Is it fair that a significant number of Texans work hard at full-time jobs, yet do not get the health insurance coverage provided to others?

If public policies reflect values in action, we must ensure that our values are heard. For our values to be heard, we must speak out. MHM and CPPP ask you to stand up and be counted, and to actively engage in the issues that challenge your values so that our society reflects your principles.





SOURCE: State Health Accounts data, Centers for Medicare and Medicaid Services, February 2007.

Health Care: The Economic Context

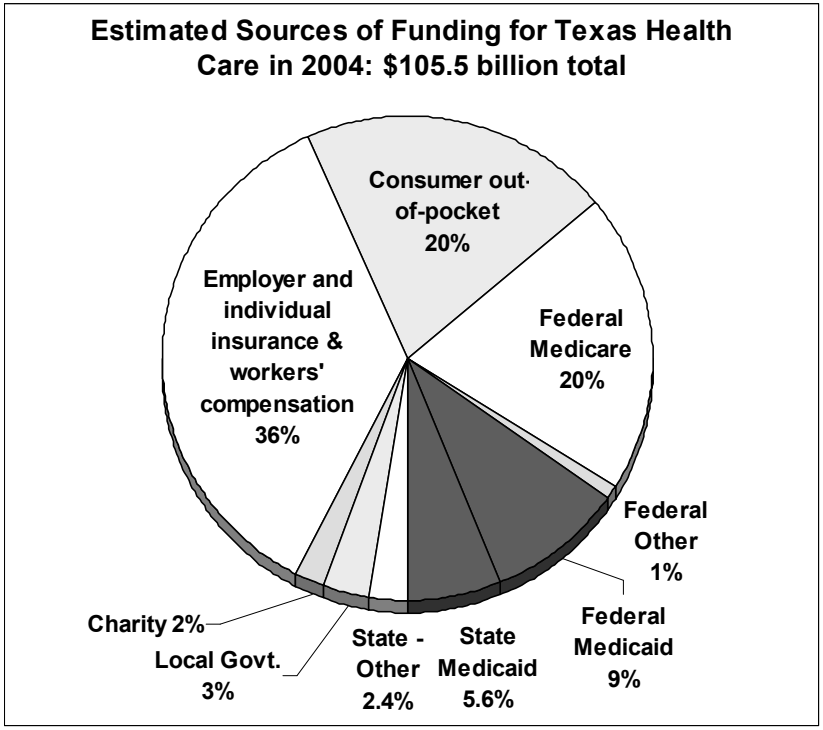
In 2004, the $105.5 billion spent on personal health care in Texas accounted for 11.7% of the Gross State Product (GSP). If health care has maintained this share of the Texas economy, it will reach an estimated $146 billion in 2009.

As shown in the top chart, health care spending became a much larger part of the Texas economy during the 1980s. It stabilized in 1993-95 at 11.0% of GSP and decreased slightly after that. Starting in 2001, health care spending once again exceeded overall economic growth, although this trend was more pronounced nationally than in Texas.

The bottom chart shows the different services and products on which health care dollars are spent. Almost 70% goes to hospitals and to physicians. Texas' health care spending looks similar to the U.S. average, except that only 5.3% of Texas dollars are spent on nursing home care, compared to 7.4% for the U.S. average.

The state Comptroller of Public Accounts has estimated that every non-state dollar (from a federal or other out-of-state source) spent in Texas on health care generates $3.51 in overall spending. Increased Medicaid, CHIP, and Medicare coverage of Texans would therefore not only reduce the need for local government funding of indigent care programs, it would also increase the economic impact of the health care industry.

SOURCES: State Health Accounts data, Centers for Medicare and Medicaid Services; Texas Comptroller of Public Accounts, *The Impact of the State Higher Education System on the Texas Economy,* December 2000.



SOURCES: State Health Accounts, Centers for Medicare and Medicaid Services, February 2007; U.S. Census Bureau, *State and Local Government Finances 2004*; Texas Comptroller of Public Accounts, *Texas Health Care Spending,* March 2001; CPPP estimates. Figures do not add to 100% because of rounding.

How is Health Care Paid For in Texas?

Personal health care spending in Texas totaled $105.5 billion in 2004. Private and public employers (36% of health care spending) and individual consumers (20%) combined pay for well over half of all health care in Texas, according to an estimate by the state Comptroller of Public Accounts. Employers' spending is primarily for health insurance premiums and workers' compensation costs, while individuals spend health care dollars on premiums, co-payments, direct payment of health care bills, prescription drugs, and other out-of-pocket costs.

Federal, state, and local government programs combined account for 41% of Texas health care spending, as shown in the chart at left. The federal contribution is almost three times as large as state and local governments' share combined, because of federal spending on Medicare and Medicaid.

It is important to note that while the source of public spending is taxes and other government revenue, the lion's share of these health care dollars ends up in the private sector. Whether it funds public employee health insurance benefits or programs for low-income people, public health care spending consists of payments to insurers, hospitals, physicians, pharmacists, and other health care providers.

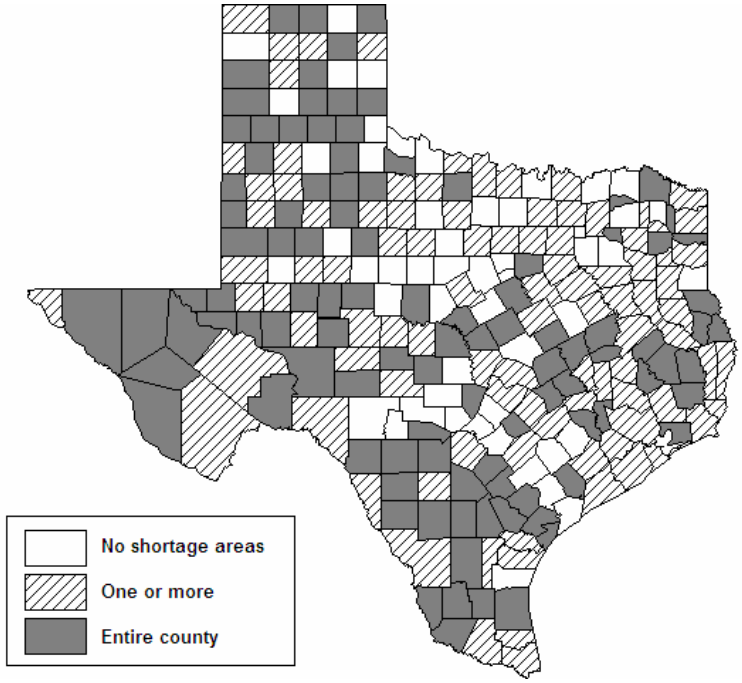
"Charity" consists of public and private hospital charity care; physician charity and bad debt; pharmaceutical companies' charity programs; and medical services funded by nonprofit groups. It is not the same as all health care spending for the uninsured. According to a survey by the Texas Department of State Health Services, non-public hospitals alone accounted for over $2 billion in uncompensated care (charity care and bad debt, adjusted for cost-to-charges ratios) in 2005.

Health Care Infrastructure Rankings

Per 100,000 population:	Texas	U.S.	Texas Rank
Hospital beds, 2007	240	270	33rd
EMTs and paramedics, 2008	54	68	38th
Physicians, 2008	246	326	40th
Registered nurses, 2008	676	836	44th
Dentists, 2008	53	77	45th
Dental hygienists, 2008	40	57	48th

SOURCES: Kaiser State Health Facts, 2009; Occupational Employment Statistics, U.S. Bureau of Labor Statistics, 2008.

Primary Care Health Professional Shortage Areas, 2009



SOURCE: U.S. Health Resources and Services Administration, 2009.

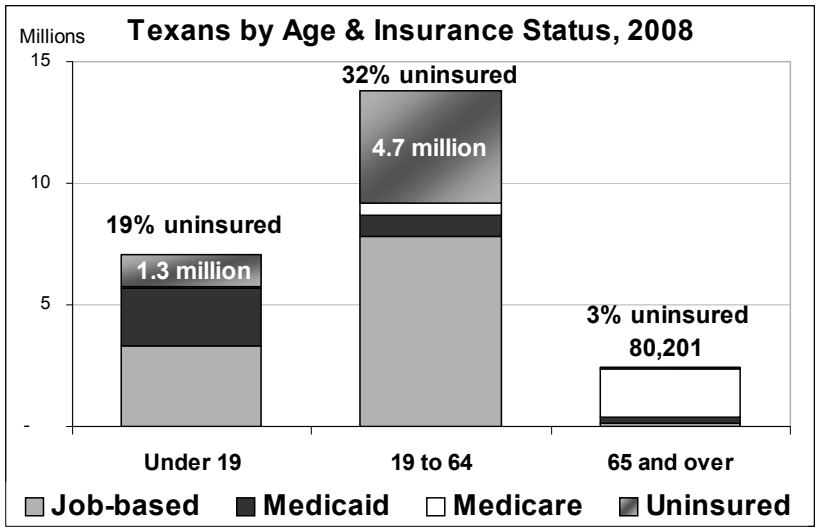
How does the State's Health Care Infrastructure Compare to Other States?

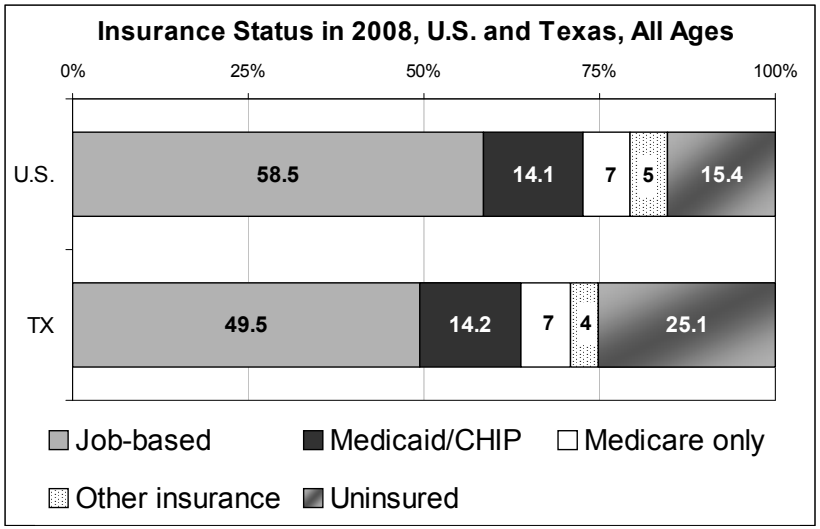
Compared to other states, Texas has a scarcity of certain kinds of health care professionals. The table at left shows Texas ranking in the bottom third of states when the number of physicians, nurses, dentists, and other health care personnel is adjusted for the total population of the state.

Even with the lower rates of health care personnel, however, health care jobs are an important part of the state economy. Private-sector health care services employed 1,074,300 Texans in 2008, with combined annual earnings of almost $58 billion. Health services' share of Texas private-sector earnings is 8.8%, the same as its share of private-sector jobs. Texas state and local governments employed another 124,800 health and hospital workers in 2008, with an estimated annual payroll of $5.7 billion.

Analyzing the state's health care infrastructure requires looking below the state-level data to the local availability of health care professionals. Federal designations such as "Medically Underserved Area" or "Health Professional Shortage Area" are used to identify regions where health professionals are in short supply. In October 2009, half of Texas counties, or 127, were wholly designated as primary medical care shortage areas; 86 counties were dental care shortage areas; and 178 counties were mental health care shortage areas. In addition, hundreds of subcounty areas—particularly in urban areas such as Harris, Bexar, and Dallas counties—have been identified as needing more medical providers. The chart at left shows counties that were wholly or partially designated as having a shortage of primary medical care providers in mid-2009. ("Areas" can be census tracts, neighborhoods, or cities; population groups such as low-income residents; or institutions such as prisons.)

SOURCES: U.S. Bureau of Economic Analysis, 2008 State Personal Income Accounts; U.S. Census Bureau, 2008 Annual Survey of State and Local Government Employment and Payroll; U.S. Health Resources and Services Administration, 2009.





SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009. Top chart does not show the small amount of people covered by federal military health care or non-employer-based private insurance, shown in the bottom chart as "other insurance." Top chart also includes CHIP coverage in the "Medicaid" category for Texans under 19.

Who is Insured?

Of the $69 billion spent on health care in Texas in 1998, the Comptroller of Public Accounts estimated that $4.7 billion paid for health care for the uninsured, while almost $65 billion in health care was for insured Texans. On average, this equaled $967 in health care spending per uninsured Texan, compared to $4,296 for a Texan with health insurance. Being insured is clearly linked to having access to health care (as measured by spending) for the average Texan.

Three-fourths of Texans do have health insurance, primarily through their employer or a government program—Medicare or Medicaid. **Residents aged 65 or over** are the most likely to be insured. In 2008, 92.2% of Texans 65 and over were covered by Medicare. Only 3.2% of senior Texans lacked insurance of any kind in 2008.

Among **working-age Texans (19 to 64)**, the primary source of coverage is employment-based insurance, covering 54% of these adults. But because Medicaid and Medicare coverage for working-age adults is low (6% and 3%, respectively), Texans in this age group are the most likely to be uninsured (32% in 2008). Among Texas **children**, 46% were covered because a family member had employment-based insurance, and the remainder were mostly divided between Medicaid and CHIP (33%) or no insurance at all (19%) in 2008.

Texas has the highest uninsured rate—25.1% in 2008—in the nation. The U.S. average is 15.4%, or 46.3 million uninsured nationwide. Over 6 million Texans had no health insurance in 2008.

Single-year estimates of uninsured Texans—people who lacked any kind of health coverage for an entire calendar year—are from the Census Bureau's 2009 Current Population Survey (CPS), the source of the statistics cited above. Other studies reveal that Texans are also more likely to lack insurance for shorter or longer periods of time.

For example, a March 2009 Families USA study estimates that nationally, 33% of nonelderly Americans—86.7 million people—were uninsured for all or part of 2007 and 2008. Of these uninsured

people, three-fourths (74.5%) went without coverage for 6 or more months. One-fourth (25.3%) of the 86.7 million were uninsured for the entire 24-month period. Persons who go for longer periods without insurance tend to have lower incomes, be in fair or poor health, or be middle-aged (who have higher rates of chronic disease).

For Texas, Families USA estimated that about 9.3 million nonelderly individuals—44% of all residents under 65, the highest rate in the U.S.—were uninsured for some or all of 2007 and 2008. Almost 81%, or 7.5 million, of these Texans went without coverage for six months or more. Most (83%) were part of a family with one or more workers.

The 9.3 million nonelderly Texans who experienced a spell of being uninsured over a 24-month period in the Families USA study is much larger than the state's 6 million nonelderly uninsured in the 2009 Current Population Survey, because the pool of Texans with no insurance includes people who remain uninsured for long periods of time, as well as others who regain coverage at some point. But, while some Texans uninsured in 2007 regained coverage in 2008, a new group of different individuals lost coverage in 2008. To sum up: Texans are at higher risk than other Americans of being uninsured for both short and longer periods.

Within Texas (see table at right), the estimated percentage of residents of all ages or children with no health insurance is highest along the U.S.-Mexico border, and in the metro areas of Houston, Dallas, and Odessa. Border-area economies are more likely to lack the kind of higher-paying jobs that would either offer employer-based coverage, or pay high enough salaries so that workers could purchase insurance coverage for themselves and their families. Border areas are also likely to have much higher than average unemployment rates and larger shares of residents who are low income (below 200% of the federal poverty line).

Uninsured Rates by Metro Area, 2008

	All Residents	Children under 18
Abilene	18.2%	9.5%
Amarillo	19.9	12.7
Austin-Round Rock	20.7	16.4
Beaumont-Port Arthur	19.2	13.3
Brownsville-Harlingen	35.7	23.3
College Station-Bryan	16.2	13.0
Corpus Christi	22.8	14.1
Dallas-Plano-Irving	25.1	19.7
El Paso	31.8	21.1
Fort Worth-Arlington	22.0	16.0
Houston-Sugar Land-Baytown	24.9	18.4
Killeen-Temple-Fort Hood	14.2	9.5
Laredo	36.2	22.6
Longview	22.9	18.9
Lubbock	16.6	11.2
McAllen-Edinburg-Mission	38.0	22.1
Midland	20.6	14.7
Odessa	29.4	28.2
San Angelo	20.0	13.7
San Antonio	21.4	14.7
Sherman-Denison	21.9	15.9
Texarkana	21.0	10.5
Tyler	22.3	13.8
Victoria	21.2	16.2
Waco	20.3	15.8
Wichita Falls	16.7	10.7
Rural Texas	19.7	15.3
Texas average	**24.1%**	**17.8%**
U.S. average	**15.1%**	**9.9%**

SOURCE: U.S. Census Bureau, American Community Survey 2008.

Factors explaining the lower rate of employer-based health insurance coverage in Texas

	Texas	U.S. Average
ASSOCIATED WITH MORE ACCESS		
Manufacturing jobs as % of all jobs, 2008	9.9%	11.2%
Workers represented by a union, 2008	5.6%	13.7%
Private-sector workers in a union, 2008	2.5%	7.6%
ASSOCIATED WITH LESS ACCESS		
Involuntary part-time workers as % of part-time labor force, July 2008	14.6%	14.3%
Agriculture/mining jobs as % of all jobs, 2008	2.9%	1.8%
Construction jobs as % of all jobs, 2008	9.1%	7.4%
Percent of workers in low-wage jobs, 2007	26.2%	24.5%
Percent of business employment in 2007 accounted for by firms		
with fewer than 20 employees	23.1%	24.9%
with fewer than 50 employees	39.7%	41.5%

SOURCES: Bureau of Labor Statistics, 2009; Population Reference Bureau, 2009; U.S. Census Bureau, 2007 County Business Patterns and 2008 American Community Survey; Unionstats.com, 2009, Barry T. Hirsch and David A. Macpherson.

Who has Employer-Based or Other Private Insurance?

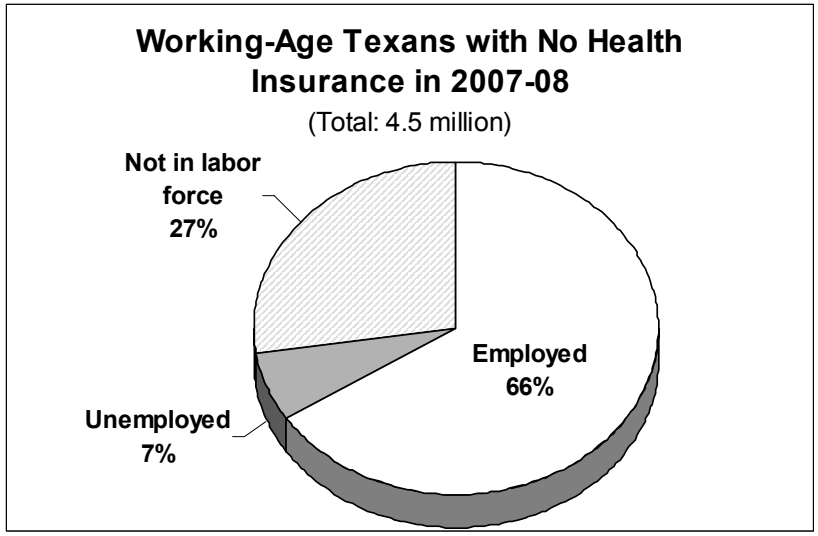
In 2008, 52% of Texans under 65 years of age had health insurance through their own or a family member's job, considerably below the U.S. average of 62%. (Only New Mexico has a lower rate of employer-based insurance coverage.) Making matters worse, ever since the 2001 economic downturn, the trend has been for a smaller share of Texans to get health insurance through their job. In 2000, 61% of Texans under 65 had employer-based health insurance.

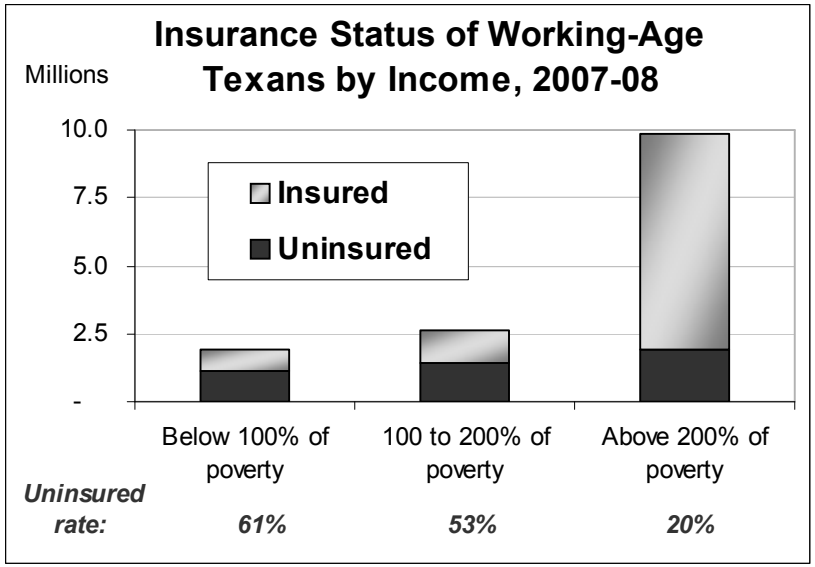
Texans at private firms with up to 24 employees were most likely to lack coverage: 52% of workers at these small firms had no private insurance in 2008. At firms with 25 to 99 employees, 38% of workers lacked private coverage. Even at firms with 100 to 499 employees, though, 29% of workers lacked private coverage. Thus, Texas' low rate of employer-based coverage cannot be attributed primarily to the percentage, or share of employment, of small businesses in the state. (On both those scores, Texas is very similar to national averages.)

Factors that are a bigger contributor to Texas' lower rate of job-based coverage include a smaller share of manufacturing and larger share of construction and farming jobs; low rates of unionization; and a higher share of workers employed in low-wage jobs or part-time jobs involuntarily (i.e., they cannot find full-time jobs).

Employers who provide health insurance benefits to their workers, and the workers who receive them, got federal tax subsidies totaling $148 billion in 2008, according to the federal Office of Management and Budget.* In comparison, Medicare outlays in 2008 totaled $391 billion; Medicaid and the Children's Health Insurance Program cost $208 billion in federal funds.

* OMB estimates the cost of tax expenditures on health insurance (including medical savings accounts, but not workers' compensation) by determining the amount that would be required to "provide the taxpayer the same after-tax income" as the tax expenditure.





SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement 2008 and 2009. "Working-Age" is defined as 19 to 64 years old, so these charts exclude workers who are under 19, or 65 and over.

Who is Working and Uninsured?

A popular misconception is that only people who are jobless lack health insurance. It is true that 55% of **unemployed** working-age Texans in 2007-08 were uninsured, versus 29% of **employed** Texans who are uninsured. However, being employed still leaves working-age Texans with a 29% chance of being uninsured. Another way to look at the same statistics: the employed account for two out of three uninsured working-age Texans (see top chart).

Several factors explain why so many working Texans are uninsured. One is that limits on Medicaid eligibility in federal law exclude many adults from that safety net program: namely, childless adults 19 to 65 years old, unless they are pregnant or disabled. Medicaid policy decisions made by Texas further limit the program's ability to serve working-poor parents. Wages—even from a part-time, low-paying job—make most adults ineligible for Medicaid because of very stringent income requirements for adults. Texas Medicaid only covers parents with incomes below 21% of poverty, or $308/month for a working parent with two children. At the minimum hourly wage of $7.25, working even 11 hours a week would disqualify a parent from continuing to receive Texas Medicaid.

In 2008, when statewide unemployment averaged 4.9%, almost one-third of Texas adults under 65 were low-income (below 200% of poverty, or $35,200 for a family of three). Most low-income workers have earnings that are not low enough to fall below the Medicaid adult income cap, but not high enough to enable workers to buy health insurance for themselves or their dependents, even if their employer is willing and able to share the cost. More than half (53%) of working-age Texans from 100 to 200% of poverty were uninsured in 2007-08, not much better than the 61% uninsured below poverty.

Texans with incomes above 200% of poverty have a much better chance of being insured, even though in total numbers, more of the uninsured (1.9 million) are in this income group than are poor (1.2 million) or between 100 to 200% of poverty (1.4 million uninsured). In 2007-08, 20% of working-age Texans above 200% of poverty had no health insurance.

Monthly Household Budget, Two Parents/One Child, 2007

	Monthly budget/taxes without health insurance	Health Insurance Premiums (employee share)	Percent Increase Needed to Cover Premiums
Abilene	$2,174	$335	15%
Amarillo	2,276	313	14
Austin-Round Rock	2,990	309	10
Beaumont-Port Arthur	2,117	344	16
Brownsville-Harlingen	1,972	206	10
Bryan-College Station	2,624	309	12
Corpus Christi	2,473	344	14
Dallas-Plano-Irving	2,917	344	12
El Paso	2,286	344	15
Fort Worth-Arlington	3,071	344	11
Houston-Baytown-Sugar Land	2,909	344	12
Killeen-Temple-Fort Hood	2,242	301	13
Laredo	2,222	277	12
Longview	2,254	344	15
Lubbock	2,259	339	15
McAllen-Edinburg-Pharr	2,295	260	11
Midland	2,192	339	15
Odessa	2,115	339	16
San Angelo	2,300	344	15
San Antonio	2,725	293	11
Sherman-Denison	2,534	344	14
Texarkana	2,241	344	15
Tyler	2,340	344	15
Victoria	2,387	344	14
Waco	2,358	301	13
Wichita Falls	2,195	344	16

SOURCE: Center for Public Policy Priorities, Family Budget Estimator, 2007.

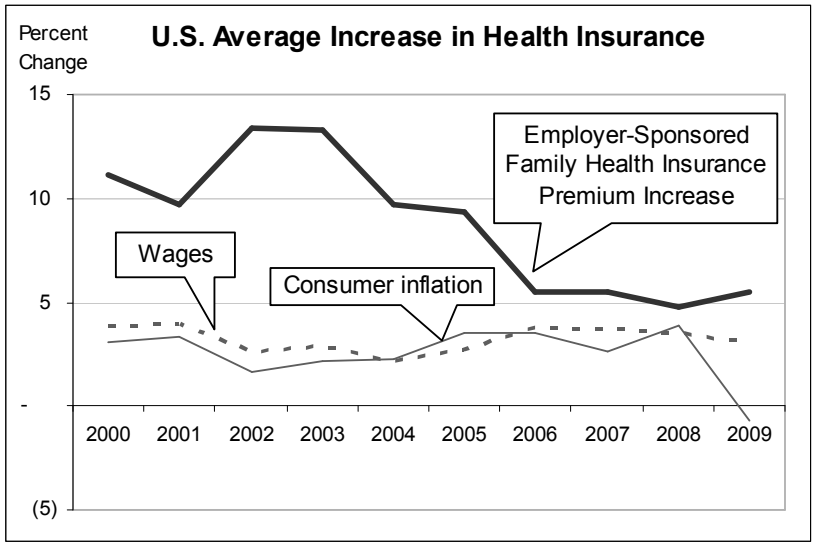
Why More People Don't Buy Health Insurance on Their Own

Health insurance costs vary widely depending on where a beneficiary lives, what their medical history or condition is, and what benefit level is chosen. As a result, it is difficult to determine exactly how much income a Texas family needs to be able to buy its own health insurance.

One attempt to estimate Texas local health coverage costs is the Family Budget Estimator (FBE), released by the Center for Public Policy Priorities in 2007. The FBE uses the cost of family coverage under the Employees Retirement System (ERS) health plan for state employees to model a metro-level cost of insurance for workers with employer-sponsored coverage.* For a two-parent, one child family, monthly budgets rise 10% to 16%, depending on the metro area, if the employee's share of premium costs is included. The FBE also provides estimates of health insurance costs for workers *without* employer-sponsored coverage (not shown in the table at left); household budgets increase by 30% to 42% if health insurance premiums are included.

Family budget increases to cover the cost of health insurance are inversely linked to how high or low other, non-medical costs of living are. For example, in the table at left, Fort Worth-Arlington has the highest non-medical household expenses (mainly because of housing and child care costs); adding $344 for premiums requires only a 11% increase. In contrast, residents of lower-cost areas such as Wichita Falls would need a 16% increase in their family budgets to cover $344 for the employee's share of health insurance.

*ERS is the largest employee group in Texas; smaller employers and individual purchasers of health insurance would face much higher costs than the amounts used in the FBE. Thus, the FBE estimates should be interpreted as the minimum, not average, cost of health insurance.



U.S. Average Health Insurance Premiums for a Family of Four, Employer-Based Coverage

	Monthly	Yearly	Increase from Prior Year (percent)
2002	$ 663	$7,954	12.8%
2003	756	9,068	14.0
2004	829	9,950	9.7
2005	907	10,880	9.3
2006	957	11,480	5.5
2007	1,009	12,106	5.5
2008	1,057	12,680	4.7
2009	1,115	13,375	5.5

SOURCE: Kaiser Family Foundation/Health Research and Educational Trust Surveys of Employer Sponsored Benefits, 1999-2009.

Why More Employers Don't Provide Health Insurance

The primary reason businesses don't offer health insurance is the same reason individuals don't purchase it on their own: the high and rapidly rising cost of premiums.

Nationally, family premiums for employer-based coverage averaged $1,115 per month in 2009. For Texas firms, average premiums paid for single and family coverage since 1996 have been close to the U.S. average, with the exception of single-employee coverage at small Texas businesses. These premiums were more costly than the national average from 2000 to 2006.

From 2008 to 2009, family health insurance premiums rose nationally by an average of 5.5% for all employers, and by 5.0% for employers with 3 to 199 workers. Counter to the trend from 2004 to 2008, premium increases were higher than the prior year's. Premium increases are also higher than consumer inflation or wage gains.

In the 2007 and 2009 sessions, the Texas Legislature created two public-private partnership programs to make health insurance more affordable for small businesses. **Healthy Texas** is a new statewide plan that will make basic, lower-cost coverage available to eligible small employers with low-income employees by covering a share of high-cost medical claims through a state-funded "reinsurance" pool. Healthy Texas is expected to start offering coverage in the summer of 2010 with monthly premiums averaging $200 per person.

Three-share programs make coverage more affordable for low-wage employees of small businesses by dividing the cost of a basic benefit plan among employers, workers, and public funds. Regional three-share programs are already operating in the Austin, Galveston, and Houston areas; programs are being developed in the Brazos Valley, Dallas, and El Paso. In September 2009, Texas received a federal grant of up to $10 million a year for five years for Healthy Texas start-up costs and for premium or cost-sharing assistance for low-income individuals in Healthy Texas and three-share programs.

Medicare Rankings

	Texas	U.S. Average	Texas Rank
Medicare payments per enrollee, 2006	$9,076	$7,941	4th
Medicare payment per hospital day, 2004	$4,896	$4,421	8th
Medicare spending as a percent of total personal health care spending, 2004	18.9%	19.2%	20th
Medicare Advantage (managed care) enrollees as a percent of all Medicare beneficiaries, 2009	17.3%	22.5%	24th
Elderly (aged 65 and over) enrolled in Medicare, 2007-08	91.3%	93.3%	41st
Social Security disability insurance (SSDI) beneficiaries as a percent of 18-to-64 population, Dec. 2007	3.2%	4.0%	43rd

SOURCES: CQ's *State Fact Finder 2007*; Centers for Medicaid and Medicare; Kaiser Family Foundation State Health Facts; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Who Gets Medicare?

Medicare is a federal health insurance program funded with payroll taxes on workers and employers participating in Social Security. Qualifying for Medicare usually requires working—or having a spouse who worked—for at least 10 years in Medicare-covered employment.

Medicare served almost 2.9 million Texans in 2008, or one out of seven insured Texans. About 79% of Texas Medicare recipients are aged 65 and over; the other 21% are under 65 but disabled or with end-stage renal disease. In 2007 almost 2.7 million Texans had Part A coverage, for in-patient hospital expenses; 2.5 million Texans opted for supplemental Part B, which covers outpatient costs such as doctors' fees.

In Texas, Medicare enrollment relative to the number of residents 65 or older is slightly below the U.S. average, but spending per beneficiary is higher. Medicare spending for Texas enrollees is considerably above the national average for home health care, nondurable medical products, medical equipment, and hospital care.

Medicare rankings for Texas look much better than for Medicaid, in which states have some latitude in determining eligibility, services, and payments. (See following pages on Medicaid.) For Medicare, eligibility and cost-sharing requirements are basically the same nationwide, with beneficiaries paying coinsurance and deductibles for hospital and other costs, and monthly premiums for Part B.

Congress added a prescription drug benefit (Rx/Part D) to Medicare, effective January 1, 2006. By January 2008, about 2.3 million Texans, or 85% of the state's Medicare beneficiaries, had drug coverage through a stand-alone plan, Medicare Advantage, employer or union plans, or dual-eligibility coverage. The national average was also 85%.

Medicaid Rankings

	Texas	U.S. Average	Texas Rank
Nursing home residents with Medicaid as primary payer, 2007	65%	64%	10th
Percent of Medicaid enrollees in managed care, June 2008	69.6%	70.9%	29th
Medicaid spending as a percent of total personal health care spending, 2004	14.5%	17.4%	34th
Medicaid payments per disabled enrollee, 2006	$10,615	$12,874	36th
Medicaid payments per enrolled child, 2006	$1,607	$1,708	39th
Medicaid recipients as a percent of poor residents, June 2008*	76.7%	111.3%	45th
Medicaid payments per elderly enrollee, 2006	$6,371	$10,691	47th
Medicaid payment per day for nursing facility care, 2007	$106	$158	48th
Medicaid nursing facility spending per person served, 2005	$19,471	$26,096	49th

* Not all people below the poverty line (100% of poverty) are eligible for Medicaid. Nationwide, the ratio of Medicaid recipients to people below the poverty line exceeds 100% because some eligibility categories have income cut-offs above 100% of poverty.

SOURCES: Centers for Medicaid and Medicare; Kaiser State Health Facts; U.S. Census, American Community Survey; AARP Public Policy Institute.

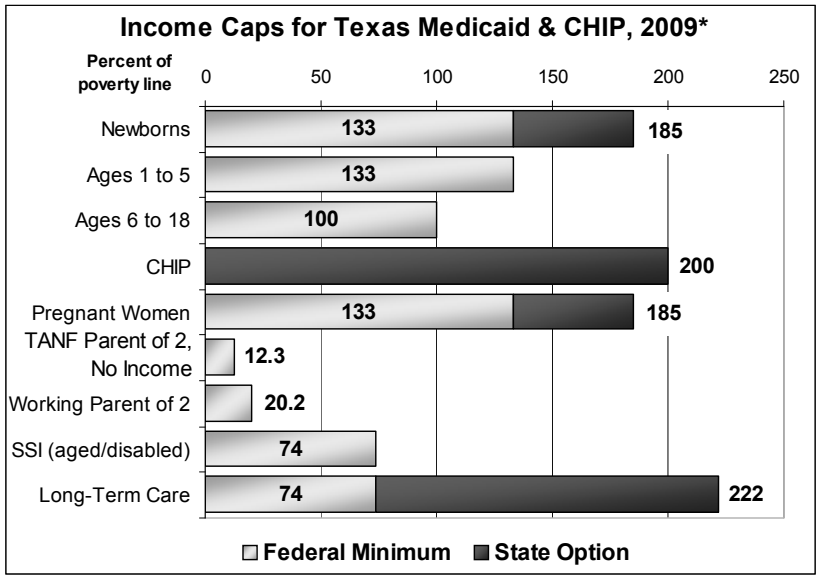
Who Gets Medicaid?

Medicaid is the federal health care program that covers low-income people, as well as some elderly and persons with disabilities. In September 2009, Texas had 2.8 million Medicaid enrollees; 2.0 million (72%) of them were under the age of 19. The state budget anticipates a Medicaid caseload of almost 3.2 million by 2011.

To receive or "draw down" federal Medicaid funds, states (and/or local governments) are required to match a portion of these funds by spending their own, non-federal money. In Texas, most Medicaid spending decisions are made during the biennial legislative sessions.

After meeting minimum federal standards for Medicaid coverage, states can set their own guidelines beyond the minimum for the different categories of low-income people eligible for Medicaid. States also decide how much to pay providers of Medicaid services. The combined effect of Texas' restrictive eligibility and low payments produces the Medicaid rankings seen in the table at left.

How Much More in Medicaid Matching Funds Could Texas Get? Texas generally receives about $1.50 in federal Medicaid funds for every state dollar invested in the program. (The match is even more favorable in fiscal 2009 and 2010 due to temporary increases authorized by federal economic recovery legislation.) In practical terms, the primary limiting factor in getting more federal funds has been the state's willingness to put up its share of Medicaid funding. For example, Texas could, without any special waiver, increase Medicaid coverage of parents with dependent children. Texas has at least 700,000 poor parents who are uninsured—nearly five times the number of parents who currently get Medicaid. If Texas were to cover these 700,000 parents below poverty through Medicaid, the full cost for a year would be roughly $2.6 billion, about $1 billion of which the state would have to fund at the usual match rate ($1.50 state to $1.00 federal). This would bring about $1.6 billion in federal matching dollars to Texas. Texas could also increase coverage of children and pregnant women if it was willing to provide the state match.



Eligibility Category	Annual Income Limit, 2009*
Children	
Medicaid for Newborns	$33,874
Medicaid, ages 1 to 5	24,352
Medicaid, ages 6 to 18**	18,310
CHIP, ages 0 to 18	36,620
Adult or Disabled	
Medicaid for Pregnant Women	33,874
Medicaid for TANF Parent of 2, No Income	2,256
Medicaid for a Working Parent of 2	3,696
SSI (Aged or Disabled)	7,884
Long-Term Care	24,264

* Annual income limit is for a family of three for child and parent categories. For SSI and Long-Term Care, income cap is for one person.

** Some children in foster care or adoption programs may be covered through age 21.

NOTE: Eligibility criteria are not shown for the Women's Health Program, the CHIP Perinatal Program, or Medicaid for certain foster care youth.

Medicaid and CHIP Income Eligibility Comparisons

Recent Eligibility Changes. The 2009 Legislature created a program to allow children with disabilities in families with incomes up to 300% of the federal poverty level (about $66,000 per year for a family of four) to purchase Medicaid coverage on a sliding-scale basis. In 2011, this new program is expected to serve about 2,400 children whose families make too much to qualify for Medicaid, but not enough to fully provide health care services for their disabled child.

Children's Medicaid and CHIP. When comparing states' coverage of children, both Medicaid and CHIP must be considered, because states have the option of using the CHIP block grant to create a separate CHIP program or to expand children's Medicaid coverage. Thirty-nine states including Texas operate separate CHIP programs; the other 11 and the District of Columbia use their CHIP funds to expand children's Medicaid.

For children from birth to 5 years old, the federal minimum requirement for Medicaid eligibility is 133% of the poverty line. For children 6 to 18, the federal minimum is 100%. Texas goes beyond the minimum only for newborns, covering them up to 185% of poverty; 15 states cover newborns at a lower level than Texas. (Federal law prohibits Texas from lowering its level, unless it gives up all federal CHIP funding).

Texas CHIP coverage begins where children's Medicaid coverage ends, and goes up to 200% of the federal poverty line.

Today, 30 states and the District of Columbia use Medicaid and CHIP to cover children with family incomes above 200% of poverty: 19 states and D.C. cover children up to 300% of the poverty line or higher, and another 10 states cover children to 250% to 275% of poverty. New York has the highest income limit at 400% of poverty for federally supported coverage of children. Three states (Illinois, Massachusetts, and Wisconsin) cover additional children using state funds, and several states offer full-cost buy-in access to children above the limits for state and federal assistance.

Medicaid Maternity Coverage. Texas is one of 18 states offering maternity coverage up to 185% of poverty. Another 21 states cover women up to 200% of poverty or higher. The District of Columbia and Wisconsin have the most generous income cap, at 300% of the federal poverty line.

CHIP Perinatal. The 2005 Legislature created the CHIP Perinatal program, which allows women who do not qualify for Medicaid maternity coverage—but whose babies will qualify for Medicaid or CHIP—to access prenatal care and delivery services. In September 2009, about 25,400 pregnant women and 29,000 newborns were covered through the program.

Including Texas, 15 states have operated programs that provide prenatal services through CHIP. Some states are restructuring their programs because of a new federal option to allow coverage of pregnant women in CHIP.

Parents' Medicaid. Only Louisiana and Alabama have a lower income cap than Texas for Medicaid coverage of parents with dependent children. On the other end of the spectrum, eight states cover parents with dependent children at 185% of poverty or higher.

Medically Needy. The 2003 Legislature eliminated coverage of parents under the Medicaid Medically Needy Spend-Down Program; coverage now exists only for children and pregnant women. This program had allowed working-poor parents with high medical bills to receive Medicaid while they were ill or injured, even though their incomes were slightly higher than regular Medicaid limits. An estimated average of 9,200 parents every month would have had this health coverage had the legislature not eliminated it.

Thirty-four states and the District of Columbia have Medically Needy coverage for adults—not just for parents, but also for aged and disabled persons.

Coverage of Aged and Disabled. All states provide Medicaid to most aged and disabled persons on Supplemental Security Income (SSI—$674 per month for an individual in 2010). Five states set

CHIP Policy Changes and Enrollment

Texas CHIP policy changes illustrate how very large enrollment changes can be created without changing income eligibility caps.

In September 2003, the Legislature made several cuts to CHIP, shortening the coverage period from 12 to 6 months, revoking income deductions, and adding asset limits for families at or above 150% of the poverty line; however, the upper eligibility cap of 200% of poverty was unchanged.

Before these changes took effect, Texas CHIP enrollment stood at 507,259. Three years later, in September 2006, CHIP enrollment had plummeted by about 215,700 children, or 43%. The shorter, 6-month coverage period is believed to have had the biggest impact on caseloads, because the number of children losing coverage each month began to exceed the number of new children enrolling.

The 2007 Legislature responded by restoring 12-month coverage, relaxing asset limits, and allowing modest deductions for child care expenses. By September 2009, 491,000 children were enrolled in CHIP. Enrollment has not fully recovered to levels seen before the 2003 cuts, but it has increased 68% from the low in September 2006.

SSI-related Medicaid caps at lower 1972 income levels, but they must allow SSI recipients with medical expenses to "spend down" into Medicaid. Nineteen states—Texas is not among them—set the SSI-related cap above the federal limit, covering more aged and disabled clients with full Medicaid benefits.

All states must provide a way for persons above SSI income levels to access nursing home and community-based care. In many states, the medically needy program for aged and disabled persons is one such route.

States also may set a "special income limit" for long-term care as high as three times the SSI cap—38 states including Texas set it at this level for nursing home care. In Texas, this is also the income limit for community care "waivers" designed to keep people out of institutions, but states can set this limit higher or lower than their Medicaid nursing home cap.

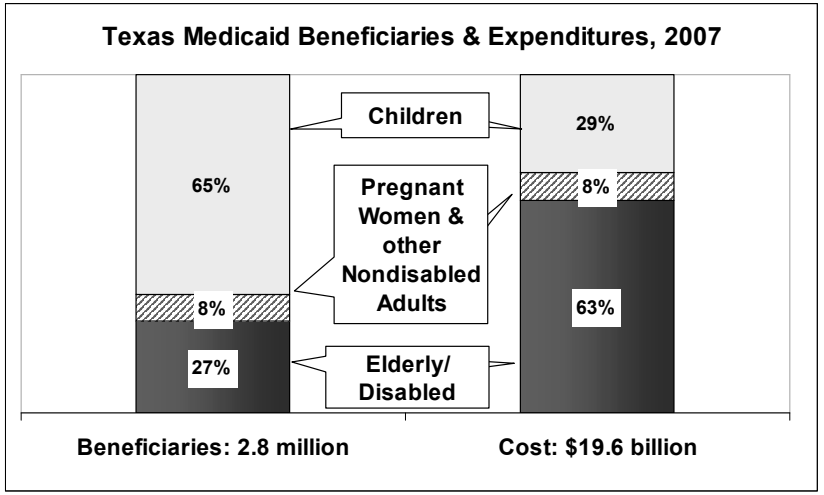
Women's Health Program. The Texas Medicaid Women's Health Program, established by the 2005 Legislature, provides family planning check-ups and preventive services to women ages 18 to 44 with incomes up to 185% of poverty. In September 2009, about 92,600 women were enrolled in the program.

Including Texas, 27 states have Medicaid family planning "waiver" programs that provide limited family planning services to certain women who are not otherwise eligible for full Medicaid coverage.

Eligibility Determination Problems

The combined effects of state agency procedures, poor private contractor performance, severe eligibility worker shortages, and computer woes from late 2005 to the present have created a crisis in Texas' public benefits eligibility determination system. The accuracy and speed of Medicaid and CHIP application processing and renewal have dropped, and Texas has seen periods of rapid decline in the number of children covered by Medicaid and CHIP. Parents report low confidence in the system as a result.

The combined number of children on Medicaid and CHIP stayed below 2003 levels until September 2007. In 2009, enrollment in children's Medicaid passed the 2 million mark, but experienced a steep decline after that peak due to performance problems in the eligibility system. The 2009 Legislature passed bills requiring the Texas Health and Human Services Commission to conduct a staffing analysis and authorizing HHSC to request additional eligibility staff if it continues to fall short on federal eligibility processing standards.



SOURCE: Texas Health and Human Services Commission, *Texas Medicaid and CHIP in Perspective*, January 2009. "Beneficiaries" is the average monthly number of Medicaid clients.

Medicaid Caseloads versus Costs

In Texas and other states, children and low-income adults are a large part of Medicaid enrollees, but a much smaller part of Medicaid spending. Children and low-income parents were three-fourths (73%) of Texas Medicaid clients in 2007, but only one-third (37%) of Medicaid spending was for these clients. Elderly clients and clients with a disability, in contrast, were about one-fourth (27%) of the caseload and two-thirds (63%) of Texas Medicaid spending.

Local Government Health Care Spending

	Texas	U.S. Average	Texas Spending as a Percent of U.S. Average
Per-capita spending on **public health**, 2007			
By local government only	$73	$122	60%
By state government only	$67	$112	60%
State and local government combined	$140	$233	60%
Per-capita spending on **hospitals**, 2007			
By local government only	$262	$236	111%
By state government only	$137	$157	87%
State and local government combined	$399	$393	102%

SOURCE: U.S. Census Bureau, 2007 Census of Government Finance.

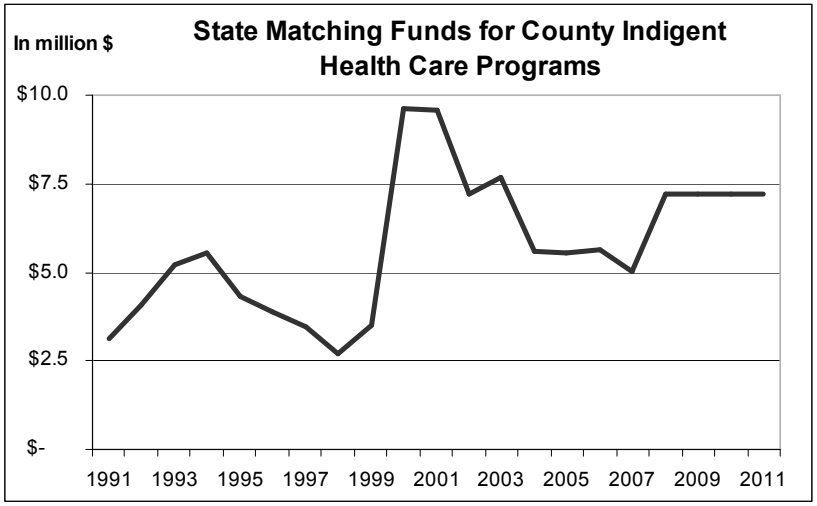
Who is Served by Local Public Health Care Spending?

Local governments in Texas and other states fund or directly operate a variety of health care programs and services, such as hospitals, clinics, and community centers serving the uninsured or underinsured; public health campaigns such as mosquito control, immunizations, and HIV prevention; and Emergency Medical Services (EMS) and trauma care. Local public hospitals account for one-fifth of all hospitals in Texas and one-eighth of hospital beds.

Because of the variety of services, and the diverse types and responsibilities of local governments, the most accurate way to compare Texas local spending is with Census Bureau data on state and local government spending. The table at left shows that Texas local governments' public health spending—although still well below the U.S. average—is higher than state government spending on public health. Hospital spending by Texas local governments is higher than the U.S. average. Texas state government hospital spending is closer to the U.S. average than is its spending on public health; this is because Texas funds health science centers and other hospitals associated with universities.

The relatively high per-capita hospital spending at the state and local levels is partly a by-product of the state's high uninsured rates: if state Medicaid spending (reported by the Census Bureau as "public welfare" spending) were increased enough to serve more of the state's uninsured, then state and local hospital spending on indigent care could decrease by an even greater amount, because of federal matching funds for Medicaid.

All acute care hospitals—public, for-profit, or nonprofit—reported a total of $5.7 billion in charity care for 2005, or $2.8 billion when adjusted for the differences in hospitals' charges and what they usually receive in payments (the "cost-to-charge" ratio). Texas public hospitals accounted for almost two-thirds, or $1.8 billion, of this adjusted charity care amount. Local public hospitals reported $1.5 billion in adjusted charity care, and state hospitals accounted for the remaining $326 million in adjusted charity care in 2005.



SOURCES: Legislative Budget Board and Texas Department of State Health Services.

What is the Counties' Role in Providing Health Care?

Texas counties are required by state law to provide certain basic health care services to indigent residents. State law defines "indigent" at a minimum as someone with few or no assets (such as an automobile) and with an income below 21% of the poverty line. In 2009, this means an ***annual*** income of less than $2,274 for one person, or $3,845 for a family of three.

Counties can choose to serve people above the minimum income levels set in state law. Counties fulfill their responsibilities by setting up a hospital district that can collect property taxes; by owning, operating, or leasing a public hospital (alone, with another county, or with a city) funded with property and sales taxes; or by creating and funding a county indigent health care program.

Depending on which option they choose and who is served, counties may also receive state and federal funding for their indigent care services. Counties with indigent health care programs can qualify for state assistance if they spend more than 8% of their general tax revenue on state-approved basic and optional health services that are medically necessary. However, the state assistance fund has never been large enough to reimburse all counties' eligible spending, and has provided even less help since 2000-01 because of state budget cuts. In fiscal 2010 and 2011, the state assistance fund will make only $7.2 million available annually to Texas counties, down from the already inadequate level of $9.6 million in fiscal 2000 and 2001.

About one-third of the state's counties, home to more than half the state's population, have a hospital district to provide indigent care. Another 110 counties, where only one-third of Texans live, have a county indigent health program. The remaining counties have either chosen the public hospital option (29 counties, mostly rural), or use a combination of a county program and a hospital district or public hospital to serve residents.

What are Federally Qualified Health Centers?

"Federally Qualified Health Centers" (FQHCs) are a type of public or nonprofit primary health clinic funded by the federal Bureau of Primary Health Care. FQHCs and FQHC "look-alikes," which are not federally funded, are also called community health centers. Texas has almost 70 FQHCs that operate at more than 300 different sites. A state-funded incubator grant program was created to help more communities apply for FQHCs, and the federal and state governments have earmarked funds to expand or start FQHCs. But federal funding has not been maintained at the 2002 peak level, whether in Texas or nationally.

Until 2004, FQHCs received federal funds through various programs created over the years: Community or Migrant Health Centers; Health Care for the Homeless; Public Housing Primary Care; and Healthy Schools, Healthy Communities. These were consolidated into one grant "cluster" that brought $114 million to Texas in 2008. This is a significant increase from $46 million in 1994, but federal FQHC grants are still less than 0.1% of Texas health care spending.

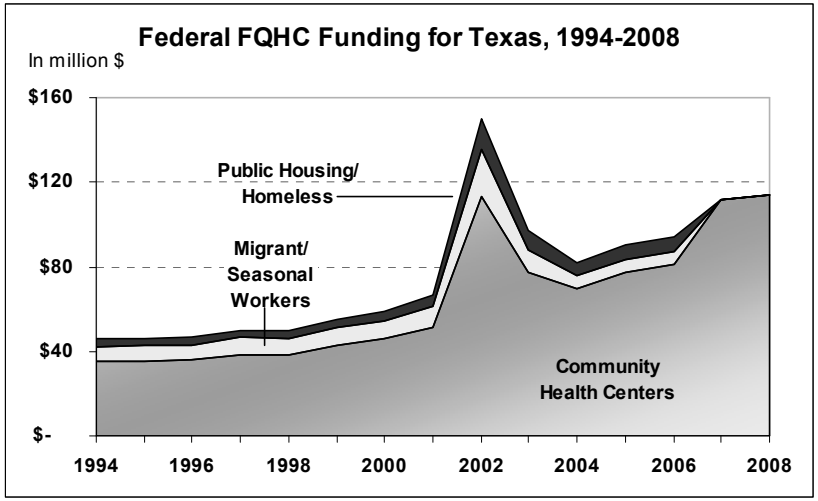
In 2007, FQHCs and FQHC "look-alikes" served over 770,000 Texans throughout the state. About 56% of Texas FQHC clients are uninsured. Along with federal and private grants, FQHC revenue comes from private insurance, Medicare, Medicaid, and CHIP. Compared to the U.S. average, Texas FQHC revenues are more likely to come from patient fees and non-governmental grants or contracts, and much less from Medicaid or private insurance.

Community health centers provide comprehensive primary health care to residents with financial, geographic, or cultural barriers to care. CHCs may also provide transportation, translation, preventive care, mental health, and dental services. These health centers are public or nonprofit agencies created by local residents and governed by consumer-majority boards of directors representing the communities served. Health centers generally require payment for services from patients, according to their ability to pay.

FQHCs are critical providers of care, serving all residents requesting care and not excluding persons based on immigration status. As of October 2009, Texas FQHCs could be found in 94 counties. Texas

FQHCs are most heavily concentrated along the U.S.-Mexico border and in South and East Texas. While FQHCs serve significant numbers in San Antonio, Austin, and El Paso, their presence in Dallas and Fort Worth is limited.

FQHCs provide *primary* care benefits to their clients, but they do not provide specialty care or hospital care. Thus, any plan to expand FQHCs as a way to provide coverage to the uninsured must also find a way to fund and provide access to specialist and hospital care.



How FQHCs were Funded, 2007

% from each source	Texas	U.S. Average
Federal Grants	28.3%	20.7%
Medicaid	24.1	36.5
Medicare	5.3	6.0
Other Public Insurance	2.0	2.6
Private Insurance	2.7	7.3
Patient Self-Pay/Fees	11.7	6.6
Foundation/Private Grants/Contracts	7.1	4.2
State/Local Grants/Contracts	8.4	9.8
Other Revenue	10.4	6.3

SOURCES: U.S. Census Bureau; Kaiser State Health Facts.

Selected Statistics About Elderly Texans

	Texas	U.S.
62-to-74-year-olds with health insurance, 2007-08:		
Men	90.7%	95.1%
Women	91.1%	94.8%
75+-year-olds with insurance, 2007-08:		
Men	97.3%	98.8%
Women	97.4%	98.6%
Low-Income Status of Age 65+ residents, 2007-08		
Below Poverty Line	12.3%	9.7%
Between 100% and 200% of Poverty	29.2%	26.5%
Age 65+ with any Disability, 2008	42.4%	38.1%
And in a rural area	43.1%	38.6%
Age 65+ with Self-Care Difficulty, 2008	11.4%	9.2%
Age 65+ with Ambulatory Difficulty, 2008	28.9%	24.7%
Age 65+ with a Cognitive Difficulty, 2008	11.8%	9.8%
Median Hourly Wage, Personal & Home Care Aide, May 2008	$7.05	$9.22
Median Hourly Wage, Home Health Aide, May 2008	$8.03	$9.84

SOURCE: AARP Public Policy Institute, 2009; U.S. Census Bureau, 2008 American Community Survey; Bureau of Labor Statistics 2008 Occupational Employment Survey.

What Major Gaps Exist in Public Programs?

Disabled and Elderly: Several large gaps in the public health care system exist for Texans who are elderly or who have a disability. This is a problem because fewer elderly Texans are insured, and more live in poverty, than elderly people in the U.S. on average.

One major health care gap for the elderly that Congress recently took steps to address is prescription drug coverage. A "Part D" drug benefit was added to Medicare in 2003. Ongoing Medicare policy issues include the "donut hole," or gap in coverage, that beneficiaries with high drug costs face; outreach to ensure that beneficiaries select the plan that is best for them; out-of-pocket costs that grow faster than retirees' fixed incomes; and the impact that federal deficits may have on the Medicare program.

With drug coverage at least partially addressed, access to affordable and quality long-term care may be the most important remaining gap. The Medicare nursing home benefit is very limited and in most cases is not an option for those needing long-term care. Medicare pays for a nursing home only after someone has been hospitalized, and for only 100 days for each incident (or "spell") of illness.

Another major gap exists for elderly and disabled Texans who are receiving monthly Social Security disability payments but are still in the two-year waiting period required before Medicare coverage can begin. If people in this situation have incomes low enough to qualify them for Supplemental Security Income (SSI), Medicaid can help with their medical costs; otherwise, they have to find another way to pay for their medical bills.

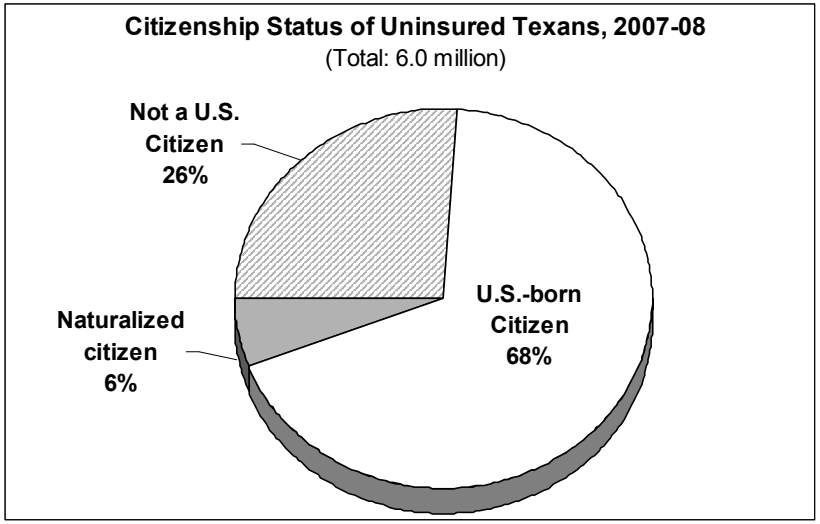
The table summarizes indicators that point to a higher need in Texas for health care services for the elderly, and for the elderly and disabled, than in the U.S. on average. Quality of care is also an issue in Texas, which has median wages for personal and home care aides and for home health aides that are not much higher than the federal minimum wage.

Immigrants in General: Texas has 3.7 million foreign-born residents, the third largest number of immigrant residents (after California and New York) among the states. Immigrants in Texas are much less likely to be insured through Medicaid, Medicare, or any other source of coverage than are native-born residents.

Almost 1.1 million foreign-born residents of Texas have become naturalized U.S. citizens. They are uninsured at higher rates (33%) than are U.S.-born residents of Texas (20%).

Well over half (60%) of the 2.6 million immigrants in Texas who are not U.S. citizens—legal permanent residents, undocumented immigrants, and other foreign-born residents—are uninsured, a rate three times as high as that for native-born residents. Still, as the chart illustrates, non-citizens, both legal and undocumented, are only one-fourth (1.6 million) of Texas' uninsured.

Compared to other large states with similar demographics, Texas has by far the highest percentage (40%) of children of immigrants who are also uninsured. This is true despite the fact that children of immigrants, more often than not, are U.S. citizens and thus eligible



SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008 and 2009.

for CHIP or Medicaid on the same terms as any other U.S. citizen child. Many Texas children live in families that include U.S. citizens, legal immigrants, and undocumented members. One-fourth of all Texas children live in "mixed families" (one or more parent is a non-citizen, either legal or undocumented), and one-third of Texas children in low-income families (below 200% of the poverty line) are in mixed families.

Immigrants Not the Cause of Texas' Uninsured Ranking: As mentioned earlier, immigrants, whether legal or unauthorized, are much more likely to be uninsured than are U.S.-citizen residents. But if state estimates are adjusted to remove non-citizens from the equation, Texas still has one of the worst rankings in terms of uninsured residents, with 4.5 million children and adults—21% of the population—lacking health insurance in 2007-08. In comparison, California's U.S.-citizen uninsured rate is 14%; New York's is 11%.

Legal Immigrants: Federal law lets states choose whether or not to provide Medicaid to legal permanent residents based on when they entered the United States. Only Wyoming did not continue Medicaid for those who arrived before enactment of the 1996 federal welfare reform law. Thus, legal immigrants in Texas who were in the U.S. before August 22, 1996, are eligible for Medicaid on the same basis as U.S. citizens.

However, Texas is one of seven states* that do not provide Medicaid to legal immigrants who arrived **after** August 22, 1996 (and after the immigrant completes a federal 5-year "bar" on participation). Federal law requires all states to pay for emergency care for otherwise-eligible immigrants under the "Emergency Medicaid" program, so opting to provide full Medicaid benefits allows states to draw down federal funds to cover prenatal care, prevention, primary care, and chronic care. In 2001 the Texas Legislature passed a bill to provide post-1996 legal immigrants with Medicaid coverage, but the legislation was vetoed by the governor.

* The other states are Alabama, Mississippi, North Dakota, Ohio, Virginia, and Wyoming.

Unlike Medicaid, states' CHIP programs are required by federal law to include legal immigrant children. Thus, legal immigrant children in Texas who entered the U.S. after August 1996 are covered by Texas CHIP if they meet the income standards. In addition, under the Texas CHIP statute, state-funded CHIP benefits are provided during the five-year "bar" on federal funding.

Undocumented Immigrants: The estimated 1.4 million to 1.6 million undocumented immigrants living in Texas face numerous barriers to health care access. Undocumented immigrants have never been eligible for Medicaid or CHIP, and in 1996, federal welfare reform further restricted undocumented immigrants' access to certain federal public benefits.

However, services funded through the federal Maternal and Child Health Block Grant (Title V), Family Planning (Title X), the Primary Care Block Grant, and Federally Qualified Health Center funds may not be restricted based on immigration status. Federal law also mandates that no restrictions may be placed on federal, state, or local benefits providing emergency care (including labor/delivery and mental health emergencies), immunizations, diagnosis and treatment of communicable illnesses, and "other programs delivered at the community level necessary to protect life or safety."

State and local governments are allowed to provide health services to undocumented residents beyond those mandated above, but a controversial provision of federal law currently states that new (post-1996) state laws must be passed to reauthorize such programs.

State and Federal Policy Debates: The 2003 Texas Legislature passed a law permitting local governments to provide health care to their undocumented residents. Local officials retained the authority they already had (before the 2003 law) to decide if their communities would fund health care for undocumented immigrants, so the law did not make any major expansions to access. Rather, it was designed to resolve a debate sparked in 2001 by a Texas Attorney General's opinion that use of local funds to serve the undocumented violated federal law, unless Texas law specifically permitted it. Other 2003 session efforts to expand health care coverage for immigrants failed, and many of that legislative session's cuts to Medicaid, CHIP, and other health programs resulted in reduced care for *all* low-income immigrants.

2007 session: Bills filed during Texas' 80th Legislative Session included several proposals—none of which passed—to further limit non-citizens' access to health and social services. However, a great diversity of opinion exists on issues related to immigration; for example, large segments of Texas' business community support comprehensive immigration reform. While it is clear that debate of these issues will continue to take place, it is not clear whether any significant changes in Texas policies will gain majority support.

Federal Update: Since July 2007, federal law requires most U.S. citizens enrolled in or applying for Medicaid to prove their citizenship (legal immigrants already had to provide their official immigration documents to enroll in Medicaid). The new requirement was expected mostly to create problems for eligible U.S. citizens who lack ready access to a birth certificate, as well as create new fears or confusion resulting in lower enrollment by qualified persons in families made up of U.S. citizens and foreign-born non-U.S.-citizens.

Alabama and Virginia analyzed Medicaid denials for the new document policy and found a disproportionate impact on African-American and non-Hispanic white clients. Follow-up interviews found that Hispanic clients were accustomed to having their U.S. citizenship questioned and thus took care to have birth certificates on hand, whereas most black and non-Hispanic white Virginians never expected to have to prove their citizenship, and had a harder time producing birth certificates.

Texas Medicaid officials have tracked denials attributed to the new policy and reported nearly 10,000 in the first five months, mostly newborns, children, and pregnant women. However, closer study found that workers were not using denial codes accurately, largely due to the serious shortage of workers and the related inability of workers to find time to learn the new policies. Thus, the true impact of the policy in Texas is not yet fully understood.

Health Care Access Issues Specific to Children

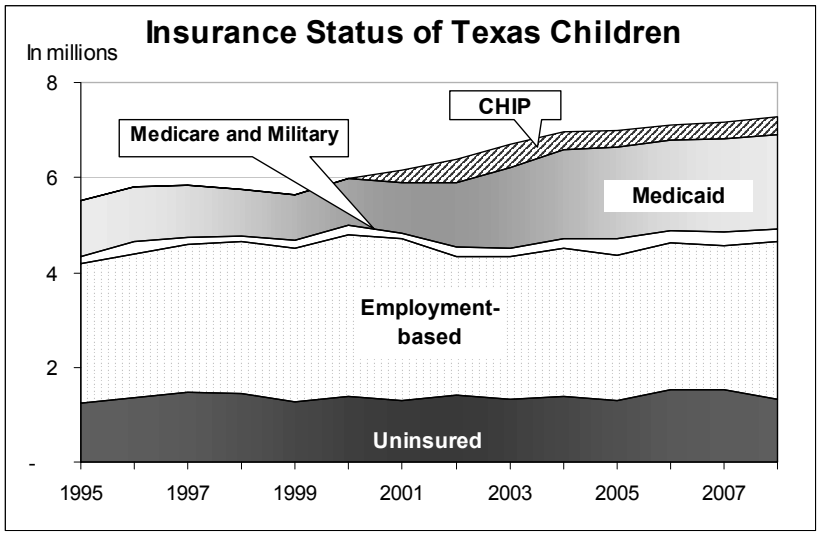
Children make up a larger share of Texas' population than they do of most other states. In 2008, 28% of Texans were under 18, compared to the U.S. average of 24%, giving Texas the second youngest population. Children in Texas are much more likely to be poor and uninsured. Texas had the 8th highest child poverty rate in 2008, at 22.5%, and the highest share of children under 19 uninsured in 2008, at 19%—well above the national average of 10%.

In absolute terms, employer-based health insurance for Texas children peaked in 2000 at 3.4 million. In 2008, 109,000 fewer children had employer-based coverage, compared to the levels seen before the 2001 economic recession. This is mainly due to employers no longer offering health insurance or other benefits such as pensions.

Children's Medicaid enrollment stood at almost 1.2 million in August 1995, then fell each year after that to a low of 976,000 in August 1999. In 2000, children's Medicaid enrollment started growing again because of simplified eligibility procedures, outreach efforts, and a worsening economy.

By August 2002, 1.35 million children were served by Texas Medicaid; by November 2005, children's enrollment had reached 1.83 million. However, enrollment fell to 1.72 million by October 2006 because of problems with the eligibility determination system. Enrollment wavered between 1.80 million and 1.86 million from May 2007 to January 2009, and between 1.9 million to 2.0 million for most of 2009. Legislative budget projections call for very little growth in children covered in the next two years: 2.15 million in fiscal 2010, and 2.18 million in fiscal 2011.

Texas began enrolling children in the Children's Health Insurance Program (CHIP) in May 2000. Enrollment climbed rapidly, peaking at about 529,000 in May 2002. Changes made by the 2003 Texas Legislature to CHIP reduced the number of children served and also reduced the benefits package.

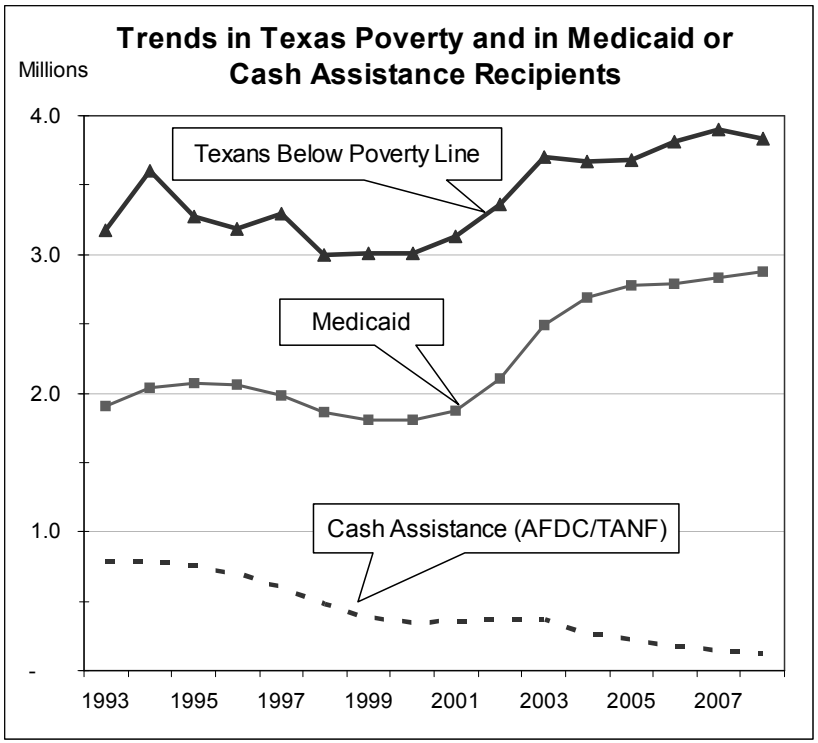


NOTE: Medicaid and CHIP include children up to age 18; other categories are for children 17 and younger prior to 2002. "Employment-based" means the child is insured through a family member's job. Chart does not include children covered by non-employment-based private insurance.

SOURCES: U.S. Census Bureau, Annual Social and Economic Supplement 1995-2009; Texas Health and Human Services Commission.

The 2003 cuts, followed by problems related to changes in the eligibility determination system (starting December 2005), drove enrollment down to 291,530 in September 2006. Various restorations enacted by the 2007 Legislature, such as 12-month continuous coverage for most CHIP children, helped enrollment recover to 491,000 by September 2009. The CHIP perinatal program, which began in January 2007, covered an additional 29,000 children and about 25,400 mothers in September 2009.

Early studies of CHIP showed high levels of satisfaction from enrolled families, as well as a shift away from using emergency rooms and hospital clinics to doctor's offices. Before enrolling in CHIP, 19% of kids regularly used the emergency room as a source of care, and 43% were taken to a doctor's office outside of a hospital. After being enrolled in CHIP, ER use was reported by only 10% of children's parents, and 61% said their care provider was a doctor's office outside a hospital.



SOURCES: Poverty data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; caseload data from Texas Health and Human Services Commission and Department of Human Services, operating budgets, and annual reports.

Health Care Access Issues for Children and Adults Receiving and Leaving Cash Assistance

When Medicaid was created in the mid-1960s, its benefits were available only to recipients of federal/state cash assistance—a welfare program known after 1996 as Temporary Assistance for Needy Families (TANF). In 1972, federal law also created Supplemental Security Income (SSI) to provide cash assistance to certain elderly and poor people with disabilities. Receiving SSI or being eligible for TANF still automatically qualifies someone in Texas for Medicaid, but in addition, many other categories of individuals have been made eligible for Medicaid by federal expansions in the late 1980s and other changes to federal law. Specifically, certain low-income children and parents; pregnant women and their infants; and certain elderly and disabled persons are eligible for Medicaid even if they do not receive TANF or SSI.

In August 2009, of the Texas Medicaid caseload of 3 million people, fewer than 1% were adult TANF recipients, and 4% were children on TANF. Another 57% were other low-income children, 4% were disabled children, 13% were elderly, 13% were adults with a disability, 4% were pregnant women, and fewer than 2% were poor parents not receiving TANF cash assistance.

Rising Medicaid caseloads and costs can lead to increased support for state TANF or Medicaid policy changes that directly or indirectly attempt to discourage Medicaid participation by children. However, because the cost of covering aged and disabled patients is much higher, removing children from Medicaid will not change the underlying factors driving long-term growth in Texas Medicaid costs. In 2009, Texas' budgeted monthly cost for a Medicaid managed care disabled/blind recipient—excluding long-term care or prescription drugs—was $406, more than twice the cost for nondisabled Medicaid children ($192 per month), and one-third higher than the cost for TANF parents ($305 per month).

Health Care Access Issues Specific to Indigent Care

The results of an 18-state study published in 2003 show that even with a safety net of local hospitals and health clinics to treat the uninsured, significant barriers to health care remain, such as cost-sharing requirements, high prescription drug costs, and other financial burdens that discourage the indigent from seeking future care.

For example, two-thirds to three-fourths of rural residents who were prescribed drugs as a result of seeking outpatient or emergency room (ER) hospital care said that they were unable to pay the full cost of the medications. About 30% said they did not get all of their medications because of an inability to pay.

Those using urban or suburban hospital ERs were most likely to report that hospital staff did not offer to look into financial assistance options on their behalf. When assistance was offered, it was more likely to be an installment plan, rather than discounting or waiving the medical bill.

About half of the uninsured who received care said they had unpaid bills or other debt owed to the health care facility. Of those, half said their debts would keep them from going back to the facility if their health problems continued.

More recently, data from the federal Behavioral Risk Factor Surveillance System indicate that in 2008, almost 21% of Texas adults reported that they did not see a doctor in the previous year because of the cost. This was the highest rate reported in the U.S. (14% national average).

SOURCES: The Access Project, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?,* January 2003; Kaiser State Health Facts analysis of Behavioral Risk Factor Surveillance System Survey Data, Centers for Disease Control and Prevention, 2008.

Why Inadequate or No Insurance is a Problem for Individuals and Families

People who support limiting the government's role in ensuring access to health care often downplay the importance of being insured, arguing that those who can't pay can instead go a local health clinic, emergency room, or community health center. However, the negative health consequences of being uninsured have been well documented. Major studies, as summarized by Families USA, have found that, compared to the insured:

- Uninsured children and adults are less likely to have annual exams and other preventive care. Uninsured adults are less likely to be screened for cancer, heart disease, and diabetes.
- Uninsured adults are less likely to follow up on recommended medical tests or care, and are more likely to end up being hospitalized unnecessarily as a result of an untreated condition.
- Uninsured people with arthritis, heart disease, high blood pressure, and other chronic conditions are less likely to have these conditions cared for through visits to a health provider or medication.
- Uninsured people are sicker and die prematurely compared to those with insurance. A September 2009 Harvard study estimates that 4,675 working-age Texans die annually due to a lack of health insurance.
- When hospitalized, the uninsured get fewer and substandard services compared to the insured. They are also often charged more than 2.5 times what people with insurance (and therefore, negotiated discounts) are billed for hospital services.

One study found that in 2007, almost two-thirds (62%) of all bankruptcies were related to medical expenses, up from about half (46%) in 2001. Being underinsured was more common than being uninsured for those seeking bankruptcy protection. The elderly and women, especially single heads-of-households, were most affected by their inability to pay off medical debt.

Why Inadequate or No Insurance is a Problem for Employers

When workers or their children lack health insurance, they are less likely to have medical conditions diagnosed and treated. This can lead to increased absenteeism and turnover; reduced productivity; increased workers' compensation, disability, and other health care costs; and impaired job performance. Not all of these costs can be quantified, and even when they can be, the cost to the employer may still be lower than the cost of providing health insurance to workers and their dependents. This is particularly true for low-wage and part-time employees, who are less likely to be insured than are high-wage or full-time employees.

Increasing the availability of employer-provided coverage, or of employer support for universal coverage, will require a better understanding on the part of business leaders and other policy makers of a few key points.

First, having insurance means workers are more likely to be in good health, to have increased earnings and productivity associated with good health, and to remain with the employer rather than going to work for a competitor.

Second, a lack of insurance is damaging to the rest of the labor force and the local health care provider infrastructure.

Third, if the uninsured end up getting health care that is either more expensive than it would have been if they saw a doctor sooner, or that they cannot fully pay for themselves, the cost of this care will be shifted to other payers, including private-sector employers and taxpayers in general. Families USA estimates that in 2005, the cost of employer-based family coverage in Texas was $1,551 higher due to unpaid costs of health care for uninsured Texans.

Why Inadequate or No Insurance is a Problem for State and Local Taxpayers

Families USA estimates that uninsured Americans pay out of pocket for at least one-third (37% in 2008) of the cost of health care services they receive. The remaining cost of health care received by the uninsured ends up being covered primarily by local, state, and federal taxes, or through higher premiums paid by those who are insured. Economists estimate that two-thirds to three-fourths of the cost of health care provided to uninsured Americans is directly converted into higher hospital charges and higher private health insurance premiums.

Studies also show that when people are not covered by Medicaid or CHIP, they tend to use other health care services—such as public hospital emergency rooms—that are much more expensive. Not only does this increase the cost of health care, it also means that local communities pay these higher costs without the benefit of federal matching funds that Medicaid or CHIP would draw down.

Conversely, when children have consistent access to a doctor, medical costs per child can actually decrease. In one analysis by the Texas Children's Hospital CHIP HMO (health maintenance organization) in Houston, claims decreased at least 20% for children continuously enrolled for a year or longer.

A study by Texas economist Ray Perryman estimated that for every $1 in state tax revenue that is cut from Medicaid and CHIP,

- local taxes go up 51 cents;
- local health care providers will have 53 cents of uncompensated care;
- state tax revenue falls by 47 cents; and
- $2.81 in federal funds is lost.

Other negative effects cited by Perryman include higher health insurance premiums and other health care costs, and decreases in retail sales and other private-sector economic activity.

Conclusion

This primer has presented a brief but broad picture of health care in Texas, giving readers ways to contribute to federal, state, and local debates about improving access to health care. We hope this primer has successfully informed you, as well as engaged you to participate in future discussion and action.

Clearly, health care is a vital part of the Texas economy; a significant employer-based benefit and consumer out-of-pocket expense; and a growing fiscal challenge for taxpayers and all levels of government administering public health programs for uninsured and underinsured Texans. But even with the huge sums of money spent by consumers, employers, and taxpayers, critical health care services remain beyond the reach of too many Texans.

Encouraging and much-needed signs of progress can be seen. The 2007 legislative session authorized CHIP restorations, health care provider rate increases, and expansions of community care. The 2009 session, among other accomplishments, maintained the commitment to expanding community care, created a Medicaid "buy-in" for children with disabilities, and established a premium subsidy for the Texas Health Insurance Pool. But compared to other states, Texas still ranks very poorly on indicators such as the share of uninsured residents or state or local government per capita or per beneficiary health spending. These poor rankings indicate that much work remains to be done before we can say that adequate investments have been made in the health of our current and future workforce and in ensuring that all Texans get the medical attention they need.

For truly significant improvements in health care access for all Texans, real help in the near term has to come from Washington, D.C., not Austin. The only plausible way to ensure all Texans have access to affordable, comprehensive coverage is for our federal representatives to enact national health reform. We encourage you to get involved in the national health reform debate through the Texas Voice for Health Reform project, which you can find online at www.texasvoiceforhealthreform.org.

Suggestions for Further Reading

With the support of Methodist Healthcare Ministries, CPPP is also updating a brief report explaining what happened in the 2009 legislative session to Medicaid, the Children's Health Insurance Program, and other state health programs. See www.cppp.org for this publication and more updates.

You may also want to consult the following for more information on the critical health care issues confronting Texas:

The Access Project. *Providing Health Care to the Uninsured in Texas: A Guide for County Officials*. September 2000. www.accessproject.org/adobe/providing_health_care_to_the_uninsured_in_tx.pdf

Families USA. *Premiums versus Paychecks: A Growing Burden for Texas' Workers* . October 2008. www.familiesusa.org/assets/pdfs/premiums-vs-paychecks-2008/texas.pdf

Families USA. *The Uninsured: A Closer Look - Texans Without Health Insurance.* March 2009. www.familiesusa.org/assets/pdfs/americans-at-risk/texas.pdf

Institute of Medicine, National Academy of Sciences. *Hidden Costs, Value Lost: Uninsurance in America.* 2003. www.iom.edu/CMS/3809/4660/12313.aspx

Mental Health America of Texas. *Turning the Corner: Toward Balance and Reform in Texas Mental Health Services*. Feb. 2005. www.mhatexas.org/mhatexasMAIN/TurningtheCorner.pdf

Task Force for Access to Health Care in Texas. *Code Red: The Critical Condition of Health in Texas.* April 2006, and 2008 update. www.coderedtexas.org

(continued)

Texas Comptroller of Public Accounts. *The Uninsured: A Hidden Burden on Texas Employers and Communities*. April 2005. www.window.state.tx.us/specialrpt/uninsured05/

Texas Department of Insurance. *Working Together for a Healthy Texas,* State Planning Grant: Interim Report. September 2006. (Federal Health Resources and Services Administration grant.) www.tdi.state.tx.us/reports/life/documents/spgint061.pdf

Texas Health and Human Services Commission. *Texas Medicaid and CHIP in Perspective* (The "Pink Book"). January 2009. 7th ed. www.hhsc.state.tx.us/medicaid/reports/PB7/PinkBookTOC.html

Texas Health and Human Services Commission. Research Papers on Medicaid Reform. February 2007. www.hhs.state.tx.us/medicaid/reform.shtml#Papers

Texas Health Policy Institute. *Long-Term Care in Texas: Policy Implications.* November 2006. texashealthinstitute.org/files/LTC_Brief_2006.pdf

Texas Health Policy Institute. *Long-Term Care Primer.* Oct. 2008. texashealthinstitute.org/files/ LTC_PRIMER_FINAL_with_logo__2_.pdf

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