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Center *for* Public Policy Priorities

CPPP is a 501(c)(3) nonpartisan, nonprofit research organization committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans.

MHM is a 501(c)(3) faith-based nonprofit organization seeking to improve the health of those least served in South Texas. We provide primary care to the uninsured, as well as public policy advocacy and programs to promote wholeness of body, mind, and spirit. Our mission is "Serving Humanity to Honor God."

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The Texas Health Care Primer
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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

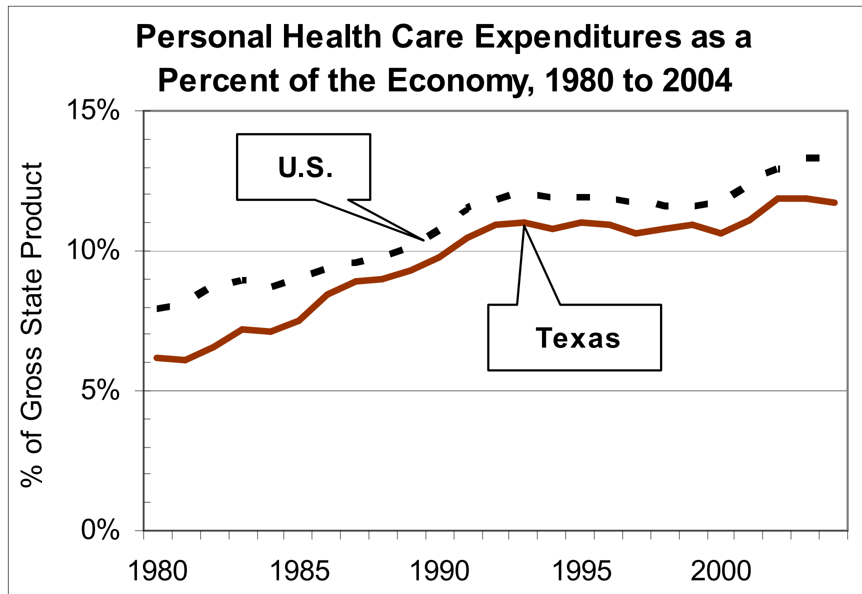
Foreword

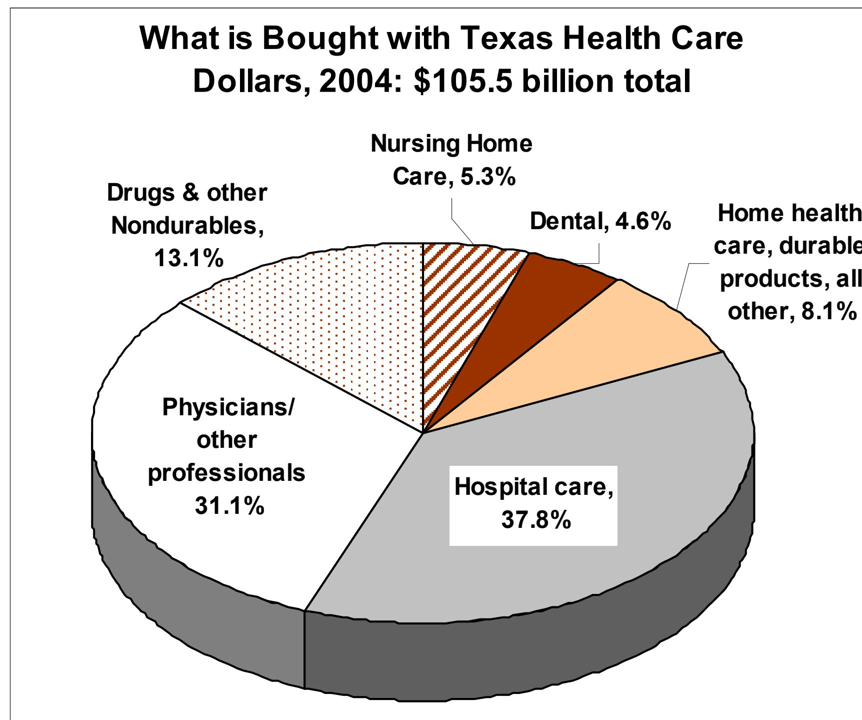
The Center for Public Policy Priorities (CPPP) and Methodist Healthcare Ministries (MHM) are pleased to release this update of our *Texas Health Care Primer*. The primer was first issued in 2003, reprinted twice, and distributed electronically to thousands of readers. As two nonprofits working to improve life in Texas communities, our partnership in creating this primer was 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 I 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.





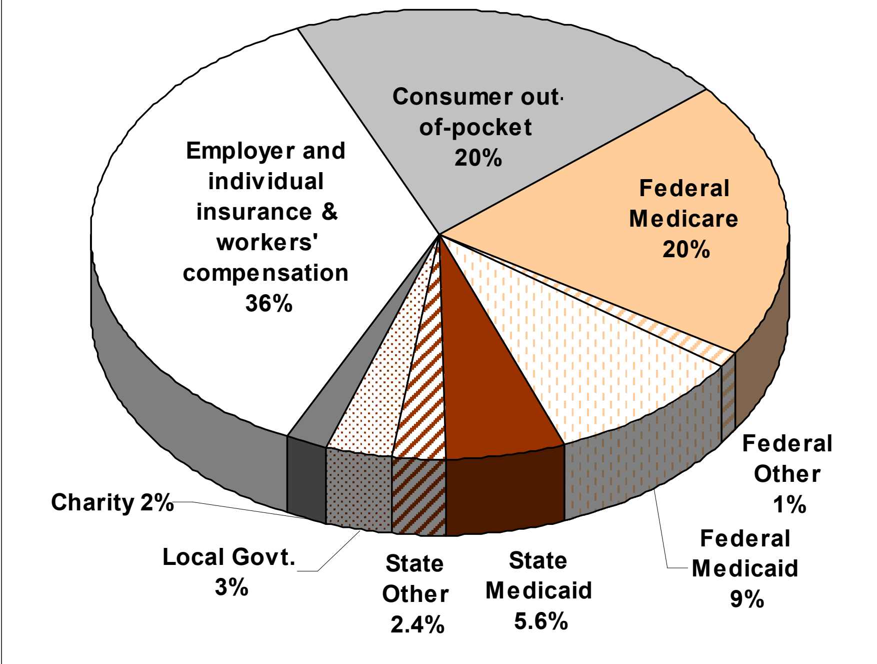
Health Care: The Economic Context

In 2004, the $105.5 billion spent on personal health care in Texas accounted for 11.7% of the Gross State Product (GSP). 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

SOURCES: State Health Accounts data, February 2007, 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.

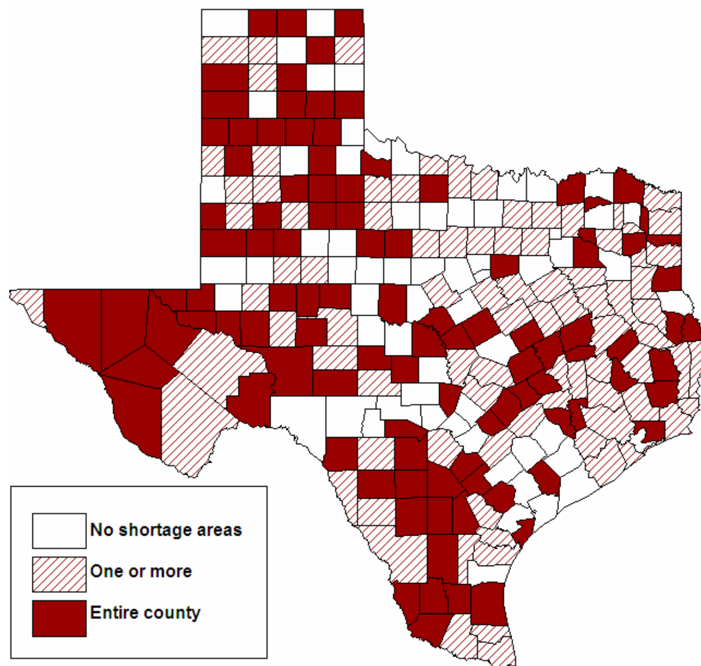
"Charity" consists of public and private hospital charity care; physician charity and bad debt; pharmaceutical companies' charity programs; and medical services funded by nonprofit groups. It is not the same as all health care spending for the uninsured. According to a survey by the Texas Department 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, 2005	250	270	30th
EMTs and paramedics, 2005	57	66	35th
Dentists, 2004	47	59	39th
Physicians, 2006	221	278	40th
Dental hygienists, 2005	39	54	43rd
Registered nurses, 2005	656	799	45th

SOURCES: Kaiser State Health Facts; Occupational Employment Statistics, U.S. Bureau of Labor Statistics; *Health, United States, 2006.*

Primary Care Health Professional Shortage Areas, 2007



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

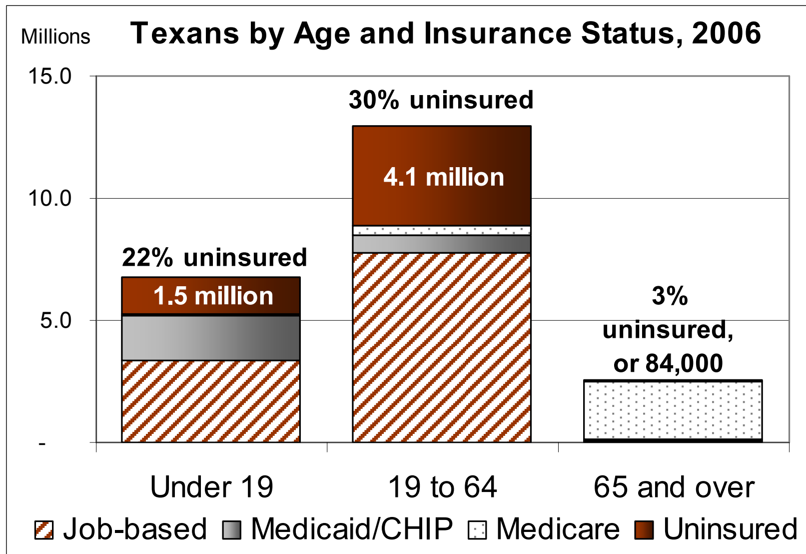
How does the State's Health Care Infrastructure Compare to Other States?

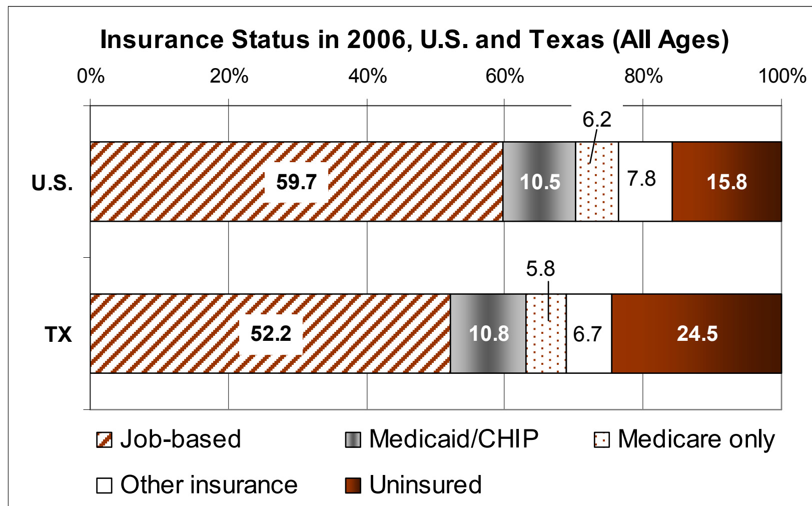
Compared to other states, Texas has a relative scarcity of certain kinds of health care professionals. The table at left shows Texas ranking in the bottom third of states when the number of dentists, physicians, nurses, and other health care personnel is adjusted for the total population of the state.

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 more than 968,000 Texans in 2005, with combined annual earnings of $47 billion. Health services' share of Texas' private-sector earnings is 9.0%, a little higher than its share of private-sector jobs (8.8%). Texas state and local governments employed another 119,200 health and hospital workers in 2006, with an annual payroll of $4.6 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 June 2007, almost 41% (104) of Texas counties were wholly designated as primary medical care shortage areas; 79 counties were dental care shortage areas; and 98 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 June 2007. ("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; U.S. Census Bureau, State and Local Government Employment and Payroll; U.S. Health Resources and Services Administration.





SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007. Top chart does not show the small amount of people covered by federal military health care or non-employment-based private insurance, shown in the bottom chart as "other insurance."

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, and almost $65 billion in health care was for insured Texans. On average, this is $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 2006, 93% of Texans 65 and over were covered by Medicare; only 3% of senior Texans lacked insurance of any kind.

Among **working-age Texans (19 to 64)**, the primary source of coverage is employment-based insurance, covering 56% 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 (30% in 2006). Among Texas **children**, 48% were covered because a family member had employment-based insurance, and the remainder were mostly divided between Medicaid and CHIP (26%) or no insurance at all (22%) in 2006.

Texas has the highest uninsured rate—24.5% in 2006—in the nation. The U.S. average is 15.8%, or almost 47 million people uninsured nationwide. Over 5.7 million Texans had no health insurance in 2006.

Single-year estimates of uninsured Texans come from the Census Bureau's Current Population Survey (CPS), the source of the statistics cited above. Other studies reveal that Texans are also more likely to lack insurance for long periods of time.

(continued)

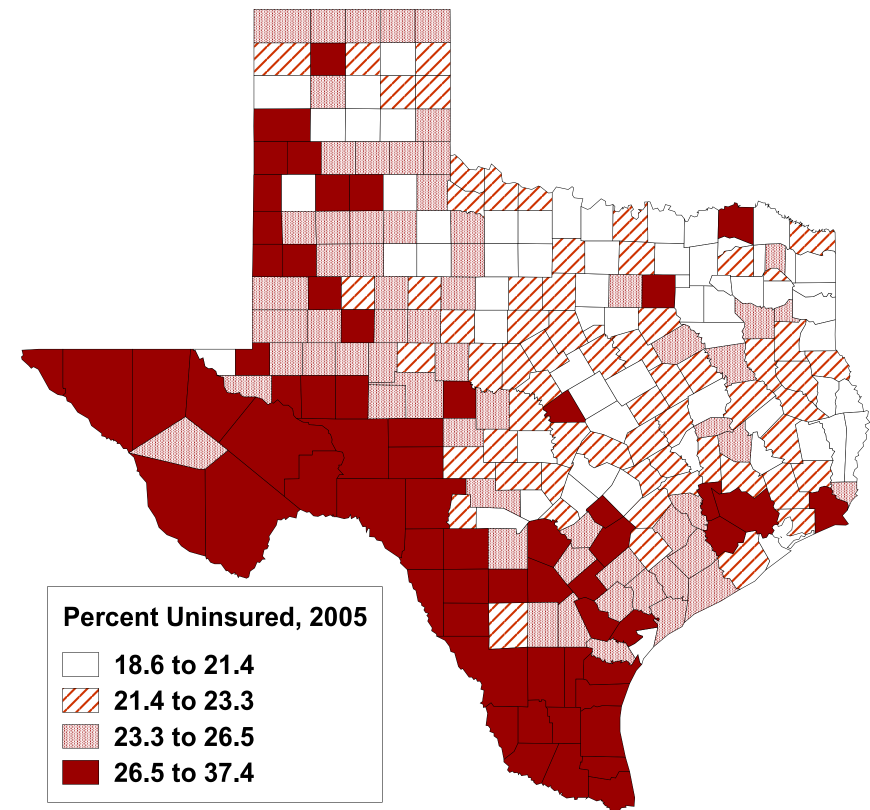
For example, a June 2004 Families USA study estimates that nationally, 32% of nonelderly Americans—82 million people—were uninsured for all or part of 2002 and 2003. Of these uninsured people, almost two-thirds (65%) went without coverage for six or more months. About 17% of the 82 million were uninsured for the entire 24-month period. Persons who go for longer periods without insurance are those with lower incomes, those in fair or poor health, and the middle-aged (who have higher rates of chronic disease).

For Texas, Families USA estimated that about 8.5 million nonelderly individuals—43% of all residents under 65, the highest rate in the U.S.—were uninsured for some or all of 2002 and 2003. Almost three-fourths of these Texans went without coverage for six months or more.

The 8.5 million Texans who experienced a spell of being uninsured over a 24-month period in the Families USA study is much larger than the 5.6 million uninsured in the 2002 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 2002 regained coverage in 2003, a new group of different individuals lost coverage in 2003. To sum up: Texans are at higher risk than other Americans of being uninsured for both short and longer periods.

Within Texas (see map at right), the estimated percentage of non-elderly residents with no health insurance is highest in counties along the U.S.-Mexico border, and in the metro areas of Houston, Dallas, and San Antonio. 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).

Under-65 Residents With No Health Insurance, 2005



SOURCES: Texas State Data Center; Provisional County Estimates, November 2006.

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, 2005	10.4%	11.9%
Workers represented by a union, 2005	6.2%	13.7%
Private-sector workers in a union, 2005	3.1%	7.8%
ASSOCIATED WITH LESS ACCESS		
Involuntary part-time workers as % of part-time labor force, June 2007	15.3%	14.2%
Agriculture jobs as % of all jobs, 2005	2.6%	1.7%
Construction jobs as % of all jobs, 2005	9.1%	7.7%
Percent of workers in low-wage jobs, 2004	26.6%	23.9%
Percent of business employment accounted for by firms with fewer than 20 employees, 2005	23.8%	24.8%

SOURCES: Bureau of Labor Statistics; Bureau of Economic Analysis; Economic Policy Institute; U.S. Census Bureau.

Who has Employer-Based or Other Private Insurance?

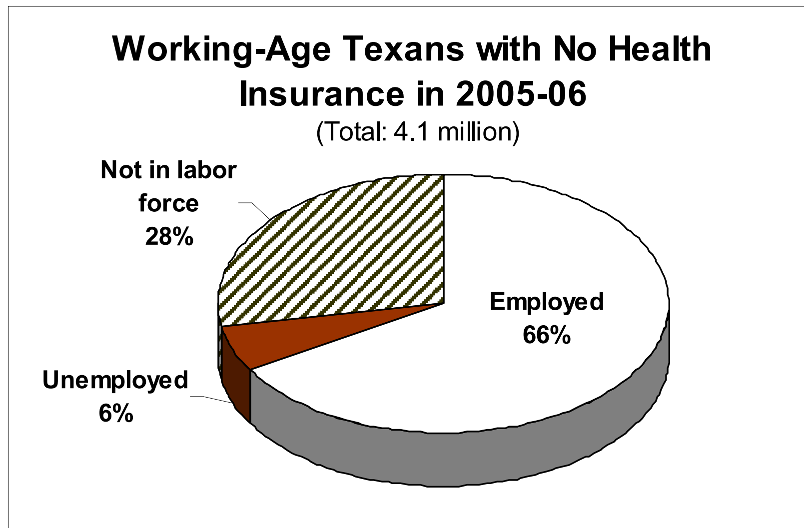
In 2005-06, 55% of Texans under 65 years of age had health insurance through their own or a family member's job, considerably below the U.S. average of 63%. (Only New Mexico had a lower rate of employer-based insurance coverage.) Making matters worse, after the 2001 economic downturn, the trend was for fewer Texans to get health insurance through their job. In 2000, 60% of Texans under 65 had employer-based health insurance.

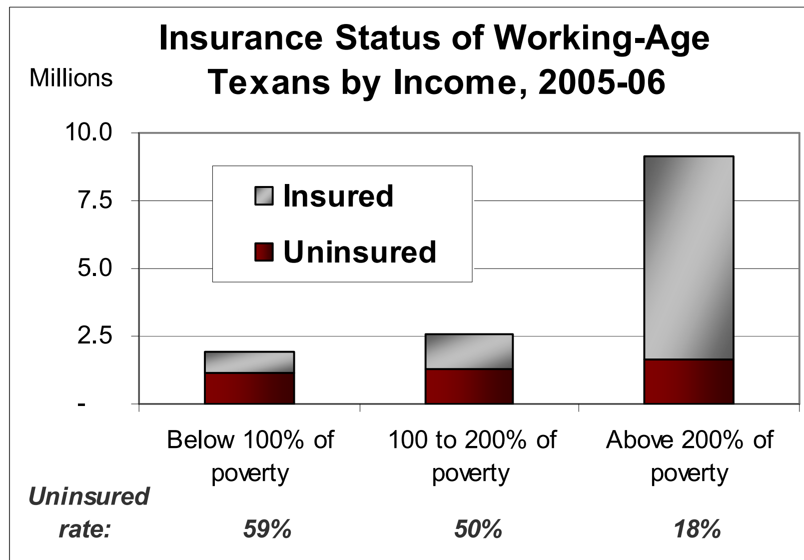
Texans at firms with up to 24 workers were most likely to lack coverage: 41% of workers at these small employers were uninsured in 2003. At firms with 25 to 99 employees, 29% of workers were uninsured. Even at firms with 100 to 499 employees, though, 21% of workers were uninsured. Thus, Texas' low rate of employer-based coverage cannot be attributed solely 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 do explain the lower rate of employer-based coverage include a higher share of workers employed involuntarily at part-time jobs (i.e., they cannot find full-time jobs); a lower share of manufacturing and higher share of construction and farming jobs; and low rates of unionization, all of which make Texas workers less likely to have employer-based health insurance.

Employers who provide health insurance benefits to their workers, and the workers who receive them, get federal tax subsidies totaling $147 billion in 2007, according to the federal Office of Management and Budget.* In comparison, Medicare outlays in 2007 are expected to reach $367 billion; Medicaid and the Children's Health Insurance Program will cost $197 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 2006 and 2007. "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 51% of **unemployed** working-age Texans in 2005-06 were uninsured, versus 27% of **employed** Texans who are uninsured. However, having a job still leaves working-age Texans with a 27% chance of being uninsured. A related statistic: the employed accounted for 2 out of 3 uninsured working-age Texans in 2005-06 (see top chart).

Many 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 22% of poverty, or $308/month for a working parent with two children. At the minimum hourly wage of $5.85, working even 14 hours a week would disqualify a parent from continuing to receive Texas Medicaid.

In 2005, when Texas unemployment averaged 5.3%, one-third of its adults under 65 were low-income (below 200% of poverty, or $32,180 for a family of three in 2005). Most low-income workers have earnings that are not low enough to meet the Medicaid adult income cap, but not high enough to enable the worker to purchase health insurance for themselves or their dependents, even if their employer is willing and able to share the cost. Half (50%) of working-age Texans from 100 to 200% of poverty were uninsured in 2005-06, compared to 59% of those below 100% of poverty.

Texans with incomes above 200% of poverty have a much better chance of being insured, even though in total numbers, there are more uninsured in this income group (1.6 million) than among the poor (1.1 million) or other low-income (1.3 million uninsured). In 2005-06, 18% 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.

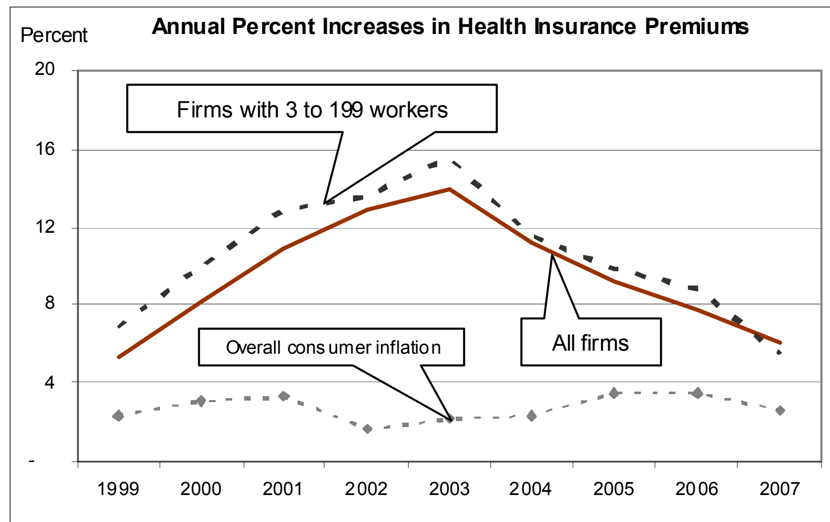
Why More People Don't Buy Health Insurance on Their Own

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 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 these higher costs for 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 an 11% increase. In contrast, residents of lower-cost areas such as Wichita Falls would need a 16% increase in their family budgets to $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

SOURCE: Kaiser Family Foundation/HRET Surveys of Employer Sponsored Benefits, 1999-2007.

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.

Small businesses surveyed by the Texas Department of Insurance identified unaffordable premiums as the main reason they don't offer coverage to their workers.* Almost two-thirds (65%) of those surveyed in 2004 had either tried to purchase coverage for workers but found it too expensive, or did not even attempt to purchase coverage because of the high cost. Those who did offer health insurance were asked if they were likely to stop offering the benefit: 18% said this was "almost certain" or "very likely" in the next five years. Another 24% said they were "somewhat likely" to drop coverage.

Nationally, family premiums for employer-based health coverage averaged $1,009 per month in 2007. For Texas firms, single and family premium costs in the late 1990s were at or above the U.S. average. Texas premiums may be higher in part due to population characteristics, such as more obese residents with more diabetes and heart disease problems. Another explanation, put forth by Families USA, is that Texas' employer-based premiums are 15% higher than they would otherwise be due to uncompensated costs of health care for uninsured Texans.

Research by the Kaiser Family Foundation and the Health Research and Educational Trust shows that from 2006 to 2007, private health insurance premiums rose an average of 6.1% for all employers, and by 5.5% for employers with 3 to 199 workers. As was the case in 2004, 2005, and 2006, the 2007 premium increases were lower than the prior year's. However, premium increases are still much higher than average consumer inflation or wage gains for American workers.

* Texas Department of Insurance, *Texas Small Employer Health Insurance Survey Results: 2001 and 2004,* November 2005. [State Planning Grant, Federal Health Resources and Services Administration.]

Medicare Rankings

	Texas	U.S. Average	Texas Rank
Medicare personal health care spending per beneficiary, 2004	$8,473	$7,438	5th
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, 2007	14.0%	18.5%	24th
Elderly (aged 65 and over) enrolled in Medicare, 2005-06	94.0%	94.4%	40th
Social Security disability insurance (SSDI) beneficiaries as a percent of 18-to-64 population, 2004	2.8%	3.7%	44th

SOURCES: CQ's *State Fact Finder 2007*; Centers for Medicaid and Medicare; Kaiser Family Foundation; 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 2.5 million Texans in 2005, or one out of seven insured Texans. About 86% of Texas Medicare recipients are retirees aged 65 and over and can be of any income level; the other 14% are under 65 but disabled or with end-stage renal disease. About 2.4 million Texans had Part A coverage, for in-patient hospital expenses; 2.3 million Texans opted for 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 2007, about 2.1 million Texans, or 83% of the state's Medicare beneficiaries, had drug coverage through a stand-alone plan, Medicare Advantage, employer or union plans, or dual-eligibility coverage. In comparison, the national average was 79%.

Medicaid Rankings

	Texas	U.S. Average	Texas Rank
Nursing home residents with Medicaid as primary payer, 2005	68%	65%	14th
Percent of Medicaid enrollees in managed care, December 2006*	67.2%	65.4%	28th
Medicaid payments per enrolled child, 2004	$1,506	$1,531	33rd
Medicaid payments per disabled enrollee, 2004	$11,087	$13,014	34th
Medicaid spending as a percent of total personal health care spending, 2004	14.5%	17.4%	34th
Medicaid payments per elderly enrollee, 2004	$7,869	$11,455	46th
Medicaid recipients as a percent of poverty population, 2005**	75.2%	122.8%	48th
Medicaid nursing facility expenditures per person served, 2003	$14,430	$23,882	50th

* Texas is implementing a Medicaid managed care expansion.
** 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 Medicaid eligibility categories have income cut-offs that are above 100% of poverty.

SOURCES: CQ's *State Fact Finder 2007*; Centers for Medicaid and Medicare; Kaiser Family Foundation; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; 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 July 2007, Texas had 2.6 million Medicaid enrollees; 1.8 million (71%) of them were under the age of 19. The state budget anticipates a Medicaid caseload of 2.8 million in 2008 and 2.9 million in 2009.

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. These rankings will probably worsen once the 2003 Legislature's cuts to Medicaid eligibility and benefits (for state fiscal years 2004 and 2005) are fully reflected.

How Much More in Medicaid Matching Funds Could Texas Get? Texas receives about $1.50 in federal Medicaid funds for every state dollar invested in the program. In practical terms, the limiting factor on getting more federal funds is 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 as many as 500,000 poor parents who are uninsured—more than five times the number of parents who currently get Medicaid. If Texas were to cover these 500,000 parents below poverty on Medicaid, the full cost for a year would be roughly $1.4 billion, about $540 million of which the state would have to fund. This would bring about $810 million 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.

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

Medically Needy. The 78th Legislature eliminated coverage of parents under the Medicaid Medically Needy Spend-Down program (coverage continued for children and pregnant women), effective September 1, 2003. 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. In 2006, an estimated average of 10,100 parents every month went without health coverage due to the 2003 Legislature's elimination of this program.

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.

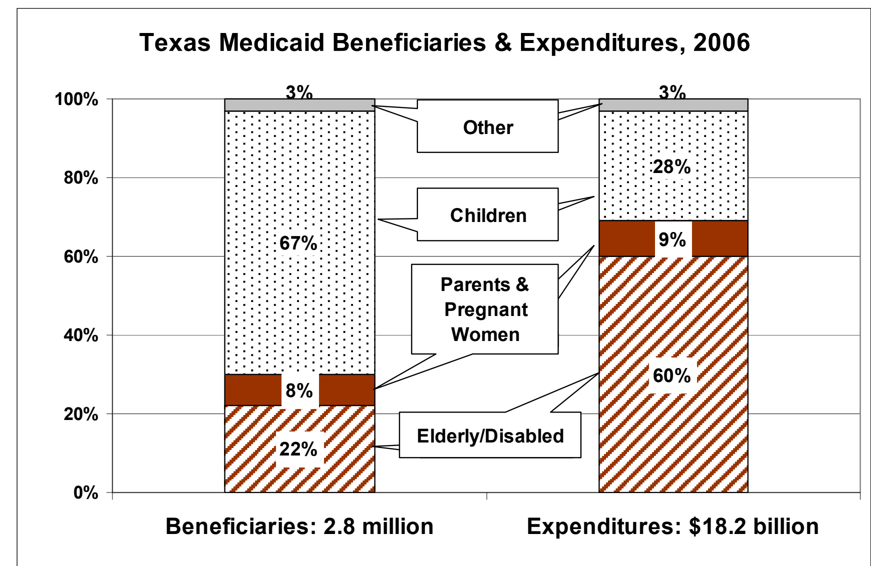
Coverage of Aged and Disabled. All states provide Medicaid to most aged and disabled persons on Supplemental Security Income (SSI—$623 per month for an individual in 2007). Five states set SSI-related Medicaid caps at lower 1972 income levels, but they must allow SSI recipients with medical expenses to "spend down" into Medicaid. Nineteen states 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—35 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.

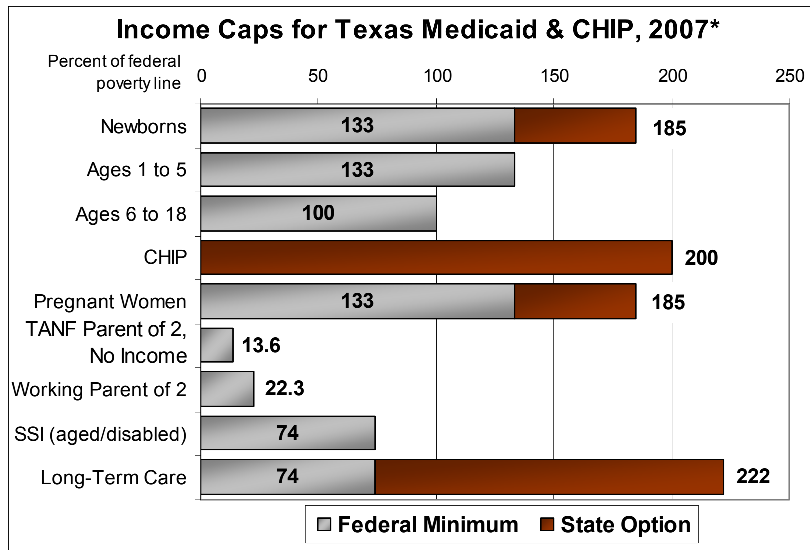
Eligibility Determination Problems. The combined effects of state agency procedures, poor contractor performance, and eligibility worker shortages from late 2005 to the present have resulted in rapid declines in the number of children covered by Medicaid and CHIP. In July 2007, the combined number of children on Medicaid or CHIP was below the number covered in September 2003. The accuracy and speed of Medicaid and CHIP application processing and renewal have dropped and have not recovered. Parents report low confidence in the system as a result. The 2007 Legislature set goals to improve the eligibility system, created new oversight of its performance, and authorized hiring additional staff.

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 of Texas Medicaid clients in 2006, but well below half (37%) of Medicaid spending was for these clients. Elderly clients and clients with a disability, in contrast, were about one-fifth of the caseload and three-fifths (60%) of Texas Medicaid spending.



SOURCE: Texas Health and Human Services Commission, Presentation to the House Appropriations Committee, February 2007.



Eligibility Category	Annual Income Limit, 2007*
Medicaid for Newborns	$31,765
Medicaid for Children ages 1 to 5	22,836
Medicaid for Children ages 6 to 18**	17,170
CHIP for Children ages 0 to 18	34,340
Medicaid for Pregnant Women	31,765
Medicaid for TANF Parent of 2, No Income	2,256
Medicaid for a Working Parent of 2	3,696
SSI (Aged or Disabled)	7,476
Long-Term Care	22,428

* 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: The table above does not include the eligibility criteria for the Women's Health Program or the CHIP Perinatal program, or Medicaid for certain current or former foster care youth. See text for details.

Medicaid and CHIP Income Eligibility Comparisons

Recent Eligibility Changes. The 2007 Legislature authorized changes that will increase coverage under two new special Medicaid programs. In September 2007, the state will begin allowing all properly credentialed health care providers to refer uninsured women who have incomes below 200% of the federal poverty level and are diagnosed with breast or cervical cancer for Medicaid coverage of treatment. About 1,200 more women per year are expected to be covered for their cancer treatment as a result of this change. Legislators also approved an extension of Medicaid coverage for young adults formerly in foster care. That coverage, which used to end at age 21, is now extended to the 23rd birthday for young adults enrolled in higher education.

Two programs created by the 2005 Legislature began operating in January 2007: the CHIP Perinatal Program and the Medicaid Women's Health Program. The perinatal program allows women who do not qualify for Medicaid maternity coverage—but whose babies will qualify for CHIP or Medicaid—to access prenatal care and delivery services. This initiative was covering 10,511 newborns and 30,267 pregnant women in September 2007. The Women's Health Program, providing check-ups and family planning care for women ages 18 to 44 with incomes up to 185% of poverty, was covering over 60,900 women in October 2007.

A Buy-In Program for working adults with disabilities who are not poor enough to qualify for Medicaid, but earn less than 250% of the federal poverty level, was launched in September 2006. As of August 2007, 14 Texans were enrolled in the Buy-In Program.

2007's Senate Bill 10. The 2007 Legislature also authorized several Medicaid experiments in how benefits are delivered, and authorized a new "waiver" which could potentially expand health coverage to significant numbers of currently uninsured adults. The Medicaid program will experiment with rewarding clients for healthy behaviors and allow some adults to try a medical savings account. Tailored benefit packages will be developed for different populations' needs,

with a pledge not to reduce benefits in the process. New options to use Medicaid to pay for employer-based insurance will be tested, as will emergency room co-pays for non-emergency care where a free alternative is available.

For persons not already included in Medicaid, a new “Health Opportunity Pool” will be created using existing health care spending that could be matched with federal funds to cover more adults, through both local and statewide programs. Because the law passed is very broad, and details have not been finalized, it is not possible to say how many adults could be covered in the next two years as a result.

Children’s Medicaid. 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-six states including Texas operate separate CHIP programs; the other 14 use their CHIP funds to expand children’s Medicaid.

For children 1 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. Twelve states cover children up to 200% of poverty or higher; another five states cover children up to 185% of the poverty line.**

The only area of Texas’ child Medicaid coverage in which some states have lower income caps is newborn coverage; 16 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). Hawaii, Missouri, and Vermont have the highest child Medicaid caps, at 300% of the poverty line.

*At publication time, CHIP was undergoing Congressional reauthorization for fiscal 2008 and beyond.
**Many of these states chose the Medicaid expansion option for CHIP.

CHIP. Texas CHIP coverage begins where children’s Medicaid coverage ends, and goes up to 200% of the federal poverty line. Nineteen states cover children over 200% of poverty: 13 in separate state CHIP and state-funded programs, and 6 in Medicaid. New Jersey has the highest CHIP income cap at 350% of the poverty line. Three state programs currently have no upper income limit: Illinois, Massachusetts, and Pennsylvania subsidize the coverage of children up to 300% to 400% of poverty, and allow buy-in for children at higher incomes. Other states are considering similar major expansions of access to care for children.

Nine states set the CHIP cap below 200% of poverty—four have separate state CHIP programs, and five states chose the Medicaid expansion option for CHIP.

Medicaid Maternity Coverage. Texas is one of 18 states offering maternity coverage up to 185% of poverty. Another 16 states cover women up to 200% of poverty or higher. Minnesota has the most generous income cap, at 275% of the federal poverty line.

CHIP Policy Changes

Texas CHIP policy changes illustrate how very large enrollment reductions can be created without changing income eligibility caps. In September 2003, before eligibility policy changes passed by the 2003 Legislature started taking effect, Texas CHIP enrollment stood at 507,259. Two years later, in September 2005, CHIP enrollment had plummeted by about 180,700 children, or 36%. This drop was larger than the 2003 session projections by state officials that policy changes would reduce enrollment by 160,000 to 169,000 in 2005. Though the upper cap of 200% of poverty was not changed, all income deductions were revoked, and new limits on cash and vehicle assets were added for families at or above 150% of the federal poverty line. 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. Official projections call for at least 100,000 more children to enroll in CHIP by 2009 as a result.

Local Government Health Care Spending

	Texas	U.S. Average	Texas Spending as a Percent of U.S. Average Spending
Local government per-capita spending on **public health,** 2005	$71	$121	59%
State government per-capita spending on public health, 2005	$32	$105	30%
State and local government per-capita spending on public health, 2005	$103	$226	46%
Local government per-capita spending on **hospitals**, 2005	$249	$206	121%
State government per-capita spending on hospitals, 2005	$129	$143	90%
State and local government per-capita spending on hospitals, 2005	$377	$349	108%

SOURCE: U.S. Census Bureau, Government Finances.

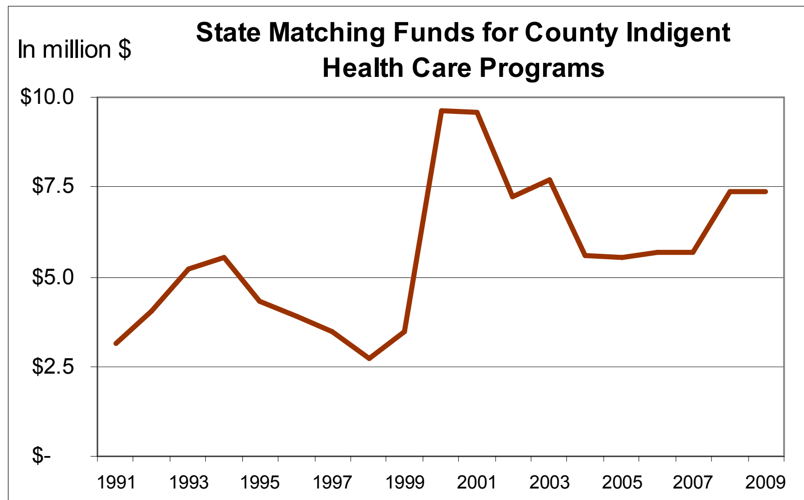
Who is Served by Local Public Health Care Spending?

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 under-insured; 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-third of all hospitals in Texas and one-fifth 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 U.S. Census Bureau data on state and local health and hospital spending. The table at left shows that Texas local governments' public health spending—although still well below the U.S. average—is much higher than state government spending on public health. Hospital spending by Texas local governments is higher than the U.S. average for local governments. State government hospital spending is also much more in line with the national average; this is because Texas funds health science centers and other hospitals associated with public 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 a "public welfare" expenditure) 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, and 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 2007, this means an ***annual*** income of less than $2,144 for one person, or $3,606 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 2008 and 2009, the state assistance fund will make only $7.4 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, and cited often as a key part of the Bush Administration's plan to improve Americans' access to health care. Texas has a state-funded incubator grant program 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.

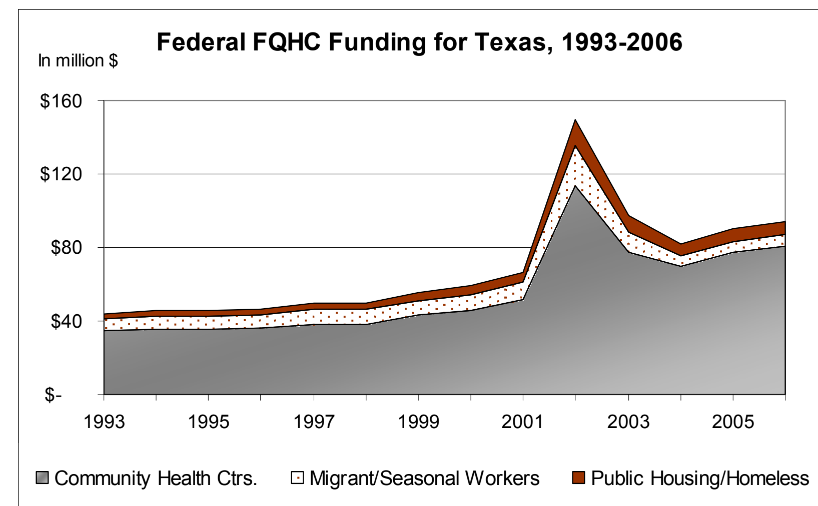
Until 2004, FQHCs were federally funded through various programs created over the years: Community or Migrant Health Centers; Health Care for the Homeless; Public Housing Primary Care; and Healthy Schools, Healthy Communities. These were consolidated into one grant "cluster" which brought $99 million to Texas in 2006. This is a significant increase from $44 million in 1993, but federal FQHC grants are still less than 0.1% of Texas health care spending.

In 2006, 49 FQHCs and 5 FQHC "look-alikes" served almost 704,000 Texans at over 250 sites throughout the state. About 59% of Texas FQHC clients are uninsured. Along with federal and private grants, FQHCs get revenue from private insurance, Medicare, Medicaid, and CHIP. Compared to the national average, Texas FQHC revenues are much more dependent on patient fees, and much less dependent on 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 July 2007, Texas FQHCs could be found in 74 counties. 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, Fort Worth, and Houston is limited.

FQHCs provide *primary* care benefits to their clients, but not 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, 2006

(% from each source)	Texas	U.S. Average
Federal Grants	27.4%	22.1%
Medicaid	24.6	36.8
Medicare	5.7	6.0
Other Public Insurance	1.6	2.3
Private Insurance	2.4	7.0
Patient Self-Pay/Fees	12.3	6.8
Foundation/Private Grants/Contracts	7.4	4.0
State/Local Grants/Contracts	8.8	9.3
Other Revenue	9.7	5.7

SOURCES: U.S. Census Bureau; Health Resources & Services Admin.

Selected Statistics About Elderly Texans

	Texas	U.S.
62-to-74-year-olds with health insurance, 2005-06:		
Men	92.3%	95.2%
Women	92.7%	95.1%
75+-year-olds with insurance, 2005-06:		
Men	97.4%	99.0%
Women	98.4%	99.1%
Low-Income Status of Age 65+ residents, 2005-06		
Below Poverty Line	12.9%	9.8%
Between 100% and 200% of Poverty	28.7%	26.4%
Age 65+ with any Disability, 2006	45.5%	41.0%
Age 65+ with Self-Care Limitations, 2005	11.9%	9.7%
Age 65+ with Mobility Limitations, 2005	19%	17%
Age 65+ with a Cognitive/Mental Disability, 2005	13.3%	11.5%
Median Hourly Wage, Personal and Home Care Aide, 2005	$6.32	$8.34
Median Hourly Wage, Home Health Aide, 2005	$6.65	$9.04

SOURCE: AARP Public Policy Institute; U.S. Census Bureau, American Community 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 has taken steps to address is prescription drug coverage. A "Part D" drug benefit was added to Medicare in 2003; now, ongoing 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.

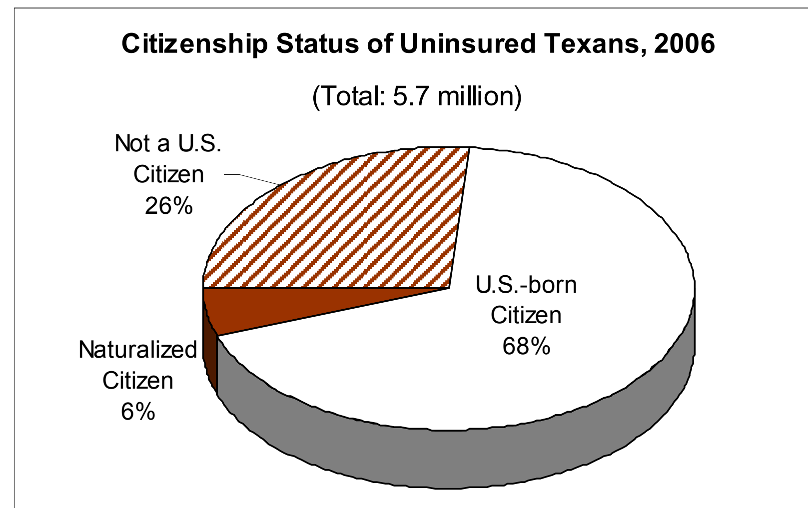
The table summarizes indicators that point to a higher need in Texas for health care services for the elderly, and for the elderly and disabled, than in the U.S. on average. Alarmingly, since this *Health Care Primer* was last published, many of the indicators shown in the table for Texas have worsened. For example, median wages for personal and home care aides and for home health aides in 2005 were lower than in 2003.

Immigrants in General: Texas has 3.4 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 961,000 foreign-born Texas residents have become naturalized U.S. citizens. They are uninsured at a higher rate (33%) than are U.S.-born residents of Texas (20%).

More than half (61%) of the 2.5 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 (1.5 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 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; 23% of all Texas children live in "mixed families" (one or more parent is a non-citizen, either legal or undocumented), and 34% of Texas children in low-income families (below 200% of the poverty line) are in mixed families.



SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

Immigrants Not the Cause of Texas' Uninsured Ranking: As mentioned earlier, non-citizen immigrants, whether legal or unauthorized, are much more likely to lack health insurance than U.S. citizens. But if state-level estimates are adjusted to remove all non-citizens from the equation, Texas still has the worst ranking in terms of uninsured residents, with 4.1 million children and adults—20.1% of the population—lacking health insurance in 2005-06.

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 five-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 it was vetoed by the governor.

Unlike Medicaid, states' CHIP programs are required by federal law to include legal immigrant children. Thus, legal immigrant

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

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.

Two states, Alabama and Virginia, have 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

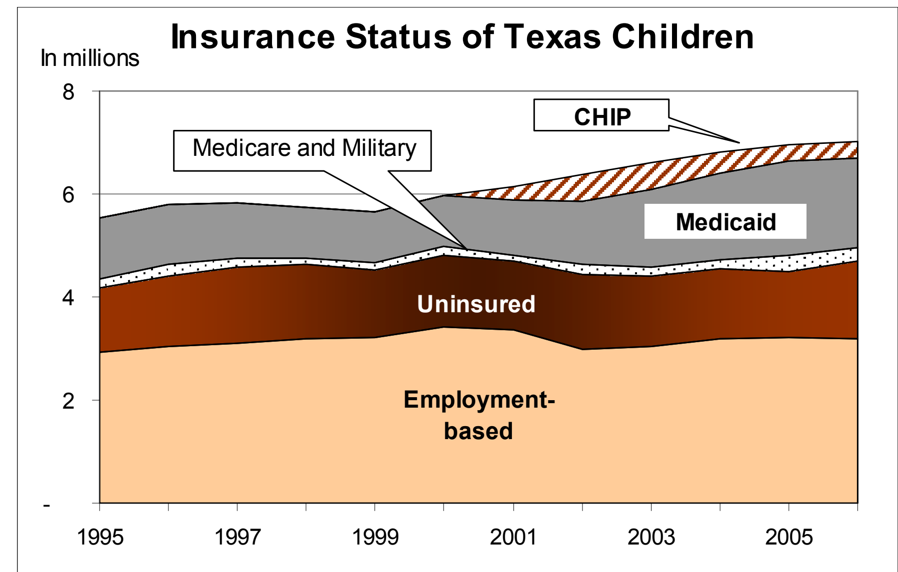
Children make up a larger share of Texas' population than they do of most other states. In 2006, 28% of Texans were under 18, compared to the U.S. average of 25%, giving Texas the third youngest population. Children in Texas are also much more likely to be poor and uninsured. Texas had the 7th highest child poverty rate in 2006, at 23.9%, and the highest share of children (under 19) uninsured in 2006, at 22%—well above the U.S. average of 12.1%.

In absolute terms, employer-based insurance coverage for Texas children peaked in 2000 at 3.4 million. In 2006, 231,000 fewer children had employer-based coverage, compared to the coverage levels seen before the 2001 economic recession. Particularly hard-hit cities include Austin and Dallas-Fort Worth, which lost thousands of high-tech and other high-paying jobs with benefits.

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 August 2005, the enrollment of children had reached 1.82 million. However, enrollment fell to 1.72 million by October 2006 because of problems with the eligibility determination system; as of July 2007, enrollment totaled 1.84 million. Official legislative budget projections call for very little growth in children covered through 2009, though state agency estimates are somewhat higher.

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

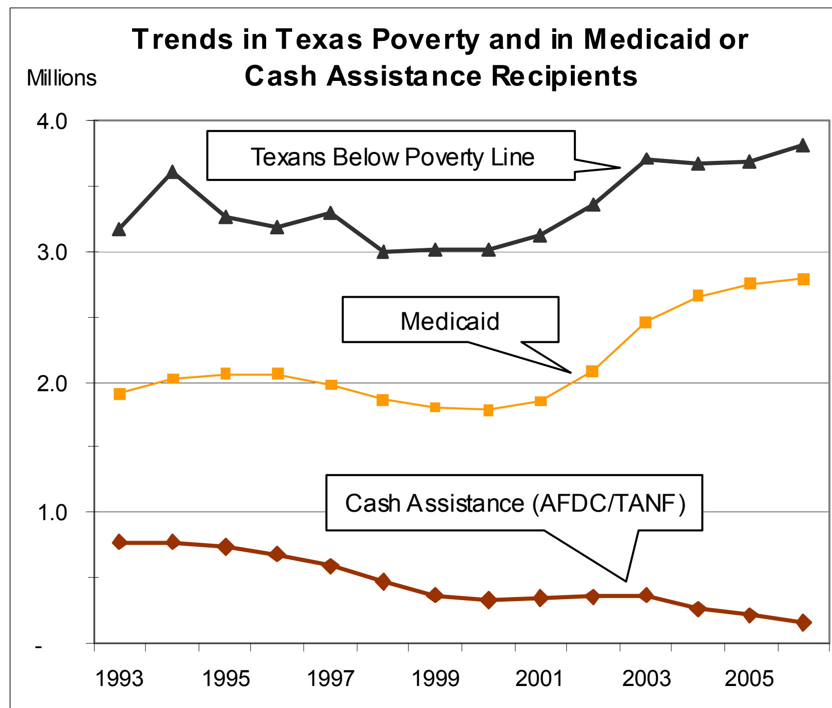


NOTE: Medicaid and CHIP include children up to age 18; other categories are for children 17 and younger prior to 2002. "Employment-based" means the child is insured through a family member's job. Chart does not include children covered by non-employment-based private insurance.

SOURCES: U.S. Census Bureau, Current Population Survey, March 1995-2007; 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. As of August 2007, enrollment had grown slightly, to 300,262, but a clear growth trend had not yet been established.

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 ER as a source of care, and 43% were taken to a doctor's office outside of a hospital. After being enrolled in CHIP, emergency room 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 July 2007, of the Texas Medicaid caseload of 2.6 million people, fewer than 1% were adult TANF recipients, and only 4% were children on TANF. Another 58% 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 2006, Texas' average monthly managed care cost for a Medicaid disabled/blind recipient—excluding long-term care or prescription drugs—was $670, almost five times the cost for Medicaid children ($112 to $142 per month), and almost three times the cost for TANF parents ($229 per month).

Health Care Access Issues Specific to Indigent Care

The results of an 18-state study 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 medication 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 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.

SOURCE: The Access Project, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?,* January 2003.

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

People who support limiting the government's role in providing a health care "safety net" for the uninsured or underinsured often downplay the importance of having coverage, 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. When hospitalized, the uninsured get fewer and substandard services than those provided to people with health insurance.

One study found that in 2001, when almost 1.5 million American families filed for bankruptcy, about half of those surveyed cited medical bills and illness or injury as contributing factors. 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 (35%) 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. We have shown 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.

It is clear that 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 health programs that target the elderly; persons with a disability; children; or low-income uninsured or underinsured Texans.

Unfortunately, even with the huge sums of money spent by consumers, employers, and the public sector, critical health care services remain beyond the reach of too many Texans.

Encouraging and much-needed signs of progress can be seen. To cite just a few examples, the 2007 legislative session resulted in CHIP restorations, health care provider rate increases, and expansions of community care. But, compared to other states, Texas still ranks very poorly on indicators such as the share of uninsured residents, or population living in poverty, or almost any measure of state or local government per capita 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 elderly and disabled Texans get the medical attention they need.

At this time, access to health care is rising to the top of the national agenda. Americans are deeply and truly concerned about becoming uninsured or discovering their current coverage to be inadequate. The picture painted by this primer we expect helps you to understand the full implications of health care in Texas, and to feel a level of compassion that stirs you to stand up and be counted as an active and concerned member of our society.

Suggestions for Further Reading

You may wish to read a user-friendly guide published by CPPP/MHM entitled, *Texas Health Care: What Has Happened and What Work Remains (*www.cppp.org/research.php?aid=535&cid=3& scid=4). This brief report explains what happened in the 2005 legislative session to Medicaid, the Children's Health Insurance Program, and other state health programs.

Also, while this primer highlights major health care issues relevant to Texas, it obviously cannot do them all justice. Please consult the following for more information:

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

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 Association in 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. www.coderedtexas.org

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 in Perspective* (The "Pink Book"). January 2007. Sixth edition. www.hhsc.state.tx.us/Medicaid/reports/PB6/PinkBookTOC.html

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

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