TEXAS BLUE RIBBON TASK FORCE ON THE UNINSURED

Report to the 77th Legislature

February 2001

CHRIS HARRIS
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The Senate of The State of Texas Austin 78711

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February 13, 2001

The Honorable Rick Perry
The Honorable Bill Ratliff
The Honorable James E. "Pete" Laney
Members, Texas Senate
Members, Texas House of Representatives
Texas State Capitol
Austin, Texas 78701

Dear Governor, Lieutenant Governor, Speaker, and Members:

The Blue Ribbon Task Force on the Uninsured hereby submits its marjority interim report for consideration by the Seventy-Seventh Legislature. A minority report from Dr. John Goodman is also attached.

Respectfully submitted,

Chris Harris, Chair

David Bernsen

Garnet Coleman

Nancy Dickey, M.D.

Craig Eiland

Bob Glaze

Boone Powell Jr.

Eliot Shapleigh

Reasons for a Minority Report

The majority report of the BRTF was compiled by conscientious, well-intentioned people. However, we the undersigned believe the majority report has failed to identify the fundamental reasons why there are so many uninsured in Texas. Nor does the report explain why the number of uninsured in Texas continued to rise during a decade of rising incomes and unprecedented economic growth. Further, we believe that even if all the majority recommendations were fully implemented, the number of uninsured in Texas would continue to rise, indefinitely into the future.

John C Goodman

John Goodman, PhD

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ELIOT SHAPLEIGH
TEXAS SENATE
DISTRICT 29
EL PASO COUNTY

February 13, 2001

The Honorable Chris Harris
Chairman - Blue Ribbon Taskforce on the Uninsured
P.O. Box 12068
Austin, Texas 78711

Dear Chairman Harris:

Enclosed is a minority report detailing Border health issues. In my view, the story of Border health must be told in more detail than that contained in the report. Please include this material in your final printing.

Very truly yours,

Eliot Shapleigh

ES/lm
Enclosure

cc: Blue Ribbon Taskforce Committee Members

TL/Senate/Senators/HarrisChris/HarrisCBlueRibbonMinorityReport.wpd

BLUE RIBBON TASK FORCE
ON THE UNINSURED

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INTRODUCTION

It is important to note that this review of the uninsured is not unique. Every interim during the past decade has included at least one study to examine some issue relating to the uninsured in Texas. One of the most notable, a 1991 comprehensive review by the Texas Health Policy Task Force, noted that "our state faces a crisis so great that before the turn of the century, our entire health care delivery system could collapse." The system has not yet collapsed, even though the legislature failed to enact many of the sweeping changes recommended by the task force to provide Texans with universal health care coverage.

Many changes have taken place since the previous task force published its recommendations, both at the federal and state levels. Welfare reform, Medicaid managed care, HIPAA (Health Insurance Portability and Accountability Act), the Balanced Budget Act of 1997, and managed care reforms are just a few of these. However, it seems that for every problem addressed by these legislative actions, new ones have been created. The problems of the uninsured have not been resolved, and in many ways are more severe than they were in 1991.

BACKGROUND

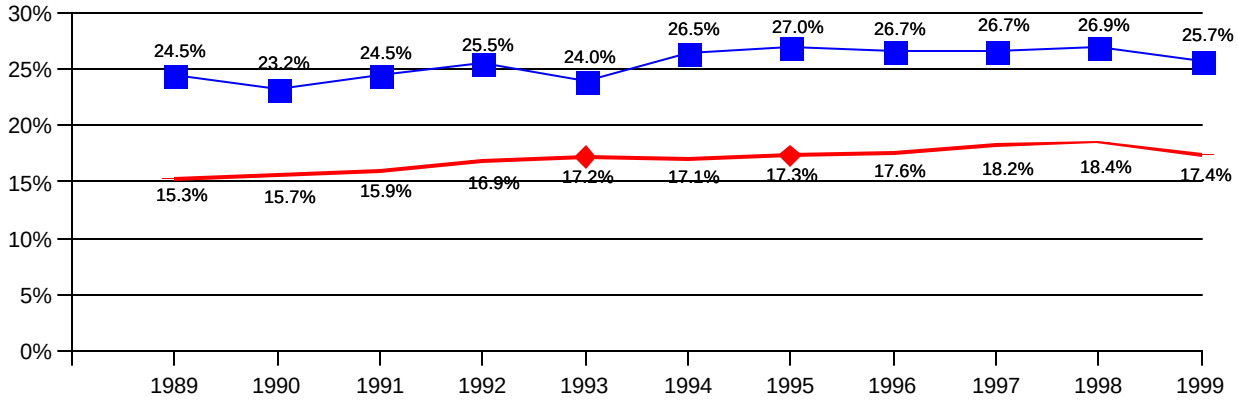
The employment-based health insurance system is the primary source of coverage for Americans. Millions more are covered through public programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Yet today, somewhere in the neighborhood of 44 million Americans lack health insurance coverage. This is a startling number when you consider the fact that almost every American age 65 and older is covered by Medicare and 30 million are covered by Medicaid. And, this has occurred despite the fact the United States has experienced rapid and sustained economic growth over the past eight years.

The most recent Census Bureau data shows that for the first time since at least 1987, the number of Americans without health insurance coverage actually declined from 1998 to 1999, going from 43.9 million to 42.1 million. This has happened despite the fact that according to a recent study health insurance premiums increased on average 8.3 percent between spring 1999 and spring 2000. [1] It appears that as long as the economy is strong and unemployment is low, employment-based coverage should expand. However, if the economy falters, the number of uninsured will quickly start to increase again.

Today, Texas has the highest rate of uninsured in the United States. In 1999, 25.7 percent of the non-elderly population in Texas was uninsured, compared with 17.4 percent in the United States as a whole. (**Figure 1**) Over a ten year period, even though the percentage of uninsured remained relatively constant, the number of Texans lacking health insurance grew from three to four million.

Figure 1

Population (0-64) without Health Insurance, Texas and U.S.



Source: United States Census Bureau.

[1] Gabel, Jon, et al. "Job-Based Health Insurance In 2000: Premiums Rise Sharply While Coverage Grows." *Health Affairs*. Vol. 19, no. 3 (September/October 2000): 144-151.

As a result of the high uninsured rate in Texas, the 76th Texas Legislature passed Senate Concurrent Resolution 6 which called for the creation of a task force to:

< examine the problem of Texans who lack health insurance;

< review demographic trends relating to the uninsured population;

< examine other state's programs, laws, and systems which address the lack of affordable health coverage; and

< devise market-based reforms which would help to reduce the uninsured population in Texas.

The task force was composed of nine members--three senators appointed by the Lieutenant Governor; three representatives appointed by the House Speaker; and three public members appointed by the Governor. The chair of the task force was Senator Chris Harris. The other members were: Senator David Bernsen, Senator Eliot Shapleigh, Representative Garnet Coleman, Representative Craig Eiland, Representative Bob Glaze, Dr. Nancy Dickey, Dr. John Goodman, and Boone Powell Jr.

This report is a compilation of the work that the task force undertook, including seven public hearings and numerous working meetings to discuss the issue of the uninsured in Texas. Hearings were held in Austin, Harlingen, Houston, Dallas, El Paso, and Gilmer. These were done to help the committee members understand the problems of the uninsured, and to provide members with a better insight of the interrelations between public programs, insurers, health care providers, and employers when dealing with the uninsured. There was also discussion on regional variations in the uninsured problem. What began as a concurrent resolution to examine and make recommendations of market-based reforms to improve access to health insurance quickly evolved into a discussion of how best to provide health insurance for all Texans.

The report is divided into six primary sections. The first section explains the demographics of the state. The second section deals with health insurance coverage. The third section relates to insurance regulation. The fourth section analyzes the amount of money spent on caring for the uninsured in Texas. The fifth section deals with future considerations, particularly at the federal level. The sixth and final section makes recommendations to be pursued by the 77th Texas Legislature when it convenes January 9, 2001.

SECTION I. DEMOGRAPHICS

Texas is a large and diverse state. When the United States Census Bureau reports a specific number or percentage relating to some issue in Texas, the information does not provide us with any detail. A single number or percentage about the state does not adequately reflect the differences which exist across regions of the state. Therefore, the task force charged the Texas Health and Human Services Commission (HHSC) to compile more detailed demographic information on the uninsured. The task force wanted to know, as specifically as possible, who the uninsured Texans are, where they live, and what their economic status is. This information, combined with data from the Census Bureau, comprise the majority of the data used in this section. Among the overall highlights from the data were:

< The number and percentage of Texans covered by employment-based health insurance increased slightly in 1999, resulting in an overall increase in health insurance coverage. The percent covered was significantly lower than the national rate, 56.7 percent versus 62.8 percent.

< On any given month, nearly one in four Texans are likely to lack health insurance coverage. Minorities comprise almost two-thirds of all uninsured Texas, with Hispanics making up about 50 percent of the total number of uninsured.

< The uninsured rate is substantially higher among non-citizens than among citizens--56 percent, compared to 24 percent for the population as a whole. Non-citizens comprise about one out of every five uninsured Texans.

< About 64 percent of those without insurance come from families and households with incomes below 200 percent of federal poverty. Families and households with incomes below 100 percent of federal poverty alone account for nearly 30 percent of all persons without insurance. **Figure 2** on the following page shows the percentage of uninsured for the entire state compared to those with incomes below 200 percent of federal poverty.

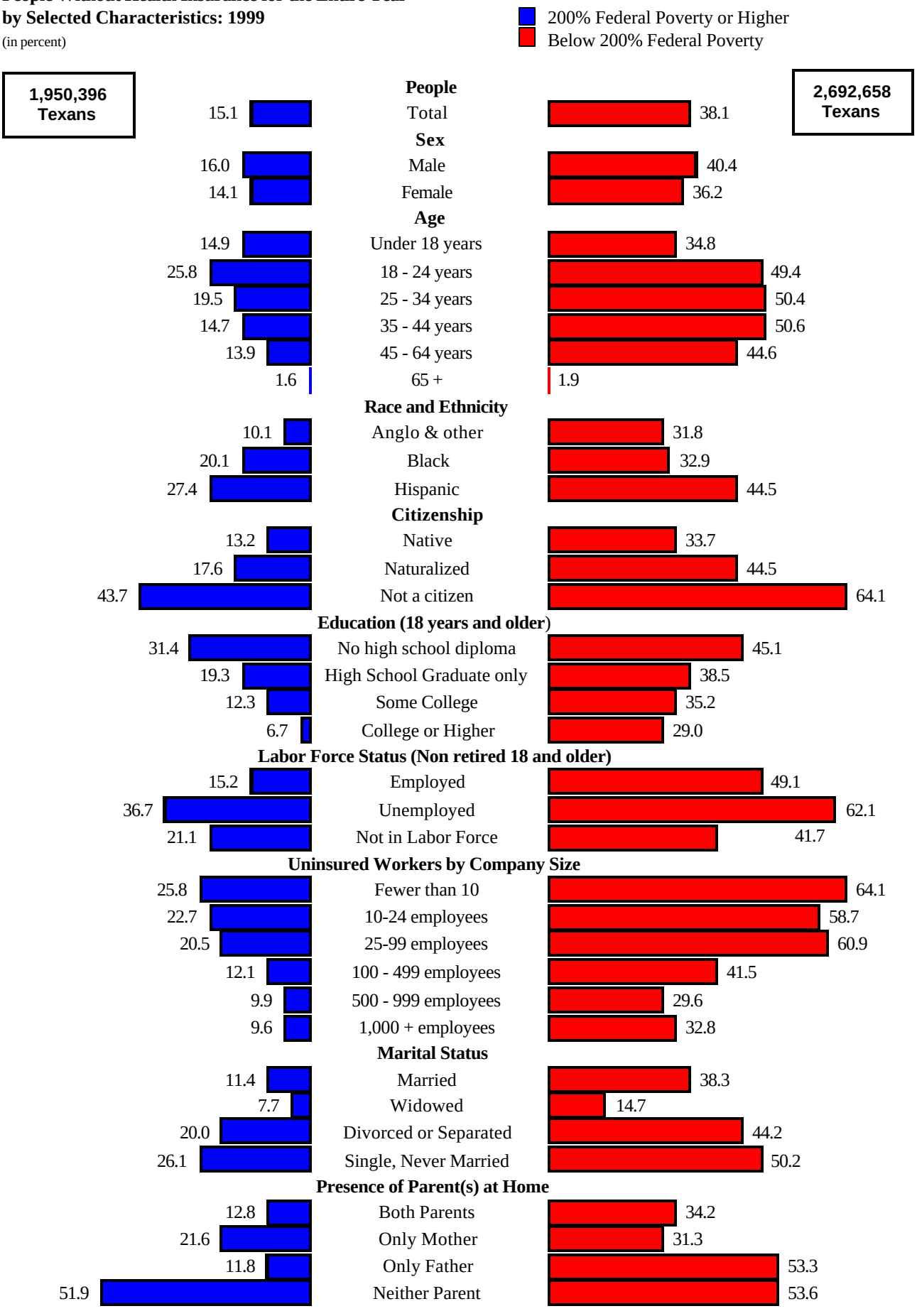
< In 1999, young adults ages 18-24 were more likely to be uninsured than any other age group--42 percent, as compared to 24 percent for the general population. The uninsured rate among young adults ages 25-34 was also substantially higher than the average at 32 percent.

< Children under the age of 18 make up close to one out of every three uninsured Texans. For dependent children under the age of 18, the overall uninsured rate is about 24 percent. However, almost three out of every four of these uninsured live in families with incomes less than 200 percent of poverty. In December 1999, the total number of Texas children estimated to be eligible for Medicaid but not enrolled was 669,000. This is almost 200,000 more than the estimated 480,000 who are eligible for CHIP. If all income eligible children were to enroll in either Medicaid or CHIP, the uninsured rate among Texas children under 18 could drop to a little more than five percent from the current estimated rate of nearly 25 percent.

Figure 2.

People Without Health Insurance for the Entire Year by Selected Characteristics: 1999

(in percent)



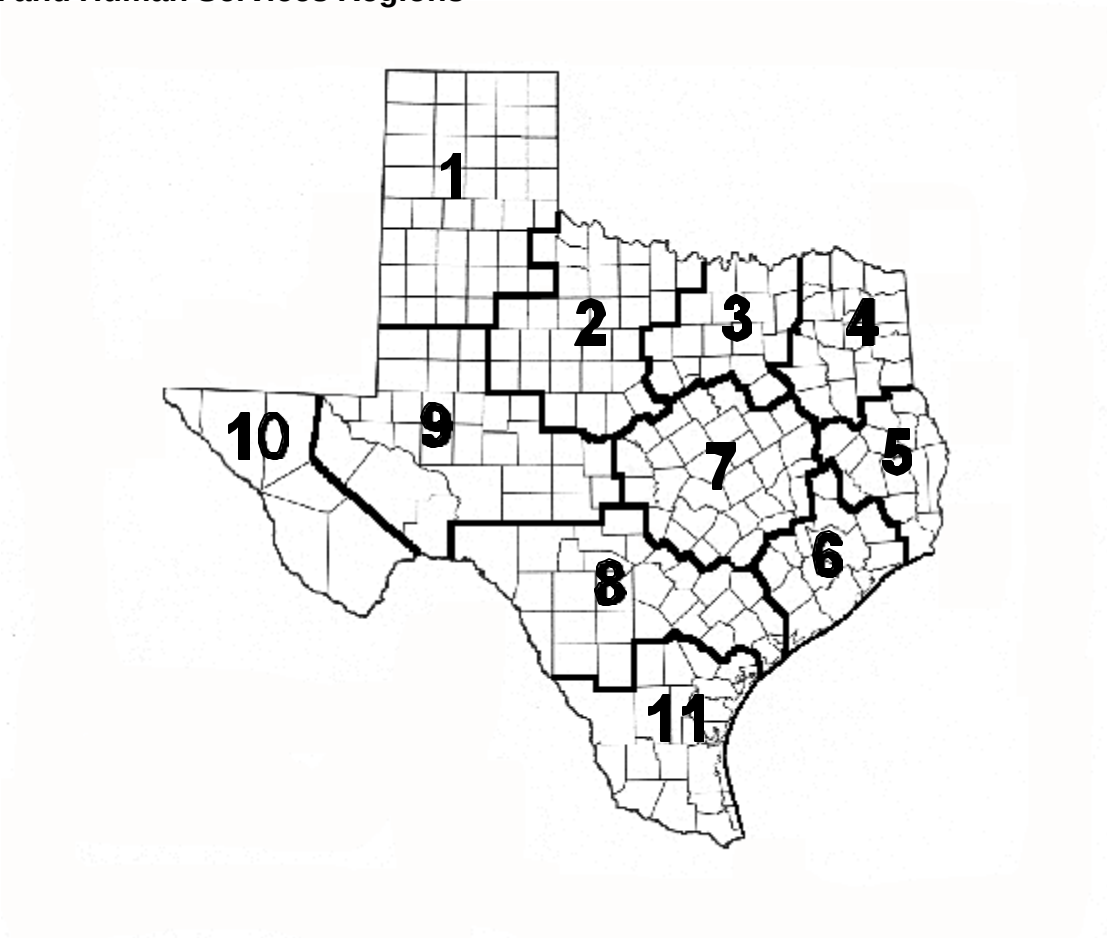
Source: Texas Health and Human Services Commission

< As the level of education increases, the chance of being uninsured among adults ages 18 and older decreases dramatically. Texans with less than a high school have an uninsured rate of about 39 percent, compared to a rate of eight percent for those who have completed college or beyond.

For purposes of this report, demographic information for the state relating to the uninsured will be broken down into six subsections: Race/Ethnicity; Age; Socio-Economic status; Educational Attainment; and Overall Uninsured Numbers. As the information and graphics show, each has a dramatic impact on the likelihood of health insurance coverage. Where possible, information was collected and reported at either a regional or county level. For regional data, the 11 Health and Human Services regions were used. **Figure 3** shows a Texas map detailing the counties which make up these regions.

Figure 3

Health and Human Services Regions



Subsection 1. Race/Ethnicity

The race/ethnicity makeup of Texas has changed significantly over the last ten years. From 1990 to 2000, the overall population grew about 20 percent, going from 16.9 million to 20.4 million. The fastest growing segment of the population was in the Hispanic category which now accounts for 31 percent of the total population, or about 6.3 million people. A breakdown of the population by race/ethnicity is shown below in **Figure 4**.

A further breakdown is shown in **Figure 5** of race/ethnicity combined age group shows the increasing growth of Hispanic in both categories under the age of 65+, particularly in the under 18 category.

Figure 4

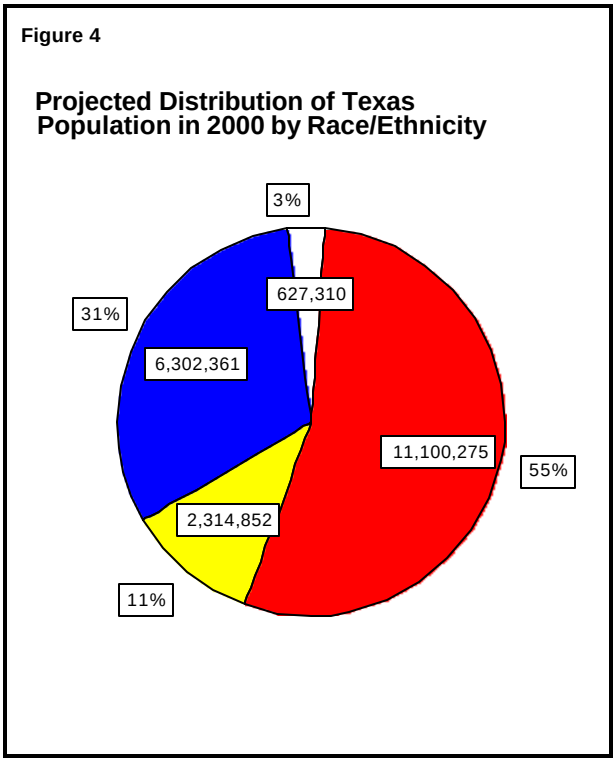
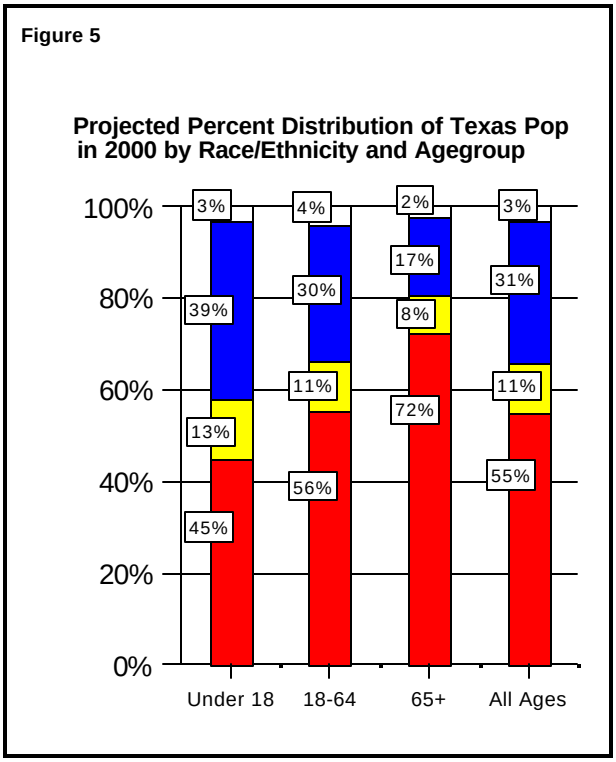


Figure 5



Minorities make up 65 percent of the uninsured population in Texas. Hispanics alone compose over half of the uninsured. **Figure 6** provides a breakdown of the uninsured by race/ethnicity in Texas.

Within each race/ethnic category, minority groups have a much higher rate of uninsurance compared to the Anglo & other category. Nearly 40 percent of all Hispanics lack health insurance coverage.

Figure 7 highlights the impact of race/ethnicity on whether an individual has health insurance coverage.

Figure 6

Percent Distribution of the Uninsured in Texas by Race/Ethnicity during the 1996-98 Period

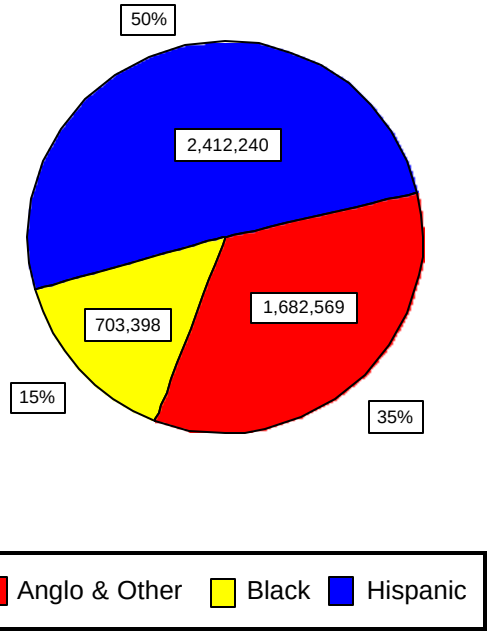
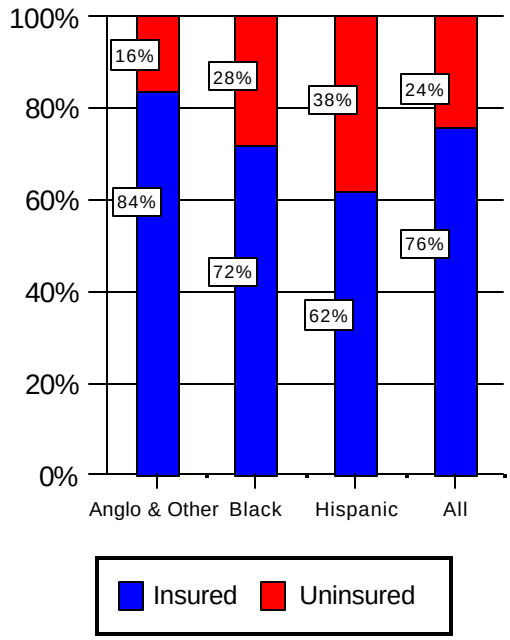


Figure 7

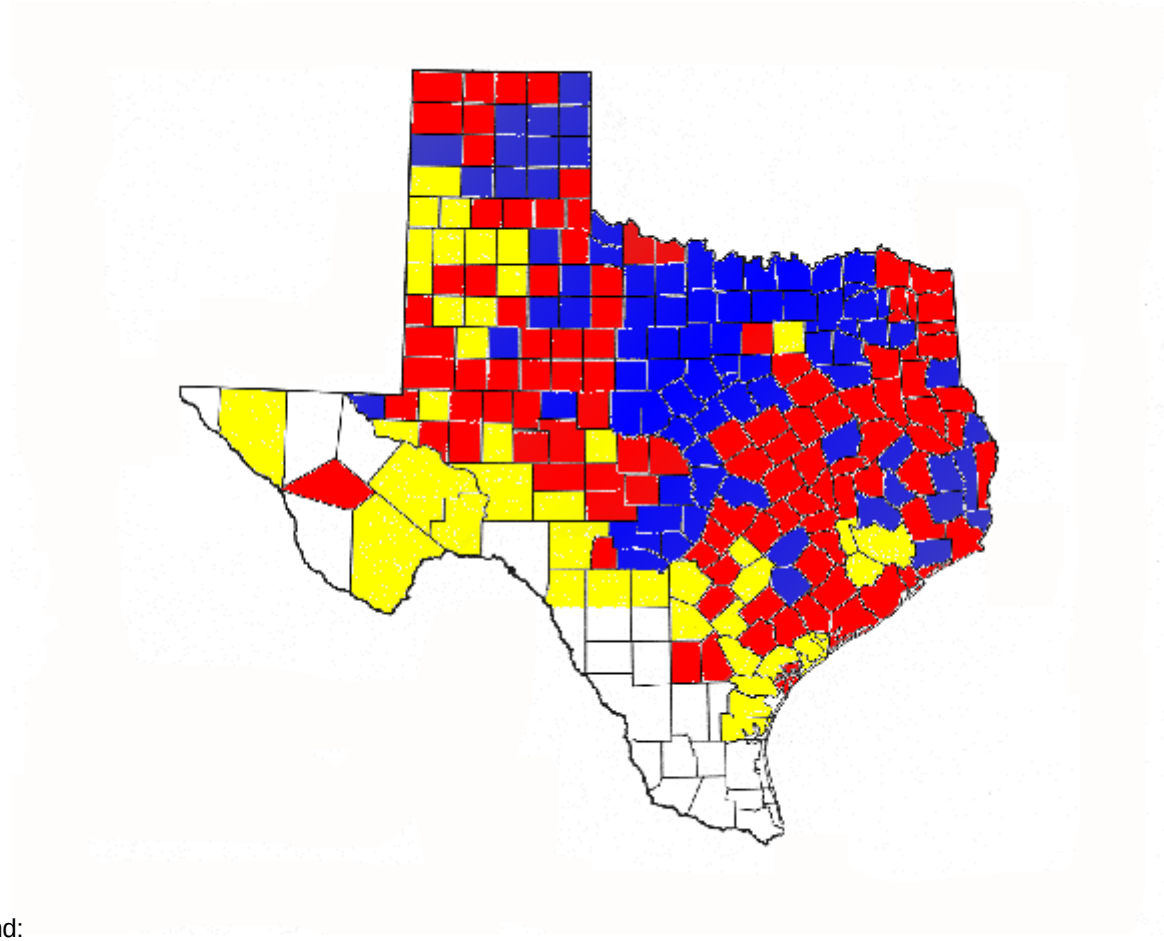
Percent Insured Versus Uninsured by Race/ Ethnicity in Texas during the 1996-98 Period



Although these numbers and percentages are very telling about the impact of race/ethnicity on the number of uninsured in Texas, they do not reflect the variation in race/ethnicity that occurs across the state. In order to get a better picture of the regional variation, **Figures 8 - 10** use a map of the state to provide a county-by-county breakout of the Texas population by race/ethnicity.

Figure 8

Percent of Population Anglo in 2000



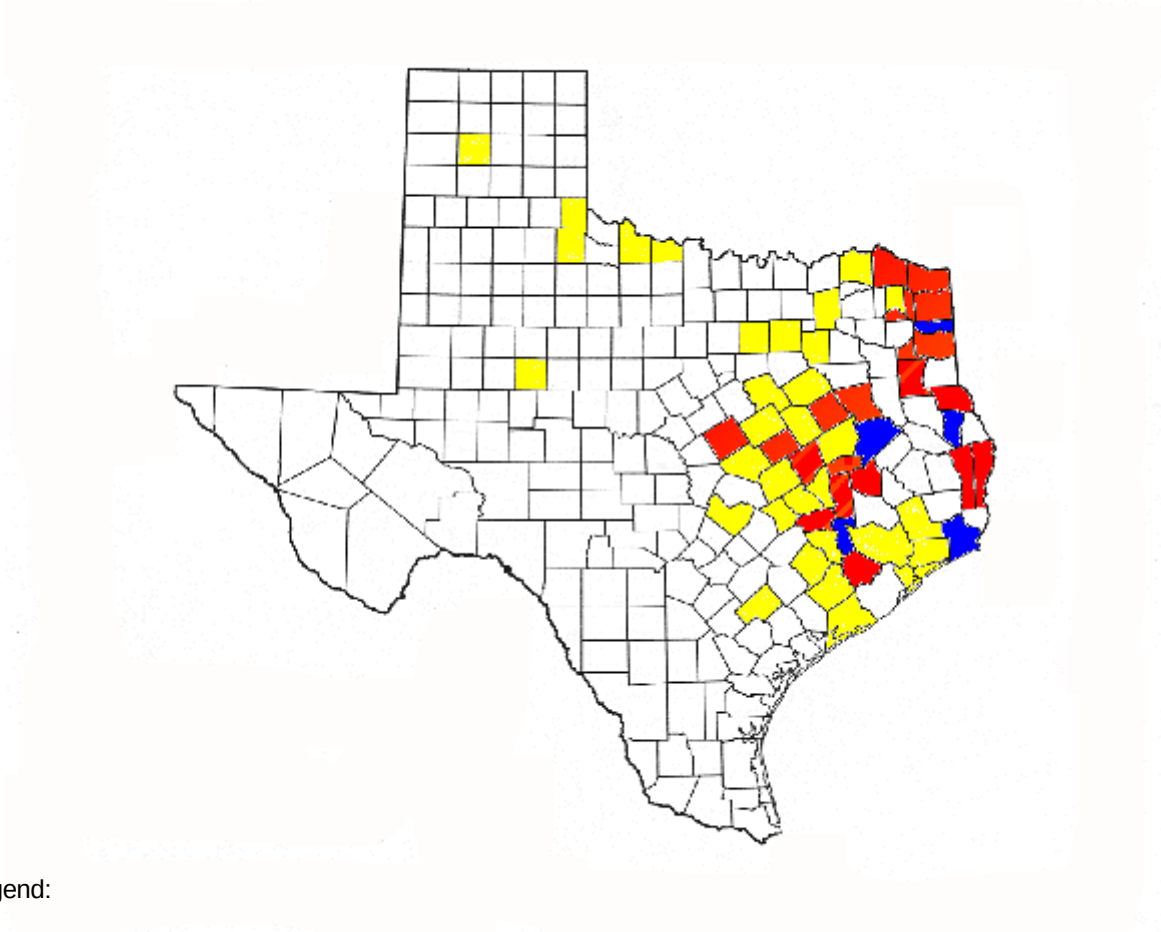
Legend:

- 1 -26.99%
- 27 - 51.99%
- 52 - 76.99%
- 77% or higher

Source: Texas Health and Human Services Commission

Figure 9

Percent of Population Black in 2000



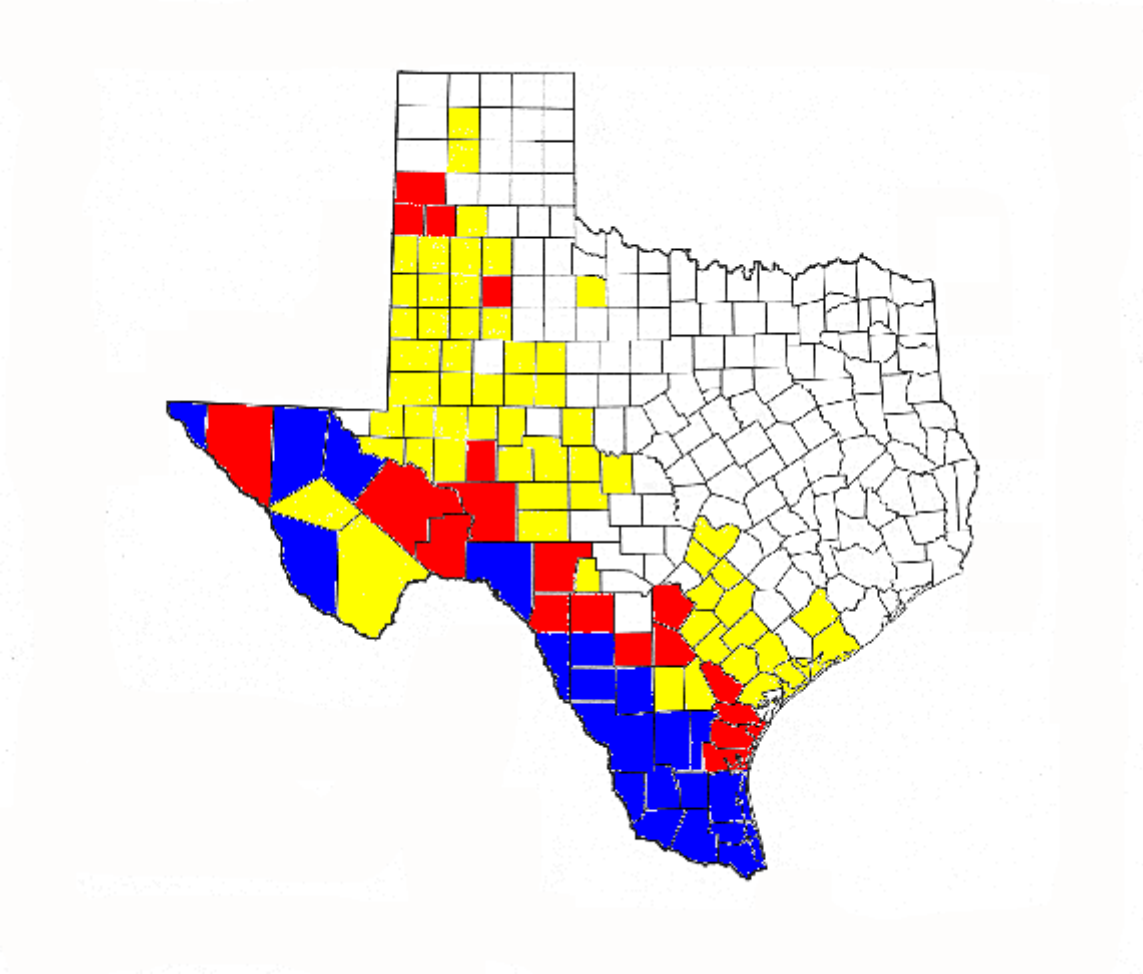
Legend:

- 0 - 9.99%
- 10 - 19.99%
- 20 - 29.99%
- 30% or higher

Source: Texas Health and Human Services Commission

Figure 10

Percent of Population Hispanic in 2000



Legend:

- 1 - 25.99%
- 26 - 49.99%
- 50 - 74.99%
- 75% or higher

Source: Texas Health and Human Services Commission

Subsection 2. Age

Age also plays a prominent role in the determination of whether or not an individual is insured. As was noted previously, almost everyone 65 years or older is covered under the federal Medicare program. **Figure 11** shows both the breakdown in the number of uninsured by age group, while **Figure 12** also breaks out the rate of insurance versus uninsurance for each specific age group. It is interesting to note the high rates of uninsurance that occur in the Ages 18-24 and Ages 25-34 categories.

Figure 11

Percent Distribution of the Uninsured in Texas by Selected Age Groups during the 1996-98 Period

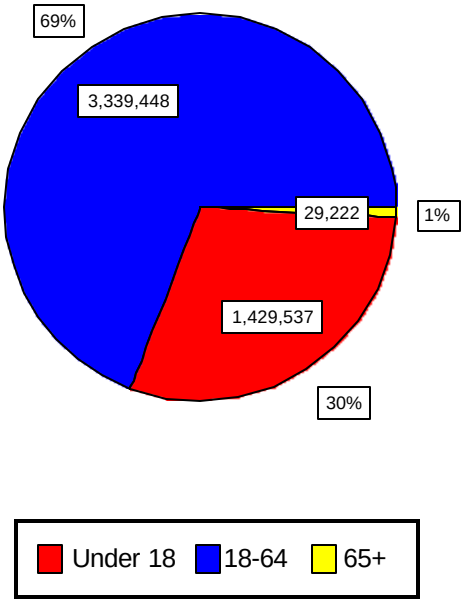
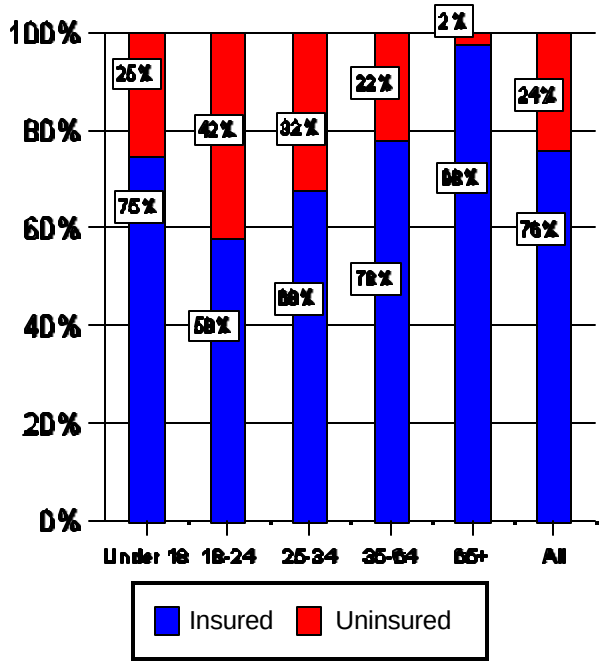


Figure 12

Percent Insured Versus Uninsured by Selected Agegroups in Texas during the 1996-98 Period



Subsection 3. Socio-Economic Status

Employment-based health insurance is the most common form of health insurance coverage in the United States. This is also true in Texas. Approximately 56.7 percent of Texans are covered through an employer. This is substantially lower than the 62.8 percent rate for all Americans. The likelihood of being covered by health insurance also rises with income. Unemployment rates and rate of poverty are both good predictors of whether or not an individual has health insurance. The rates vary widely across the state with Southeast Texas, West Texas, the Upper Rio Grande, and Lower South Texas all having significantly higher rates of poverty and unemployment than the rest of the state. **Figure 13** shows the overall rates for the state and how they have changed from 1989 to 1999. **Figure 14** shows the rates for each HHS region.

Figure 13

Rates of Poverty and Unemployment
Texas and U.S.: 1999

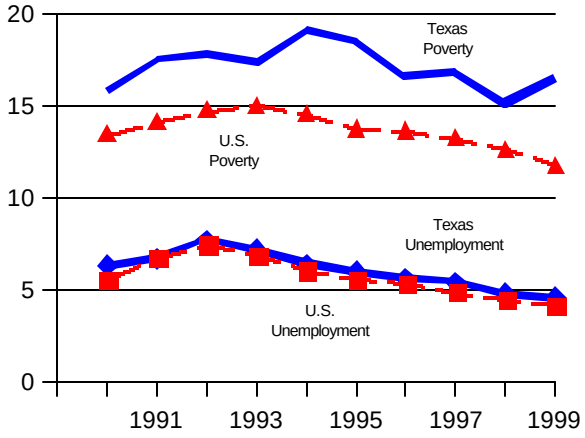


Figure 14

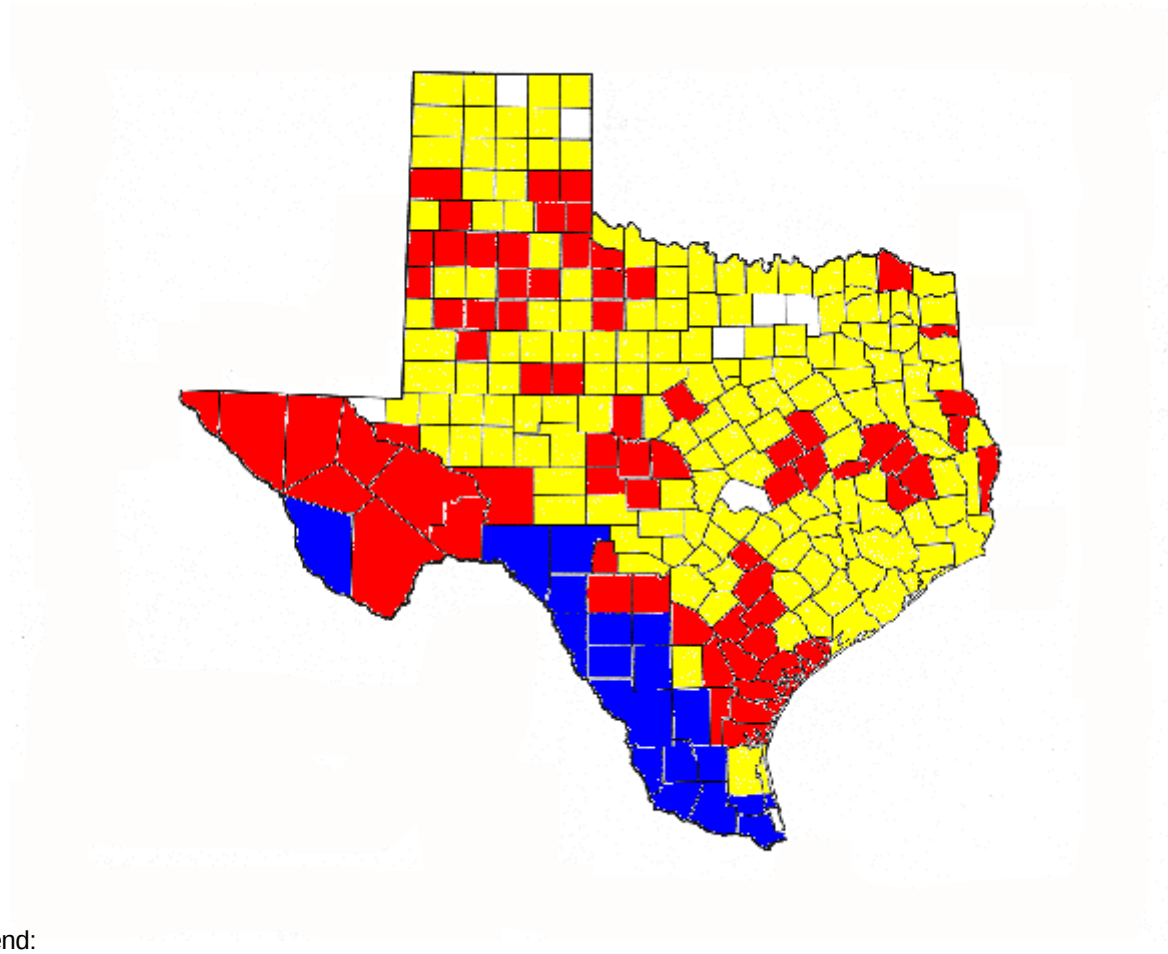
Rates of Poverty and Unemployment for Texas HHS Regions: 1999

Region	Rate of Poverty	Rate of Unemployment
1 High Plains	17.7%	3.9%
2 Northwest Texas	17.6	4.3
3 Metroplex	10.8	3.2
4 Upper East Texas	17.0	4.4
5 Southeast Texas	19.0	7.6
6 Gulf Coast	12.9	4.7
7 Central Texas	15.3	2.6
8 Upper South Texas	20.9	3.8
9 West Texas	17.8	7.2
10 Upper Rio Grande	27.9	9.4
11 Lower South Texas	32.8	9.6

Figures 15-16 shows the variation that occurs across the state. Approximately 64 percent of those without insurance come from families and households with incomes below 200 percent of federal poverty. Persons with households and families with incomes below 100 percent of the federal poverty income level account for nearly 30 percent of all persons without insurance. A breakdown of the number of uninsured by poverty level is shown in **Figure 17**, with a more detailed analysis of insured versus uninsured for each poverty level in **Figure 18**.

Figure 15

Estimated Percent of Population Living in Poverty in 1999



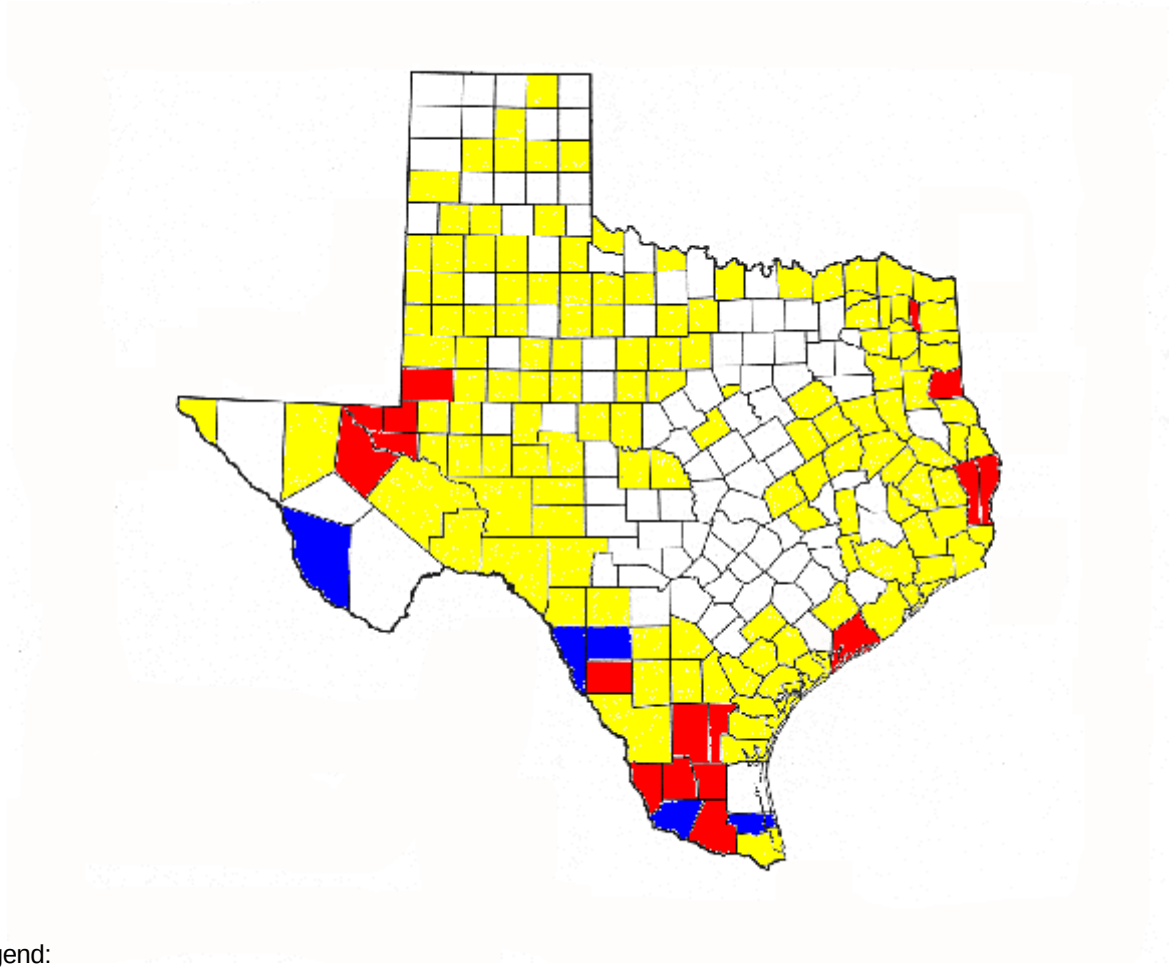
Legend:

- 0 - 10%
- 11 - 20%
- 21 - 30%
- 31% or higher

Source: Texas Health and Human Services Commission

Figure 16

Average Monthly Rate of Unemployment in 1999



Legend:

- 1 -3.99%
- 4.00 - 9.99%
- 10.00 - 15.99%
- 16.00% or higher

Source: Texas Health and Human Services Commission

Figure 17

Percent Distribution of the Uninsured in Texas by Percent of Poverty during the 1996-98 Period

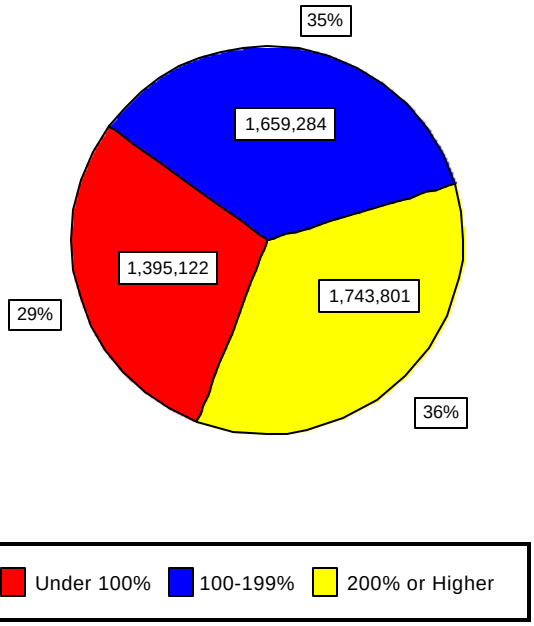
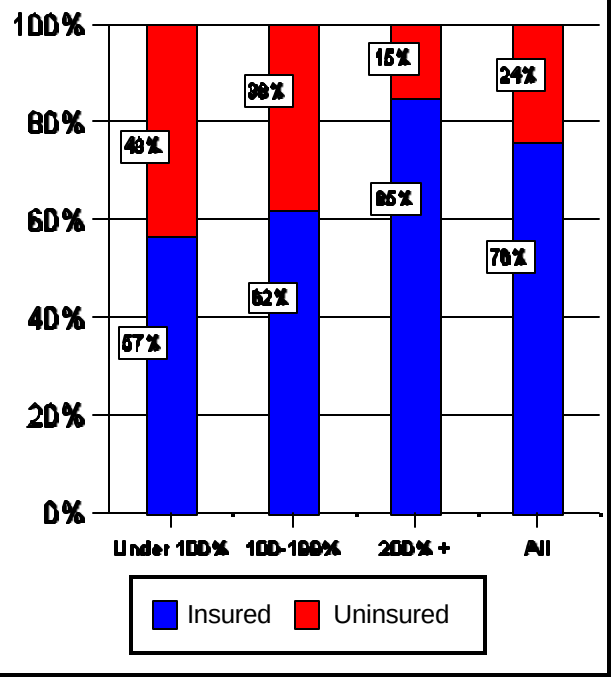


Figure 18

Percent Insured Versus Uninsured by Poverty Category in Texas during 1996-98



Most uninsured in Texas are employed. **Figure 19** shows the distribution of uninsured Texans Age 18 and older by labor force status during the 1996-98 period. Retirees are excluded from these numbers. A breakdown of insured versus uninsured for each category is shown in **Figure 20**.

Figure 19

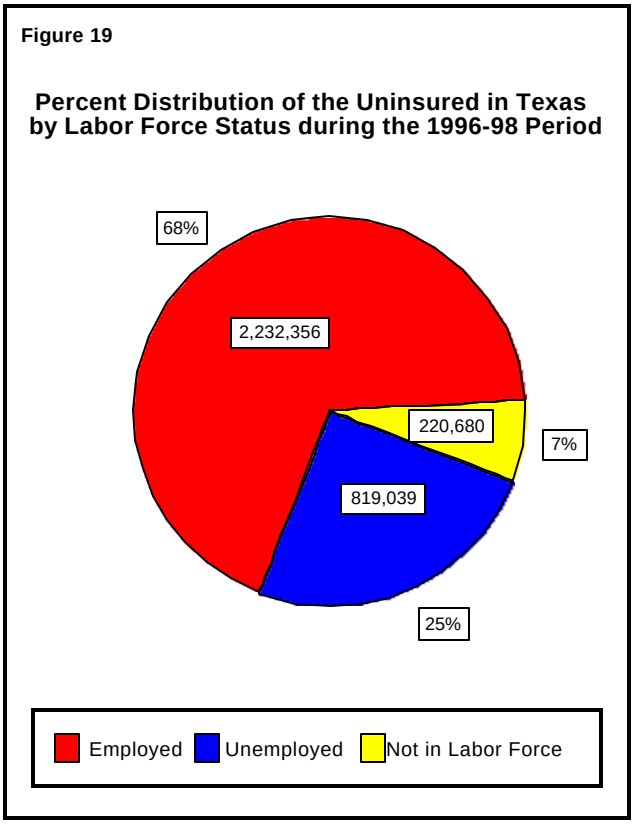
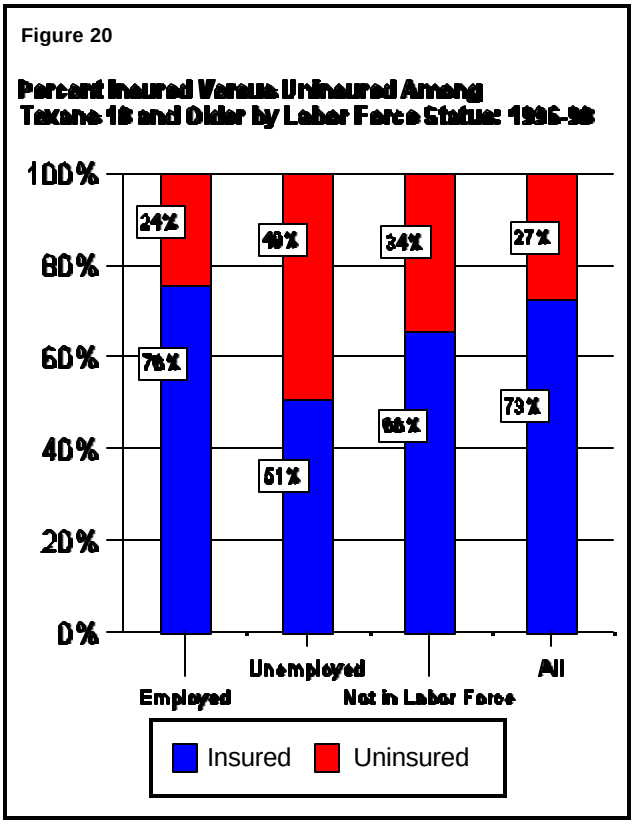


Figure 20



Subsection 5. Education

Among adults, the likelihood of being insured increases as the level of education rises. As **Figure 21** shows, 70 percent of the uninsured in Texas have a high school level of education or less. **Figure 22** provides a more detailed analysis of the insured and uninsured for each level of educational attainment.

Figure 21

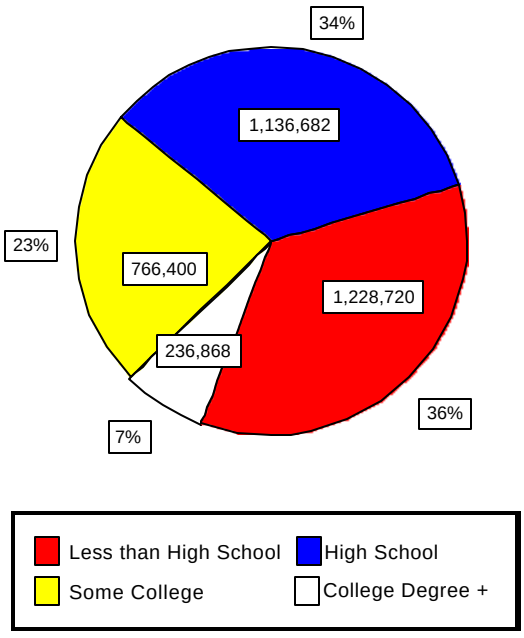
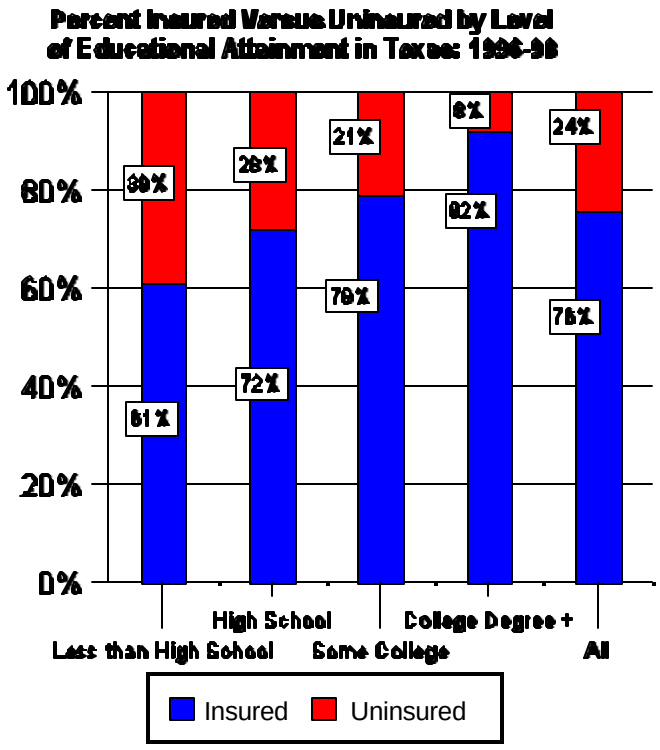


Figure 22



Subsection 6: Overall Uninsured Numbers

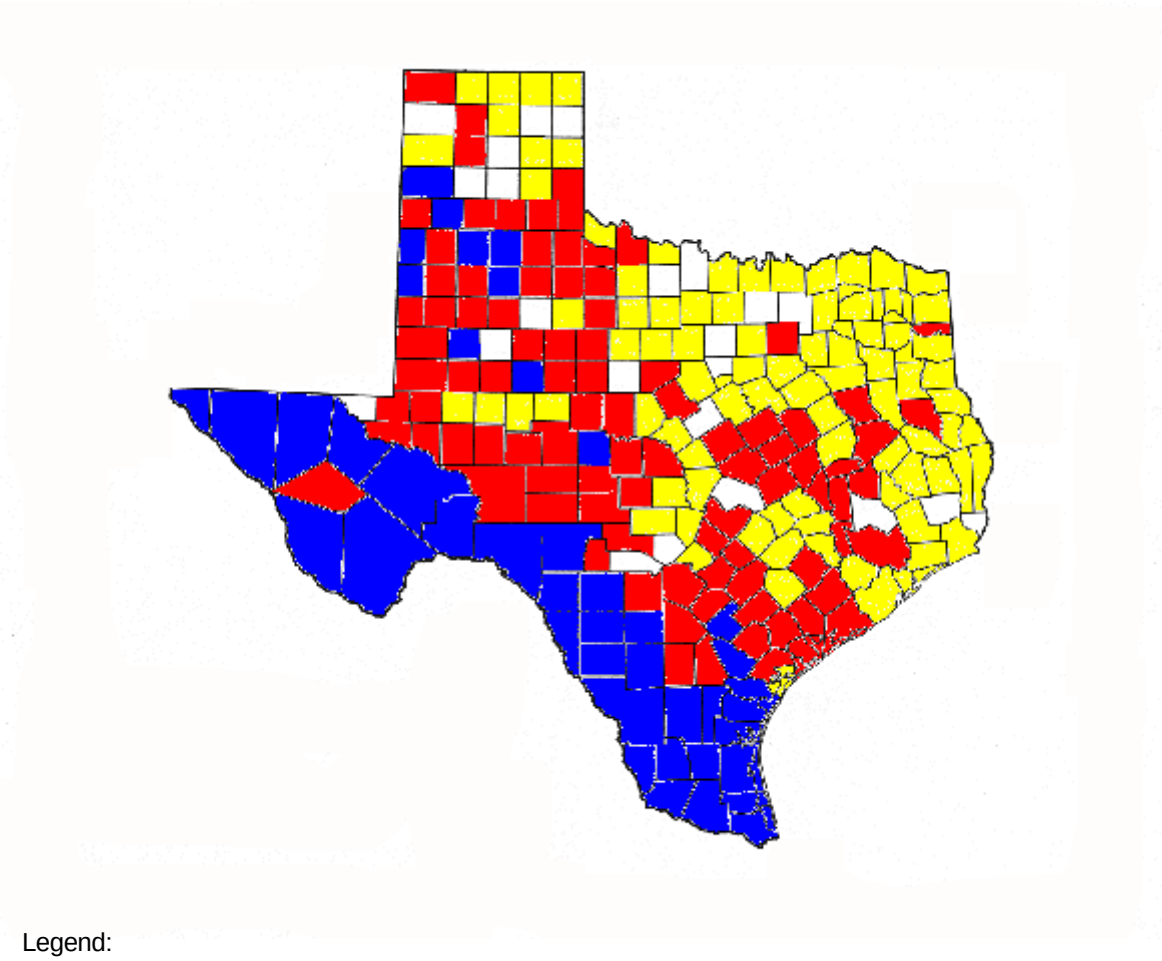
As noted earlier in the report, Texas has the highest rate of uninsured in the nation, with nearly one in four Texans likely to lack health insurance coverage in any given month. There is a wide variation in the uninsured rate across the state. **Figure 23** shows this variation for the overall under 65 population while **Figure 24** shows the variation for children under 18.

There are many other criteria which impact the probability that an individual has insurance. The U.S. Census Bureau reports these and will be providing comprehensive results on the Texas population from its Census 2000 review.

All of the demographic information provided by HHSC is detailed in the report, The Demographic Profile of the Texas Population without Health Insurance Coverage. Much of the data can also be found under the Research & Statistics section of the HHSC website at **www.hhsc.state.tx.us**.

Figure 23

Estimated Percent of Population Under Age 65 Uninsured in 1999



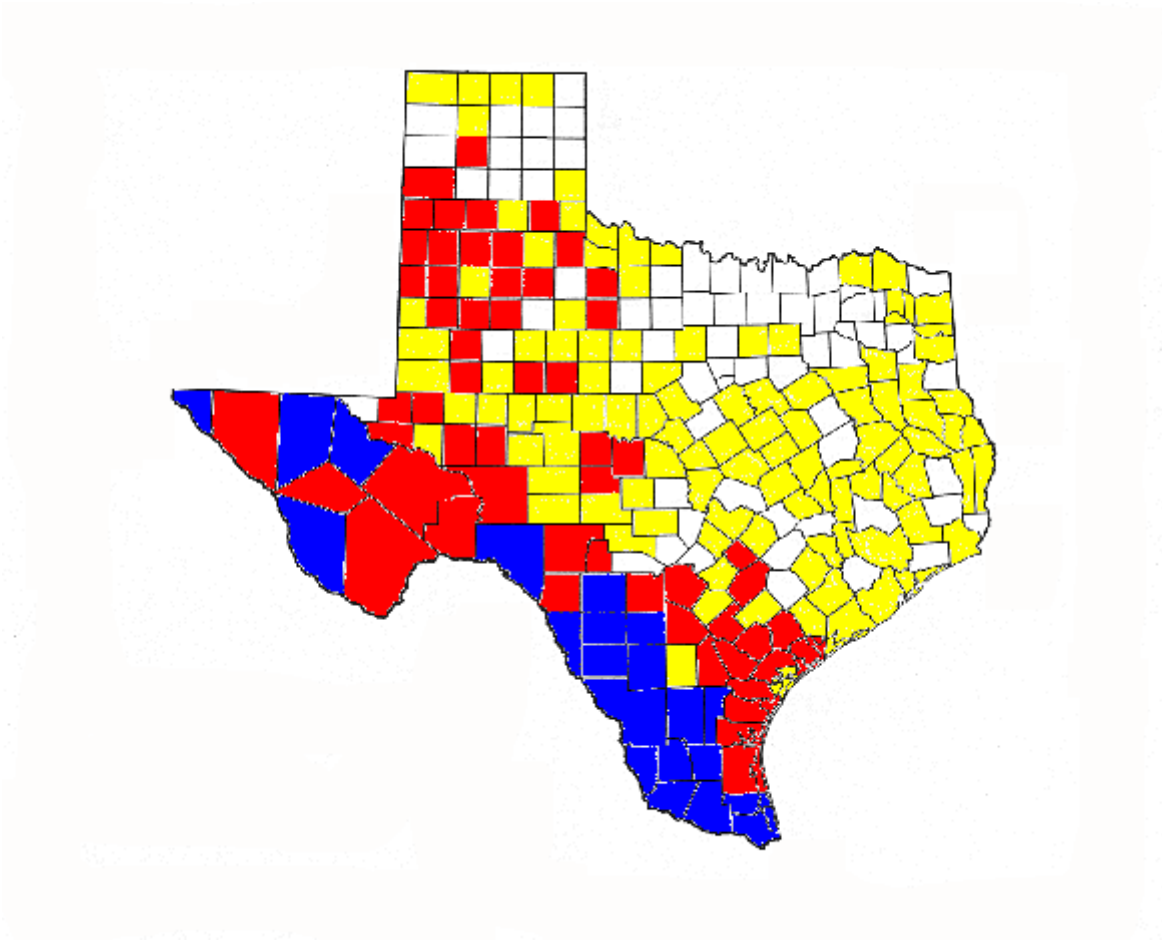
Legend:

- 19 - 22%
- 23 - 25%
- 26 - 29%
- 30% or higher

Source: Texas Health and Human Services Commission

Figure 24

Estimated Percent of Children Ages 0-18 Uninsured in 1999



Legend:

- 18-22%
- 23 - 25%
- 26 - 29%
- 30% or higher

Source: Texas Health and Human Services Commission

SECTION II. HEALTH INSURANCE COVERAGE

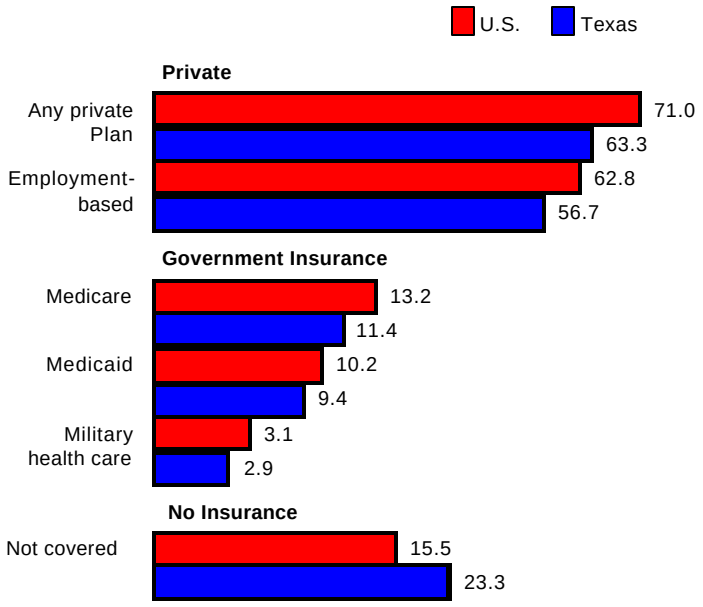
Health insurance in the United States is provided through one of two means--either it is purchased privately or it is provided through a government sponsored program. **Figure 25** shows a breakdown of health insurance coverage in Texas for 1999 compared to that of the United States. As is evidenced by the chart, Texas trails in both the number of individuals covered through private coverage and the number covered by government insurance.

Subsection 1.
Private Coverage

As was noted earlier and is evidenced by the chart at right, employment-based coverage is by far the most common type of insurance coverage in the United States.

Figure 25

Type of Health Insurance and Coverage Status: Texas and U.S., 1999 (in percent)



Source: U.S. Census Bureau

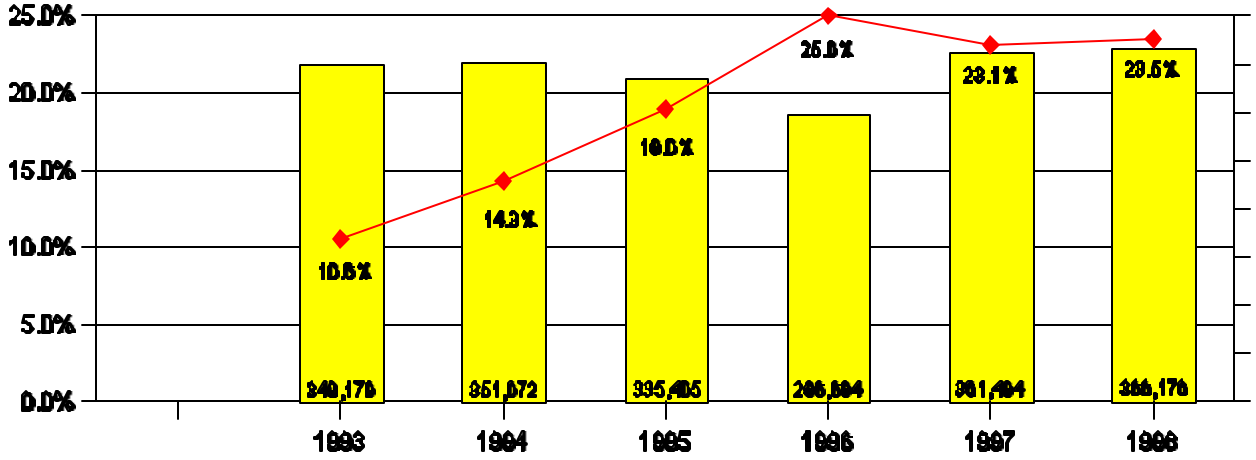
Currently, health insurance premiums paid by employers on behalf of workers are tax-deductible as a business expense. The amount paid on behalf of a worker is excluded, without limit, from the worker's taxable income.

There has been a particular focus on the part of states to assist small employers (between two and 50 workers) in obtaining health insurance. The Texas legislature in 1993 and 1995 adopted numerous reforms to make it easier for small employers to purchase health insurance coverage for their employees. **Figure 26** denotes both the number of small employers in Texas and the percentage which purchased health insurance for their workers.

According to an October 2000 Issue Brief from the Employee Benefit Research Institute (EBRI) titled "Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey," almost 57 percent of small employers did not know that they could deduct 100 percent of their health insurance premiums. It also found that many small employers (over 60 percent) were unaware of state and federal laws which had been enacted

Figure 26

Number of Texas Small Employers and Health Insurance Participation: 1993-98



Source: Texas Workforce Commission Labor Market Information & Texas Department of Insurance Figure 48 Annual Filing

to make health insurance more accessible and affordable, and that insurers could not deny health coverage even when the health status of their workers is poor. The report also found that cost was a critical factor among small employers offering health insurance coverage. Nearly all employers who have switched plans in the past five years cite cost as the main reason.

Health insurance can also be purchased individually, and a number of people obtain health insurance coverage in this manner. There is a 50 percent tax deduction provided in obtaining health care insurance for the self-employed. The deduction is currently scheduled to be increased to 100 percent by 2003. There is also a deduction available for individuals whose total health expenses exceed 7.5 percent of adjusted gross income, but it is only for those expenses that exceed this threshold.

Subsection 2. Government Insurance

Medicare/Military Health Care

Both the Medicare component and Military Health Care component are beyond the scope of this report, since both are financed and administered at the federal level. It is worth noting that since 1988, federal law has required state Medicaid programs to pay Medicare deductibles and coinsurance for some low-income people. For 1999, the state paid approximately $1 billion to pay these costs. The state paid another $1.4 billion to fund long-term care costs for Medicare/Medicaid clients. The focus of this subsection, however, will be on the State Medicaid program and the state CHIP program.

Medicaid, Welfare Reform, and CHIP[2]

The Medicaid and CHIP programs are jointly funded by the federal government and the state of Texas. Medicaid was originally created in 1965 to ensure access to health care for low income individuals. Over a thirty year period, the program has been expanded numerous times to cover a greater number of elderly, pregnant women, children, and people with disabilities. Medicaid enrollment grew rapidly in the 1980s due to program changes at the federal level and medical inflation. However, welfare reform and a booming economy have contributed to declines in the Medicaid program.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 gave states the authority to design their own cash assistance programs for needy families by promoting work and ending dependence on the government. Aid to Families with Dependent Children (AFDC) became Temporary Assistance for Needy Families (TANF). Adult recipients must now participate in work activities within two years of entering the program and may not receive federally-funded TANF benefits for more than sixty months over a lifetime (unless exempted due to some defined hardship reason). While states cannot impose any time limits for Medicaid or terminate coverage because of a TANF work sanction, many believe the changes have resulted in declines in Medicaid enrollment.

The Texas Legislature passed its own welfare reform legislation in 1995. It requires recipients who receive TANF benefits to sign a personal responsibility agreement that addresses issues such as child support cooperation, meeting preventive screen schedules, work requirements, drug and alcohol abuse counseling, and parenting skills.

Historically, individuals enrolled in TANF have been automatically enrolled in Medicaid. Welfare reform preserves Medicaid eligibility, but in most cases, does not automatically enroll these individuals for Medicaid. Individuals who no longer qualify for cash assistance may not

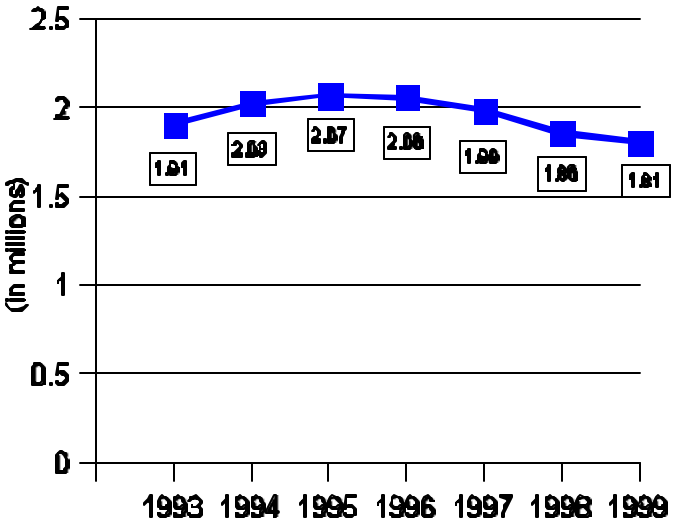
[2] Taken from testimony provided by the Texas Health and Human Services Commission at December 16, 1999 meeting and information provided by the Texas CHIP Coalition

be aware that they may still be eligible for Medicaid, and thus may fail to enroll. The Health Care Financing Administration (HCFA) has performed numerous studies which show that eligible children in low-income families that do not receive cash assistance are much less likely to enroll in a Medicaid program than are those who receive cash assistance. Furthermore, new time limits on the receipt of TANF benefits may actually deter those who qualify for Medicaid from seeking benefits because of unfounded fears that applying for Medicaid may count against their lifetime welfare benefits.

Medicaid enrollment has been declining in Texas since it peaked in January 1996 at 2,0393,881.[3] Medicaid monthly average enrollment is shown in **Figure 27**.

Figure 27

Medicaid Monthly Average Enrollment, 1993-99



Source: The Caseload Forecasting Report for The HHS Agencies (3rd Quarter SFY 2000

The Balanced Budget Act of 1997created the CHIP program to provide additional insurance coverage for children. Together, the programs were developed to cover children up to the age of 19 with incomes at or below 200 percent of federal poverty, which is $34,100 for a family of four. The Medicaid program covered an estimated one million children in 1999. However, based on December 1999 data, HHSC estimates that there are an additional 669,000 Texas children who are income eligible for Medicaid, but not enrolled.

Current estimates show that about 480,000 children are eligible for CHIP. As of January 2001, approximately 200,00 children have been enrolled. **Figure 28** shows the income thresholds for a family of four for each program.

Some children which would otherwise qualify for Medicaid based on income may not be eligible due to state-imposed assets test (i.e. countable assets must be less than $2,000 per family). Children who are not eligible for Medicaid because of the assets tests are eligible for participation in the CHIP program.

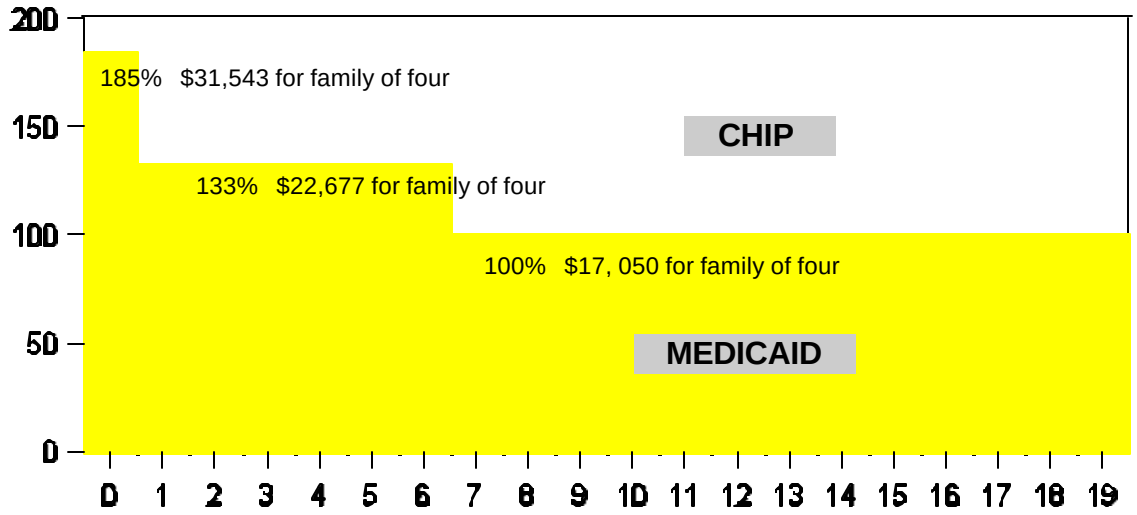
Each program has its own process for determining eligibility. CHIP has a single application, and the submission of between one to four verifications. Medicaid requires completion of

[3] Texas Health and Human Services Commission, Texas Medicaid in Perspective, Third Edition, February 1999.

between five and 19 forms, and the submission of between seven and 25 additional verification documents. CHIP allows either telephone or mail-in applications for children. Medicaid requires a face-to-face interview for both initial enrollment and re-certification. CHIP will have 12-month continuous eligibility. Medicaid requires re-certification at least every six months . CHIP does not have an asset test. As noted above, Texas limits assets to less than $2,000 per family. Even though the CHIP program provides insurance coverage to children with higher income levels than those served by Medicaid, the enrollment process for CHIP appears to have been streamlined to encourage enrollment.

Figure 28

Medicaid and CHIP Eligibility, 2000



Source: Health and Human Services Commission

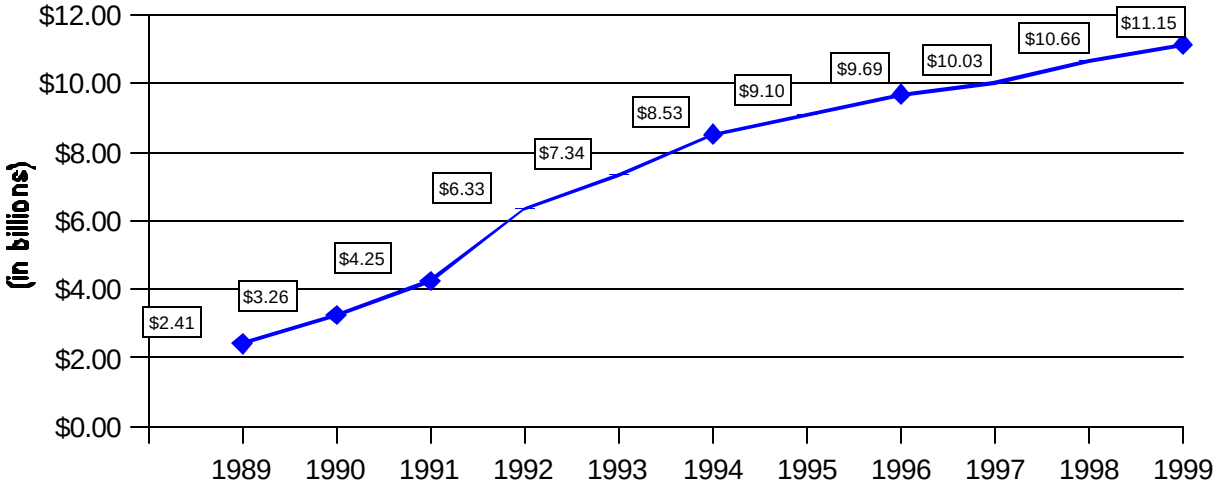
Even though the Medicaid enrollment numbers have been declining, the budget for this program has not, as shown by **Figure 29**.

A relatively small number of Medicaid's most vulnerable clients, the elderly and disabled, account for the greatest portion of costs. Children make up the majority of Medicaid recipients, but account for a relatively small portion of the expenditures. This is shown in **Figure 30**.

Finally, it is worth noting that the federal match rate for CHIP is about 12 cents on the dollar more than it is for Medicaid (74 cents for CHIP, 62 cents for Medicaid). It makes sense to enroll as many children as possible in CHIP. However, federal law requires that all Medicaid-eligibles must be enrolled in Medicaid. Even if parents want to choose CHIP for their children, they can not--it's Medicaid or nothing.

Figure 29

Texas Medicaid Expenditures: 1989-1999

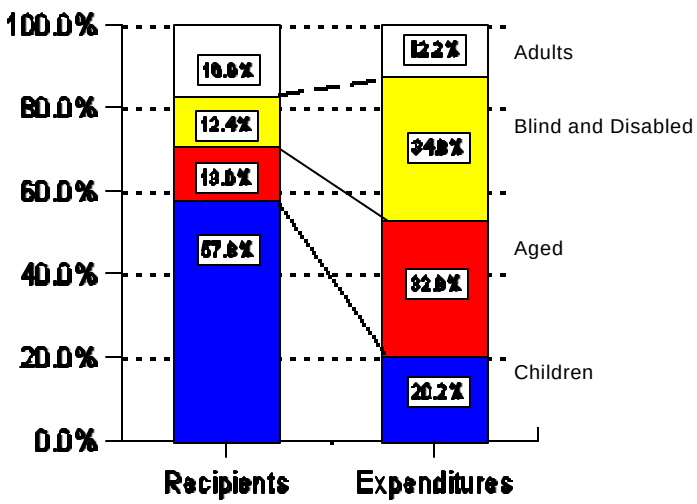


Source: Texas Department of Human Services

A recurring issue relating to Medicaid and CHIP, which was discussed at the public hearings, was the reimbursement rates. Many providers are concerned about the adequacy of the rates to even cover the cost of providing care. If reimbursement rates are not increased, it is likely that a number of providers will no longer be able to see Medicaid and CHIP clients. This could threaten the viability of the entire provider network in the state. Also, in February of 2000, HHSC convened the Border Rate Workgroup to study and recommend solutions regarding the Medicaid and CHIP reimbursement rates along the Texas-Mexico border. The workgroup's findings included:

Figure 30

Medicaid Recipients and Spending: 1998



- Texans living along the border have lacked the same level of access to health care providers and services that other parts of the state have received. The number of physicians per resident has historically been less along the border, and this has translated into an access problem for residents and lower levels of utilization; and

< Reimbursement for Medicaid managed care and CHIP capitation rates for specific areas are both based on historical information from claims paid to providers. Since utilization along the border was lower due to limited access, rates were calculated at a lower rate.

Subsection 3. Private coverage options using Medicaid and CHIP Funds

The state Medicaid program currently has about 3,000 clients participating in an employer-based program that Medicaid pays through the Health Insurance Premium Payment System (HIPPS). Using the program presents some challenges, including reconciling the Medicaid client's date of eligibility with the employees typical annual, one-month enrollment period.

Federal CHIP law allows states to use CHIP funds to buy family coverage offered through employers under limited circumstances. There are a number of restrictions. The coverage must be cost effective, meaning the cost of covering the entire family must be equal or less than the cost of enrolling only children. Also, the coverage cannot substitute for private coverage, and the employer must pay at least 60 percent of the coverage cost.[4]

[4] Health and Human Services Commission response to questions raised by Task Force, September 28, 2000.

SECTION III. HEALTH INSURANCE REGULATION[5]

Subsection 1. Federal Regulation

Employee Retirement Security Act (ERISA)

ERISA, a federal law passed in 1974, authorized employers to set up self-funded (as opposed to fully insured) health plans for the benefit of their employees. These plans are exempt from state regulation.

Health Insurance Portability and Accountability Act (HIPAA)

Under the federal law known as HIPAA, all states were required to enact certain provisions designed to improve accessibility and affordability of health insurance. Each state was allowed to enact its own version so long as certain minimum requirements are met. Prior to HIPAA, Texas had enacted many of the federal requirements related to guarantee issue and portability for small employer health benefit plans. Following HIPAA, some minor modifications were made to the law for these plans, and new provisions relating to guaranteed renewability and portability were added for large employer plans. HIPAA has helped some individuals with pre-existing conditions who change jobs maintain insurance, but only if they go from group coverage to group coverage. It has not helped make insurance attainable for those with pre-existing conditions who must go from group coverage to individual coverage. HIPAA also included other provisions in an attempt to increase health coverage: medical savings accounts and increased deductibility for the self-employed. Implementation of medical savings accounts has been limited to a few pilot sites thus far. Deductibility of insurance premiums for the self-employed will be increased to 100 percent by 2003.[6]

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[5] Taken from presentation by Texas Department of Insurance at December 16, 1999 Blue Ribbon Task Force meeting.

[6] Health Care Leadership Council, Message to the George W. Bush Administration on The Uninsured, January 2, 2001.

Subsection 2. State Regulation

Under legislation adopted by the Texas Legislature in 1997, Texas requires guaranteed issue and guaranteed renewability for all small employer plans (two to 50 employees). All health plans (large and small) must limit pre-existing condition exclusions to no more than 12 months. However, in some cases, pre-existing conditions will not apply if an individual has "creditable coverage" or "portability" under a previous health plan. "Portability" means an individual with pre-existing conditions must receive credit for time he/she had coverage under certain previous health plans. The pre-existing condition exclusion is reduced by one month for every month covered under the old plan. Federal law requires credit only as long as the break between health plans is no more than 63 days. State law, however, requires credit for any time during the preceding 12 months, even if there is a break in coverage longer than 63 days.

Texas law provides that premiums for individual health insurance must be reasonable in relation to the premiums charged. However, with a few exceptions in the small employer group plans, group health insurance premium rates are not regulated or subject to approval by the Texas Department of Insurance. Texas does not have a statute requiring community rating (i.e., all health insurance participants covered under a plan pay the same premium). However, community rating is required of all federally qualified HMOs. Within the small group market, a modified community rating structure exists that limits the premium differences charged between various groups covered under the same policy form. Plans are also limited in the premium increases they may impose both within the entire group of insured and within individual groups of policyholders covered by the same plan.

A number of inconsistencies and loopholes have been identified in the statutes which govern marketing small employer plans. These problems have resulted in certain small employers in Texas, particularly those with five or fewer employees, finding it increasingly difficult to obtain affordable health insurance. Two methods in particular have been used to minimize the likelihood of having to insure these groups:

< increasing rates for small employers based on their group size (regardless of health conditions present within the group) and

< modifying agent commission structures to remove the financial incentive for agents to market to these small employers.

Multiple Employer Welfare Arrangements (MEWAs)

MEWAs are benefit plans in which employees of more than one employer participate. In 1993, the Texas Legislature passed a law providing for licensure of self-funded MEWAs, as well as a few safeguards for plan participants. Since passage of the MEWA act, 13 MEWAs have been licensed to operate in Texas. Eight currently hold a license. TDI estimates that several hundred small employers have obtained coverage through MEWAs, but there are

various limitations which make it unlikely that MEWAs could provide coverage to a large number of Texans.

Texas Health Insurance Risk Pool (Risk Pool)

The Risk Pool became operational after Congress adopted HIPAA requiring states to guarantee portability to individuals leaving group coverage. The Risk Pool offers coverage for: (1) individuals who are "medically uninsurable"; (2) individuals leaving the group market who are eligible for "guaranteed portability" under federal law; (3) people who have been offered health insurance providing the same basic coverage as that provided in the pool but at a premium higher than the pool; and (4) individuals diagnosed with specific qualifying medical conditions. In addition, the dependents of an eligible individual may also enroll in the pool.

Premiums for Risk Pool coverage are limited to no more than 200 percent of comparable individual health insurance coverage. Losses to the Risk Pool in excess of premiums collected are paid through annual assessments on insurers and HMOs. Current enrollment in the pool was 6,659 in December 1999. Assessments for this past year totaled $18,200,000, more than 213% higher than $5,810,763 collected the previous year.

Health Insurance Mandates

Several groups have suggested that insurers should be allowed to sell health plans that do not include the mandated benefits as a way of providing more affordable health insurance for small employers. In response to this suggestion, the Texas Legislature adopted legislation in 1993 (amended in 1995) that allows small employers to purchase reduced benefit plans that exclude many of the mandated benefits.

Of the 86,000 plus small employers that purchased health plans in Texas in 1998, only 25 purchased the reduced benefit plans. When surveyed by TDI on why so few of these plans were purchased, virtually every insurer reported that employers were not interested in purchasing these plans.

The 76th Texas Legislature enacted legislation to establish a joint interim committee to study the 13 health care benefits mandated by law. The task force will not make any specific recommendations regarding mandates, but notes that the Milliman & Robertson finding that "the uninsured population would not change appreciably even if significant (e.g., 50%) reductions in health insurance premium rates could be achieved."[7]

[7] Milliman & Robertson, Inc. Cost Impact Study of Mandated Benefits in Texas. September 28, 2000. p. 104.

SECTION IV. UNINSURED HEALTH CARE COSTS[8]

The task force asked the State Comptroller's Office to determine if an estimate could be developed which reflected the total cost of health care spending on uninsured Texans. The Comptroller's office estimated that approximately $4.7 billion was spent for this purpose in fiscal 1998. The findings are summarized in **Figure 30**.

Figure 30

Texas Health Care Spending on the Uninsured: FY1998

		Method of Financing		
	Total Cost	**Local (8)**	**State**	**Federal**
Hospitals (1)				
Hospital Districts and other Local Hospitals	$ 1,637,327,000	$ 1,637,327,000	$ -	$ -
Texas MHMR Hospitals	$ 281,455,000	$ -	$ 281,455,000	$ -
Texas University State Teaching Hospitals	$ 203,664,000	$ -	$ 203,664,000	$ -
TDH Hospitals	$ 19,622,000	$ -	$ 19,622,000	$ -
Total	$ 2,142,068,000	$ 1,637,327,000	$ 504,741,000	$ -
Physician Charity Care (2)	$ 914,063,000	$ 914,063,000	$ -	$ -
Texas MHMR Community Centers (3)	$ 410,241,000	$ 72,467,000	$ 318,119,000	$ 19,655,000
University Physician Practice Plans (4)	$ 319,175,000	$ 319,175,000		
Selected TDH programs (5)	$ 240,852,000		$ 142,141,000	$ 98,711,000
Other Charitable Donations (6)	$ 166,845,000	$ 166,845,000	$ -	$ -
School District Health Expenditures	$ 160,180,000	$ 160,180,000	$ -	$ -
U.S. HHS Agencies (7)	$ 116,881,000	$ 116,881,000		
Local Health Agencies	$ 108,550,000	$ 108,550,000	$ -	$ -
DHS Non-Medicaid Long Term Community Care	$ 90,373,000	$ -	$ 19,977,000	$ 70,396,000
County Indigent Health Care Program	$ 38,908,000	$ 36,315,000	$ 2,593,000	$ -
Texas Alcohol and Drug Commission	$ 9,945,000	$ -	$ 995,000	$ 8,950,000
Total	$ 4,718,081,000	$ 3,531,803,000	$ 988,566,000	$ 197,712,000

[8] Taken from Information provided by the State Comptroller's Office to the Task Force at December 16, 1999 meeting.

This snapshot estimate includes an estimated $3.5 billion funded by local governments, private providers, and charities; $989 million funded by state agencies; and $198 million in aid received from the federal government.

Given the nature of health care programs, it often proves impossible to establish whether a program provides services for persons who have no insurance at all or for persons who are uninsured for a particular service.

Categories of Spending

According to a Texas Department of Health (TDH) survey, hospitals spent more than $2.1 billion, or 46 percent of the total, on uninsured and unreimbursed Medicaid services in fiscal 1998.

This figure includes spending by hospital districts and other local hospitals, Texas Department of Mental Health and Mental Retardation (MHMR) hospitals, Texas state university teaching hospitals, and TDH hospitals. These data come from a TDH survey of hospitals that serve Medicaid inpatients. TDH calculates the cost of treating the uninsured and unreimbursed Medicaid cases in Texas hospitals every year.

TDH adjusts these figures for inflation and to reflect hospital costs rather than charges. Costs represent the actual cost of providing health care services; charges are the amounts providers bill to patients or insurers. These adjustments are part of the process TDH uses to allocate Medicaid disproportionate share payments to hospitals.

The Medicaid disproportionate share program reimburses hospitals that spend a disproportionate share of their funds on indigent health care. Texas hospitals received more than $1.5 billion in state and federal Medicaid disproportionate share reimbursements in fiscal 1998, and can use this money for a variety of purposes.

Physicians provided an estimated $914 million, or 19 percent, of all charity care delivered in fiscal 1998. This information is based on a 1997 survey of physicians performed by the Texas Medical Association and MVA Research, Inc.

MHMR community centers spent about $410 million or nine percent on services to Texans in fiscal 1998 that were not reimbursed by any other payor, such as Medicare, Medicaid, private insurance, or patient funds. This figure is based on MHMR budget data.

University medical school physicians provide health care services in both inpatient and outpatient settings, allowing students and residents working with faculty physicians to receive hands-on training in the medical arts. These university physician practice plans provided at least $319 million (seven percent of the total in fiscal 1998) in funds that were not reimbursed by any other payor.

TDH provided funding for a variety of health care programs other than Medicaid, including Maternal and Child Block Grant programs, immunizations aid, and others primarily intended for low-income Texans. TDH funded about $281 million in these programs in 1998, or five percent of the total.

A variety of other charity care accounted for an additional $167 million, or four percent of the total. Texas hospitals received charity donations they reported in another TDH annual hospital survey for 1998; other charity care was provided by two Shriners hospitals and the United Way. In addition, some pharmaceutical companies reported spending on their own patient assistance programs.

The U.S. Department of Health and Human Services provides funding through the Health Resources and Services Administration and Indian Health Services for programs in local communities. In all, these programs provided an estimated $116 million, or two percent of the total.

Some Texas school districts purchase health care services for their students and related health care expenses not funded by other sources. The Texas Education Agency reports that school districts spent $160 million (three percent of the total) on unreimbursed health care services in fiscal 1998.

Local health agencies provide a variety of public health and health care services in their communities. These agencies spent an estimated $109 million, or two percent of the total, on unreimbursed health care in fiscal 1998.

The Texas Department of Human Services (DHS) spent about $90 million (two percent of the total) on long-term community care services for the elderly and persons with disabilities that were not funded by Medicaid, Medicare or other third party payors.

Counties that do not have hospital districts are required to report their medical expenditures as part of the state's County Indigent Health Care Program. In fiscal 1998, Texas counties in this program reported spending $39 million, or about one percent of the total.

The Texas Alcohol and Drug Abuse Commission spent an estimated $10 million (below one percent of the total) on methadone treatment and detoxification that was not reimbursed from other sources.

Previous Estimates

This estimate exceeds the estimate of $3.4 billion in uncompensated care in 1995 produced by the House Committee on County Affairs in 1998. The major reason for this variance is that the Comptroller's estimate includes $1.2 billion in charitable care from physicians and physician practice plans, as well as a more comprehensive identification of other sources of spending.

Per Capita Spending

The Census Bureau estimates about 4,880,000 Texans were uninsured in 1998, producing an estimate of almost $1,000 in per capita spending for the year.

Regional and Population Variances

It should be noted that Texas' health care spending on the uninsured is not distributed equally by population or geography. Obviously, some healthy uninsured Texans received no medical services in 1998, while a patient in a state hospital bed for a month used about $7,732 in services. Similarly, some Texas communities may spend more in federal, state, and local funds on health care for the uninsured than others, depending on the health care facilities in their area and the characteristics of their uninsured populations.

Uninsured versus Total Health Care Spending

The Comptroller's office is producing another study of total health care spending in Texas and estimates this spending totaled more than $70 billion in fiscal 1998. This study was requested by the Texas Institute for Health Policy Research, to facilitate their work with state and local community leaders on topics related to health care spending.

The total health care spending study lists unduplicated spending by purchaser. For example, it identifies the total amount spent by the state and federal government on Texas' Medicaid program and then eliminates Medicaid reimbursements from subsequently reported spending by state agencies such as MHMR. This ensures that each dollar is counted only once and that unreimbursed spending by each purchaser can be identified.

The present estimate, focusing on spending for the uninsured, involved a review of each spending category that selected the subset of programs addressing low-income persons and others most likely to be uninsured. It relies on unduplicated spending that has not been reimbursed from other programs, such as Medicaid, Medicare, and other insurers.

The uninsured study relies on one source of information not used in the total spending estimate, TDH's survey of spending on uninsured, and unreimbursed Medicaid cases. This is a more direct measure of spending for the uninsured. In the overall spending study, this amount is addressed primarily under Medicaid disproportionate share reimbursements to hospitals; state spending on MHMR services, TDH and university hospitals; and hospital district taxes and other local tax spending on hospitals.

The assumptions and specifics used in calculating these numbers can be found in the report titled Texas Estimated Health Care Spending on the Uninsured on the Comptroller's website at: **www.cpa.state.tx.us**

SECTION V. FUTURE CONSIDERATIONS

If the focus is on market-based solutions to the uninsured problem, most of the issues cannot adequately be addressed at a state level. It will require federal action to provide employers and their employees and/or individual consumers with incentives to make health insurance more affordable and a higher priority. Among the federal changes which the state should consider supporting are to:

< Provide tax credits for small employers;

< Provide flexibility to the states to create health care systems which meet the needs of their unique populations;

< Develop administrative consistency and simplification in health care sector to ensure majority of dollars are used to provide patient care; and

< Simplify Medical Savings Accounts to encourage their use.

SECTION VI. RECOMMENDATIONS

The task force is not recommending universal coverage for all Texans. The 77th Texas Legislature is already facing approximately a $600 million general revenue shortfall in the Medicaid program (about $1.4 billion in all funds) for the 2001 fiscal year. Most of this amount is expected to be recurring each year in the next biennium.

For the uninsured issue to be addressed will require federal changes--and even if those changes occurred, it is highly unlikely that the Texas Legislature, the various groups with a stake in the current health care system, or the people of this state would support the changes needed to develop a system of universal coverage. We do agree, however, that the state needs to take additional steps to try and get more people insured. Therefore, we recommend the following:

< Simplify the process for enrolling in Medicaid. As noted in the report, more than half of the uninsured live at or below 200 percent of federal poverty. HHSC estimates that over 600,000 children are eligible for Medicaid but not enrolled. Numerous people testified about the complexity and difficulty of trying to enroll their children in the Medicaid program. With the development of the CHIP program, and the simplified enrollment process for CHIP, the differences between the enrollment processes are impossible to reconcile. Even though this proposal will cost the state additional money for the Medicaid program, (which was developed to serve the "poorest of the poor") to try and deny children which the legislature deemed eligible simply makes no sense.

< Provided the enrollment processes of CHIP and Medicaid are standardized:

T Pursue a federal waiver to extend family coverage option under CHIP and Medicaid. The waiver would specifically request that family coverage be provided under employer-sponsored insurance if coverage of the family is cost-effective when compared to the coverage for the CHIP-eligible child alone.

T Pursue a federal waiver to allow a single enrollment process for CHIP and Medicaid clients which is seamless to the enrollee. The work should be initiated and completed by a private sector company.

T Pursue a federal waiver authorizing the use of Medicaid dollars to provide portion of employer-sponsored insurance coverage for TANF recipients

participating in welfare-to-work programs beyond the current period of transitional Medicaid benefits. To the extent that any family members are eligible for CHIP coverage subsequent to this, allow those premiums to be used for the continuation of employer-sponsored insurance coverage.

< Increase reimbursement for Medicaid and CHIP providers to ensure the stability and continuation of the provider network. Particular attention needs to be paid to reimbursement for providers along the border and in medically underserved areas in the state to ensure that access is maintained.

< Extend insurance coverage for dependents up to age 25 regardless of whether they are enrolled in higher education courses. Authorize the Commissioner of Insurance to set guidelines relating to any additional premium charged for coverage.

< Preclude insurance agent commissions from being calculated in such a way as to preclude Texas small employers from having full access to the small employer health insurance market.

< Authorize, encourage, and audit pilot projects across the state for local communities to design and implement local solutions to address indigent and uninsured populations. Re-examine the submission of the federal waiver that included components of Senate Bill 10 from the 74th Session which would have created state and local partnerships for health care delivery to Medicaid recipients and the indigent. The concept of giving local governmental entities the authority and responsibility for managing programs in their areas was a recurring theme heard by the task force.

< Pursue a federal waiver to expand coverage for Women's Health Services under Medicaid. The waiver would create a limited, non-entitlement family planning benefits under Medicaid for women whose incomes are below 185 percent of federal poverty.

< Require TDI to develop a rate guide for employers to use in comparing health insurance plans. Employers trying to shop around for the best price are often overwhelmed by the plan variations and cost differences among insurers.

< Require the Office of the Attorney General to pursue health insurance coverage, particularly CHIP, for children of divorced parents as part of the medical support order.

< Authorize TDI and any other state agency, subject to approval from the Legislative Budget Board and the Governor's Office, the authority to adopt necessary changes which may be required for the state to participate in federal programs adopted by the 107th Congress. This provision would only take effect if the Texas Legislature was not in regular or special session.

MINORITY REPORT OF THE BLUE RIBBON TASK FORCE ON THE UNINSURED

The Effects of Federal Policies

Over the past decade, virtually every state in the nation has made a major effort to insure its uninsured. Collectively, these efforts have failed. Nationwide, the percent of the population that is uninsured is higher today that it was in 1990.

One reason why state action has been so ineffective is that the most important government policies affecting uninsurance are federal government policies, over which state governments have little, if any, control. Perversely, federal policies actually encourage many people to choose to be uninsured rather than insured.

Federal policies also have other perverse outcomes that affect the state of Texas. In many cases, federal policies encourage people to choose public insurance (e.g., Medicaid and S-CHIP) rather than private insurance. Federal law also effectively prevents personal and portable insurance. And it prevents Texas from using its health care dollars in a way that would maximize health care outcomes.

Federal Tax Law. The federal tax law encourages all Americans to obtain health insurance through an employer by excluding employer payments for health insurance from the employees' taxable income. For a middle-income family, this means that health insurance fringe benefits escape, say, a 28 percent income tax and a 15.3 percent (FICA) payroll tax. For these families, the government is effectively paying for 43 percent of the cost of the insurance.

The subsidy is much less generous for those who earn lower incomes. For example, almost half the work force pays no income tax. For these employees, the federal tax exclusion is worth only the 15.3 percent saving in forgone payroll taxes. The reason why firms that employ low-skilled workers are less likely to offer health insurance to their employees is that untaxed health insurance (relative to higher taxable wages) is less attractive for these employees.

Whatever the reason, approximately 81 percent of Texas' small employers do not offer health insurance to their employees and if the employees purchase insurance on their own, they get virtually no tax relief. (See Figure I.) Thus for a large number of Texans, federal tax policy toward private insurance is one of indifference. There is no tax subsidy for those who insure; and no tax penalty for those who remain uninsured.

What is the alternative to having private insurance? People who do not qualify for public programs (e.g., Medicaid) must rely on their own resources and on charity care. As the majority report notes, Texas currently spends about $1,000 per year on free care for every uninsured person in the state, on the average. That implies that the value of "free" care is about $4,000 a year for a family of four.

Interestingly, $4,000 is an adequate sum to purchase private health insurance for a family in most Texas cities. Therefore, one way to look at the choice many Texas families face is: they can rely on $4,000 in free care (on the average) or they can purchase a $4,000 private insurance policy with aftertax income. Granted, the two alternatives are not exactly comparable. Families surely have more options if they have private insurance. But for many, the free care alternative will appear more attractive.

Federal Spending on Indigent Health Care. Although the federal government offers very little financial incentive for people to purchase their own insurance, it is a major source of funds for free care made available to the uninsured.

There are more than 40 federal programs that fund health services for the uninsured in Texas. The largest single program, spending more than $1.5 billion a year, is the disproportionate share hospital (DSH) payment program, designed to compensate hospitals that serve a larger than average number of indigent patients. Just over 60 percent of funds for the program in Texas come from the federal government. There are also programs for public housing residents, seasonal farm workers, legal immigrants and even undocumented immigrants.

Is there a way to redirect the money we now spend on free care in order to give people an incentive to be insured, rather than uninsured? For example, could Texas use some, or all, of its uncompensated care money and subsidize the purchase of private insurance for the families who currently rely on our indigent care system? Unfortunately, federal law makes this approach virtually impossible. In general, DSH money is money available only to offset unreimbursed hospital expenses. Other federal funding is similarly constrained.

Federal Subsidies for Public Health Insurance Programs. Approximately 1,781,000 Texans are insured under the state's Medicaid program and 239,000 children are insured under S-CHIP. Although managed by the state, these programs are created under federal law, and the federal government provides the bulk of the funding (60 percent of Medicaid and 73 percent of S-CHIP).

When Congress passed legislation creating Medicaid and S-CHIP, the clear intent was to provide insurance for those who would not otherwise be insured by the private sector. However, there is evidence that the expansion of these two programs is coming at the expense of private insurance. That is, people are dropping their private coverage in order to take advantage of their eligibility for public coverage. (See Figure II.)

It is not difficult to understand why. Families who obtain insurance coverage from an employer are benefitting from, say, a 15 percent (tax) subsidy; whereas families who qualify for public insurance enjoy a 100 percent (spending) subsidy. As a result, when people drop their private insurance and enroll in public programs, the cost to the taxpayer climbs from 15 percent to 100 percent. Thus taxpayers take on a major new burden, but little is accomplished in return.

Precisely because of the substitution of public for private coverage, the expansion of public programs is usually a very costly way to increase the number of people with insurance. For example, when Congress passed the S-CHIP program, the Congressional Budget Office (CBO) predicted large-scale substitution of public for private insurance. As a result, the CBO predicted that the cost of S-CHIP would be about $3,000 for each newly insured child, at a time when private insurance could be purchased for $500 or $600.

Under current federal law, there is not much the state can do to prevent this outcome. However, if the law were changed, states would be able to use their Medicaid and S-CHIP money to encourage private insurance instead. For example, rather than enrolling a child in S-CHIP, the same money (or some portion of it) might be used to pay the employee's share of the premium in a parent's employer-provided health plan. Such options would not only save money for the state, they would also be family friendly – allowing all members of the same family to enroll in the same health plan and see the same doctors and at the same facilities.

Federal Laws Preventing Portability. One of the disadvantages of our current system of employer-based health insurance is that employees must switch health plans every time they switch jobs. Even if they don't change jobs, once a year their employer can opt for a new health plan. And every change of health plans potentially means the employee will have to change doctors. As a result, it is a system under which there can be no continuity of care. Another problem is that when health plans are selected by employers, they will tend to meet the needs of employers rather than the needs of individual employees. The result is health insurance that is less valued by employees and less attractive to them.

An alternative to this arrangement is a system of personal and portable insurance. Employers could still pay the premiums (as they do now) in order to take advantage of the federal tax subsidy. But the insurance could be owned by the employees and they could take their insurance with them as they move from job to job on their journey through the labor market. An example of such a system is a proposal developed by the National Center for Policy Analysis and Blue Cross/Blue Shield of Texas.

An obstacle to implementing such a system is the Health Insurance Portability and Accountability Act (HIPAA). Although advertised as enabling portability at the time of its passage, HIPAA in fact makes portability impossible. The reason is that HIPAA (combined with the provisions of ERISA) makes it impossible for employers to purchase individually owned insurance for their employees.

Federal Obstacles to the Efficient Use of Public Health Care Dollars. Texas communities receive health care funding both from the state and from the federal government. These funds flow through such programs as Medicaid, S-CHIP, DSH, etc. However, each of these programs has its own set of rules, narrowly prescribing how the funds may be spent. The result is that local communities have no power to allocate resources in ways that would maximize their impact.

For example, in one community the greatest return on health care spending may come from fluoridating the water supply. In another community, the greatest return may come from improving sanitation. Yet local communities have no authority to use their diverse health care funding to achieve these goals.

An example of a community that is adversely affected by such restrictions is El Paso. As Table I shows, El Paso (upper Rio Grande) has low utilization of Medicaid per Medicaid-eligible person, but high spending for uncompensated care per uninsured person.

As a result, El Paso's low-income population overutilizes hospital care and underutilizes outpatient care. The city and its people would be better off if it were free to reallocate funds from inpatient to outpatient care. But restrictions on the use of funds apparently make this option difficult, if not impossible.

Ideally, cities like El Paso should be able to combine their funds for Medicaid, S-CHIP and DSH and freely allocate those funds so as to achieve maximum health impact.

Recommendations

The Texas Legislature should by means of resolution call on the federal government to enact changes in policies that would:

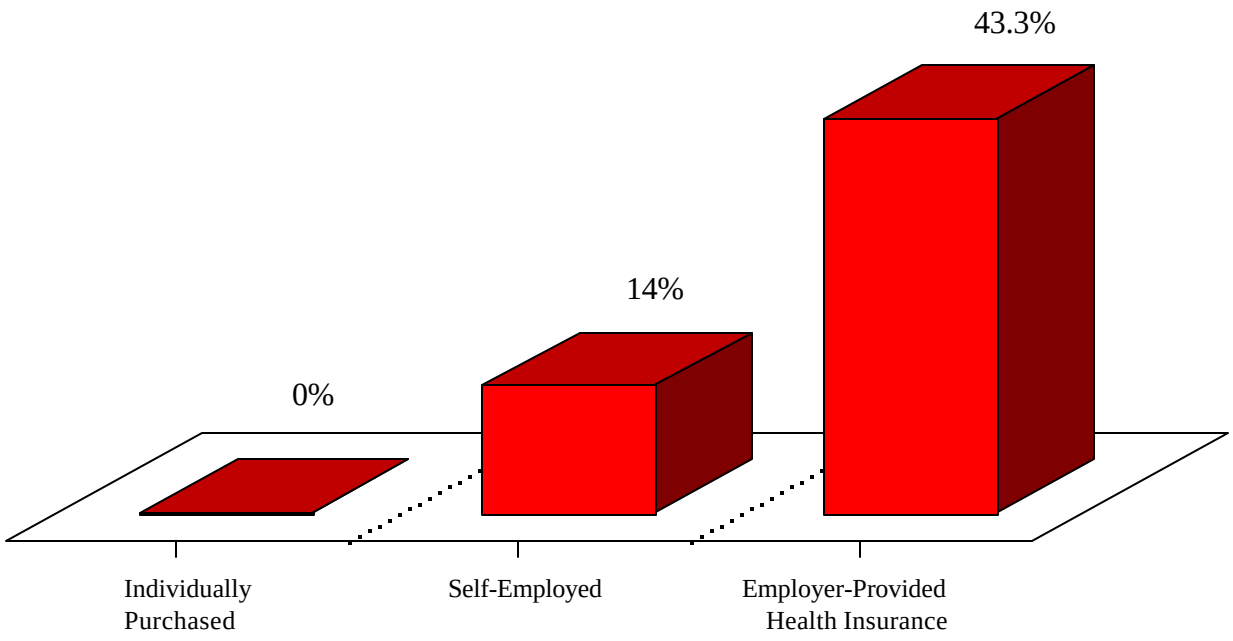
- Allow the state of Texas to combine all federal and state health care dollars currently being spent on health care for low- and moderate-income families and allocate those funds without restriction so long as the money is spent on indigent health care.

- Allow the state of Texas to use funds now available through Medicaid, S-CHIP, DSH and other programs to subsidize private insurance instead.

- Allow the state of Texas to give employers the opportunity to purchase individually owned, personal and portable insurance for their employees without tax penalty.

Figure I

Federal Tax Subsidies for Health Insurance

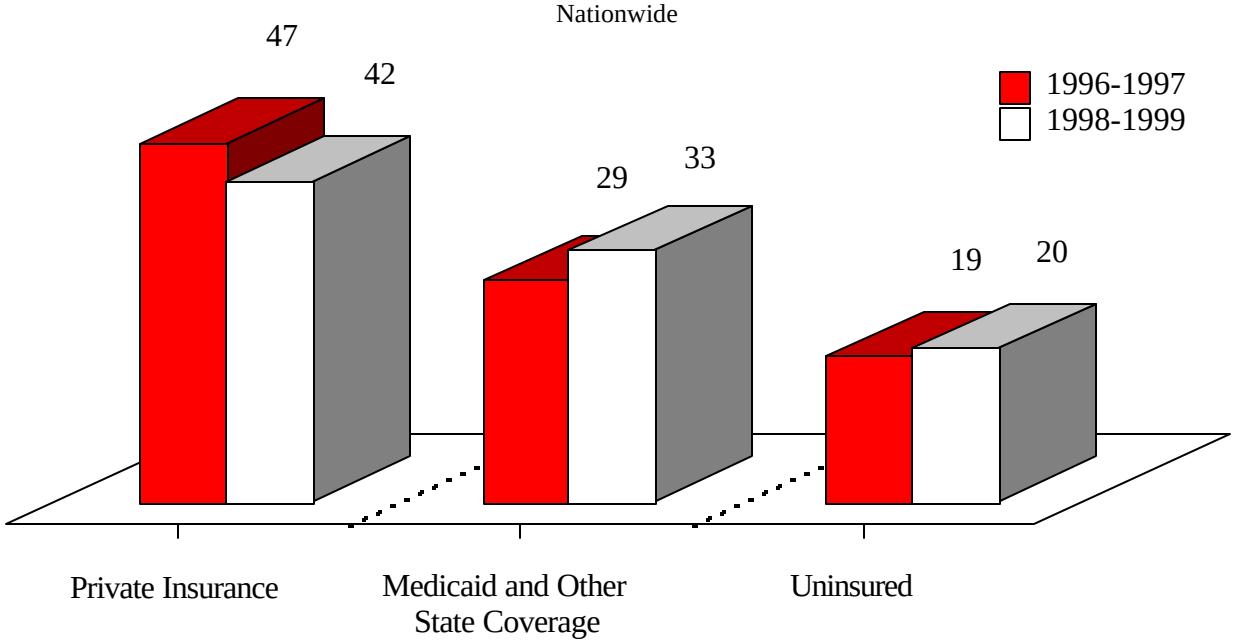


Note: Assumes taxpayer is in 28% bracket. Individually purchased insurance is not tax-deductible. Self-employed workers can deduct 50% of cost of a policy (tax rate of 28% x 50% = 14%). The employed workers save 28% federal income tax and 15.3% FICA on employer-sponsored health insurance (28% + 15.3% = 43.3%).

Figure II

Health Insurance Coverage of Low-Income Children

Nationwide



Note: 5% in 1996-1997 and 6% in 1998-1999 had other public coverage such as Indian Health Services.
Source: Center for Studying HealthSystem Change

A Proposal to Create Personal and Portable Insurance in Texas

How can the purchase of health insurance be changed to allow greater consumer satisfaction with the health care coverage? This is a proposal to combine the advantages of individual insurance with the advantages of group insurance and avoid the disadvantages of both. This new, hybrid form of insurance will be called New System Plans (NSPs). Employers who assist their employees in entering NSPs through the payment of premiums will be called Defined Contribution Employers (DCEs).

The Advantages and Disadvantages of Group Insurance. The advantages of group insurance are (1) employers' premiums are paid with pretax dollars; (2) economies of scale in purchasing; and (3) avoidance of the costs of underwriting. However, because such contracts are typically only one year in duration, the insureds have no reasonable expectation that if they get sick they will be able to see the same doctor or remain in the same network the following year. Employers can choose a different plan with different benefits and different provider networks. Also, employees eventually lose the right to continue participation in the plan if they quit work or are fired.

The Advantages and Disadvantages of Individual Insurance. The advantages of individual insurance are (1) guaranteed renewability (once in a health plan, insureds have the right to remain there indefinitely); (2) premium increases reflect the costs of the plan as a whole and not the changes in health status of individual members; and (3) the insurance is portable (unaffected by job changes). The disadvantages of individual insurance are (1) premiums must be paid with aftertax dollars (except for a partial deduction for the self-employed); (2) higher administrative costs; and (3) the costs of medical underwriting.

Combining the Advantages of Individual and Group Insurance and Discarding the Disadvantages of Both. Texas law should be changed to allow employers to buy personal and portable insurance for their employees. Even though employers initially would pay the premiums (as they do today), this insurance would be owned by the employees and would travel with them as they move through the labor market. Thus employees would get portable insurance (a characteristic of individual insurance), but they would get it at premiums that are closer to the norms of group insurance.

Evolution of the System. Although it is envisioned that employers initially will buy all their employees into the same NSP, with the passage of time some of those employees will leave and go to work for other firms. Employers will also hire new employees who are members of other NSPs. And, in most cases, the employer's initial group of employees will be able to switch to other NSPs after a transition period. The typical defined contribution employer, therefore, can eventually expect to have employees in different NSPs. Indeed, it is possible that every employee will be in a different NSP.

Source: National Center for Policy Analysis.

Table I

Spending on Medicaid and Uncompensated Care in Texas

1998

	Uncompensated Care				Medicaid			Total Care			Regional
	Number of Uninsured	Uncompensated Hospital Care *	Uncompensated Physician	Spending Per Capita**	Medicaid Eligible	Cost of Care	Spending Per Capita	Medicaid Eligible & Uninsured	Total Expenditure	Per Capita Cost	Average Variance
High Plains	**181,301**	**$81,266,048**	**$34,677,838**	**$640**	**99,668**	**$314,232,120**	**$3,153**	**280,969**	**$430,176,006**	**$1,531**	**$109**
Northwest	**110,881**	**$102,621,438**	**$43,790,608**	**$1,320**	**67,311**	**$297,876,430**	**$4,425**	**178,192**	**$444,288,475**	**$2,493**	**$1,071**
Metroplex	**1,394,754**	**$565,182,731**	**$241,174,707**	**$578**	**376,823**	**$1,256,551,9**	**$3,335**	**1,771,577**	**$2,062,909,4**	**$1,164**	**($258)**
Upper East	**241,743**	**$113,353,301**	**$48,370,107**	**$669**	**123,461**	**$491,178,158**	**$3,978**	**365,204**	**$652,901,566**	**$1,788**	**$366**
Southeast	**145,464**	**$42,192,887**	**$18,004,544**	**$414**	**103,067**	**$400,186,448**	**$3,883**	**248,531**	**$460,383,878**	**$1,852**	**$430**
Gulf Coast	**1,113,003**	**$597,689,268**	**$255,045,893**	**$766**	**430,086**	**$1,177,985,0**	**$2,739**	**1,543,089**	**$2,030,720,1**	**$1,316**	**($106)**
Central Texas	**424,106**	**$132,887,808**	**$56,705,870**	**$447**	**183,163**	**$709,836,236**	**$3,875**	**607,269**	**$899,429,914**	**$1,481**	**$59**
Upper South	**506,804**	**$243,995,560**	**$104,117,756**	**$687**	**284,757**	**$828,812,633**	**$2,911**	**791,561**	**$1,176,925,9**	**$1,487**	**$65**
West Texas	**138,687**	**$61,056,518**	**$26,054,030**	**$628**	**71,986**	**$236,872,893**	**$3,291**	**210,673**	**$323,983,441**	**$1,538**	**$116**
Upper Rio	**33,954**	**$53,308,195**	**$22,747,666**	**$2,240**	**139,530**	**$293,177,276**	**$2,101**	**173,484**	**$369,233,137**	**$2,128**	**$706**
Lower South	**554,734**	**$148,516,868**	**$63,375,100**	**$382**	**444,934**	**$1,133,040,0**	**$2,547**	**999,668**	**$1,344,932,0**	**$1,345**	**($77)**
Total Texas Average	**4,845,431**	**$2,142,070,622**	**$914,064,119**	**$631**	**2,324,786**	**$7,139,749,2**	**$3,071**	**7,170,217**	**$10,195,884,**	**$1,422**	

Source: Texas Medicaid Expenditures by County, and uninsured care are based on estimates from Texas Department of Health

* Based upon 1998 Texas Department of Health analysis of unreimbursed cost

** Unreimbursed physician care is allocated based upon the proportion of uncompensated hospital care in each region. (does not include $319,174,000 in uncompensated physician care at university hospitals.)

*** Does not include $65.87 per capita in uncompensated physician care provided at university hospitals.

BORDER HEALTH

Texans in the Border region (defined as the 43 counties closest to the Texas-Mexico Border) suffer from a seriously inadequate health infrastructure. In this area of great population growth and high unemployment, environmental pollution and lack of fiscal resources combine to perpetuate this situation. While other parts of the state and nation benefit from the prosperity realized from increased trade with Mexico, the Border region has not. In fact, if ranked as the "51st" state, the 43 Border counties rank dead last in the U.S. in per capita income. Yet with 80% of the nation's southern truck traffic passing through Border ports, these are the very communities that are the first to feel the adverse public health effects of that increased trade. Even before the enactment of the North American Free Trade Agreement, the Border region lacked an adequate public health infrastructure, and the latter half of the 1990s has not seen enough progress to deal with increasing health needs.

In May 2000, 81 percent of the Border region's counties were wholly designated as "Medically Underserved Areas" (MUAs), with an additional 14 percent recognized as partial MUAs. In non-Border Texas, 67 percent of whole counties were MUAs, and 20 percent of counties were partial MUAs. Another designation that is used in federal and state programs is the concept of "Health Professional Shortage Areas" (HPSAs). In July 2000, almost all (95 percent) of Border counties were recognized as mental health HPSAs, compared to 74 percent of non-Border counties. For primary medical care, about three-fourths of Border counties were wholly designated as HPSAs, compared to half of non-Border counties. Lower availability of various kinds of health professionals in the Border region can be seen in the following chart:

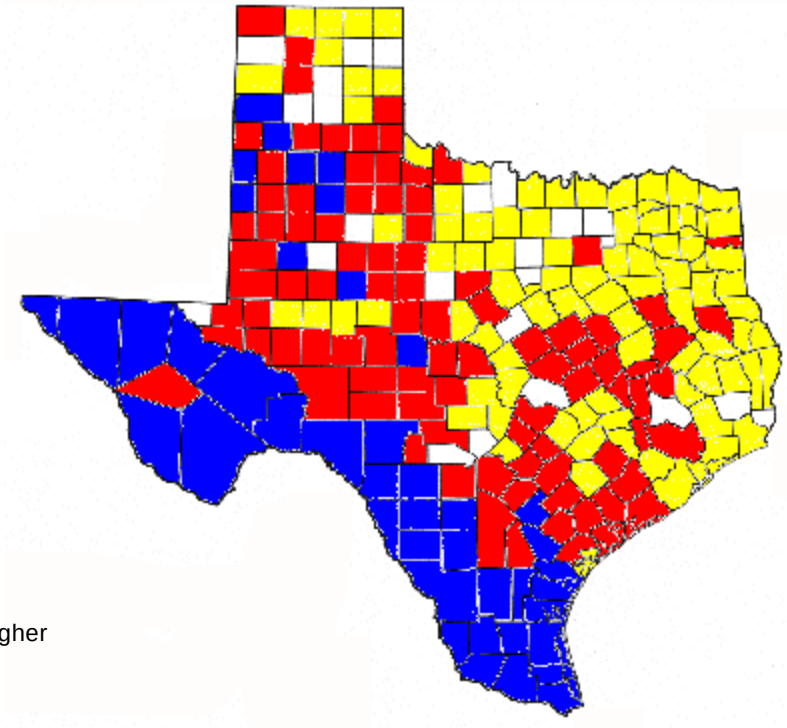
Texas Border Medical Infrastructure

	Texas-Mexico Border Counties	Rest of Texas
Population (1999)	4.1 million	15.8 million
In Poverty (1999)	1.1 million (27.8%)	2.2 million (13.7%)
Direct Patient Care Physicians (1999) (per 100,000 Population)	124.7	147.8
Primary Care Physicians (1999) (per 100,000 Population)	57.0	65.9
Registered Nurses (1999) (per 100,000 Population)	536.2	610.0
Dentists (1999) (per 100,000 Population)	31.4	42.9
Optometrists (1999) (per 100,000 Population)	8.0	11.1

Source: The University of Texas System, Texas-Mexico Border Health Coordination Office, Texas-Mexico Border Counties 1998: Demographics and Health Statistics, October 1998.

Not surprisingly, shortages of health professionals are accompanied by shortages in health care facilities. The Texas-Mexico Border Health Office of the University of Texas System reports that in 1994, the Border region had 34 acute care hospitals, compared to 434 located in the rest of the state, and 60 nursing homes, compared to 1,069 for the rest of the state.

Percent of Texans Under 65 without Health Insurance in 1999



Source: Texas Health and Human Services Commission

Given the lack of medical infrastructure, access to health care remains a challenge for many residents of the Border region. This situation is compounded by the lack of health insurance. A 1998 University of California at Los Angeles survey reported that El Paso County, with 39% of its population uninsured, has the largest number of non-elderly individuals not covered by health insurance in the country. In addition to the high number of working poor adults in the Border region who cannot afford health insurance, Texas now has an estimated 1.4 million uninsured children. The Border region is home to more than a quarter of this young uninsured population. In El Paso alone, there are an estimated 72,797 children without health insurance.

Although the state is working to alleviate this issue through the Children's Health Insurance Program (CHIP) and Medicaid managed care, the current reimbursement rates for these programs exacerbate the lack of health infrastructure. Under the current Medicaid Managed Care and CHIP Programs, reimbursement rates are determined by reviewing the utilization rates of each area or region of the state. Unfortunately, any geographic area with limited access to health care facilities and providers

will produce low utilization rates. Access is limited in the Border region because there is a lack of adequate medical infrastructure. Further, many of our citizens get medical care in Mexico, so these costs are never captured. The following chart demonstrates to some extent these disparities.

Reimbursement Rates for Medicaid Managed Care and CHIP
Across Texas
FY 2000 Rates

		RISK GROUPS		
Area	Avg. State Rate	Pregnant Women	Total Newborns	CHIP Phase II
Houston	$ 192.70	$ 648.91	$588.10	$ 86.60
Austin	150.39	546.69	455.14	68.06
Dallas	153.00	646.38	322.45	75.33
Ft. Worth	186.16	621.93	477.64	75.33
San Antonio	136.12	592.89	415.11	64.02
Lubbock	143.39	560.76	417.65	66.84
El Paso	115.96	594.26	360.31	63.96

Source: Texas Department of Health, FY 2000 Managed Care Renewal Rating, July 30, 1999, and Texas Health an Commission, Phase II, CHIP HMO Premium Rates, 4/28/00.

As Medicaid managed care is rolled out across Texas, low rates will extend to many other areas of the state and compound disparities already extant in San Antonio, Laredo and the Valley. For no other reason than historical precedent, physicians in one part of the state will be unjustifiably expected to cover a greater burden of the expense of caring for patients than their counterparts in other areas.

This policy does not make sense, nor will it motivate providers to continue serving Border cities or to open new practices in the least medically served counties in the United States. This rate disparity undermines health infrastructure in precisely those areas of the state where communities depend heavily on a health care safety net. In effect, by maintaining high rates in affluent areas of the state, Texas effectively subsidizes quality care in high per capita areas on the backs of the least affluent areas of the country which are most in need of care.

Equal pay for equal work is a value we enforce everywhere but the Texas Border. In a host of issues, from reimbursement rates to child care rates and wage rates on Border projects, our state is an active partner in perpetuating Border poverty. By persisting in past practices of paying low rates and wages, Texas itself reduces Border per capita income, already the lowest in the nation. The result is an inevitable migration of talent and capital to areas of better pay and more opportunity.

In addition to the current reimbursement rate issue, poor socio-economic conditions and the emerging implications of trade further burden the health conditions of Border residents. Tuberculosis rates in El Paso are already above the state average and threaten to increase dramatically given the incidence

of drug-resistant tuberculosis in Juarez. The rise in infectious diseases such as TB not only poses problems for Border populations in the short term, but also poses a long term threat to any area that is a destination for NAFTA traffic. Even though dengue fever is not endemic to the United States, outbreaks have occurred along the Texas/Mexico Border in recent years.

Given that existing water and sewage systems have failed to keep pace with Border population growth, residents of colonias and other Border communities also face the threat of viral infections from water pollution and contamination. In Juarez, Chihuahua, a city of 1.7 million inhabitants located where the Rio Grande enters Texas, over 65 million gallons of raw sewage are dumped daily into the river. Due to substandard sanitary conditions, many Border residents are at risk of contracting the gastrointestinal virus Hepatitis A. In 1995, El Paso had the highest number of Hepatitis A cases among the 14 counties along the Border. Environmental pollution is taking its toll on Border health as well. The Texas Department of Health (TDH) reports that there is a high incidence of anencephaly in counties bordering the United States and Mexico. While a link between the increased presence of toxins and the incidence of anencephaly has not yet been proven, studies have demonstrated a correlation between high/low volumes of maquiladora activity and high/low incidence of anencephalic babies. Furthermore, according to a survey conducted by the Texas Health and Human Services Commission of Medicaid Diagnosis Related Groups (DRG), billing records for the Border region show above average expenditures for a variety of respiratory illnesses for both adults and children. According to TDH and other studies, smoke produced by various sources, such as items burned for heating fuel by low-income residents of both countries, vehicle exhaust, open fires and industrial smoke stacks, significantly detracts from air quality and particularly affects residents' respiratory health.

Finally, nowhere have Texas barriers to Medicaid enrollment exacted a higher toll than in the Border region. With an arbitrary and lengthy enrollment process, a difficult assets test, and agencies without adequate bilingual staff, Texas has kept many thousands of Border families off the Medicaid rolls. The Border region has more than 720,000 Medicaid qualified residents, many of whom have not enrolled in the program. This has significantly contributed to an Hispanic population that is 50% uninsured in the state of Texas. With 84% of net increases in the Texas population set to occur in minority populations, this rate of uninsured Hispanic Texans will have a direct and adverse effect on Texas' health and human services budgets, local health resources and most importantly, the quality of life of Border families.