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"Serving Humanity to Honor God"

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THE TEXAS HEALTH CARE PRIMER

REVISED 2011

CPPP CENTER *for* PUBLIC POLICY PRIORITIES

CPPP Center *for* Public Policy Priorities

The Center for Public Policy Priorities is a 501(c)(3) non-partisan, nonprofit policy institute committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. CPPP pursues this mission through independent research, policy analysis and development, public education, advocacy, coalition building, and technical assistance. We pursue this mission to achieve a **BETTER** TEXAS.™

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METHODIST HEALTHCARE MINISTRIES
OF SOUTH TEXAS, INC.
"Serving Humanity to Honor God"

Methodist Healthcare Ministries is a faith-based, 501 (c)(3), not-for-profit organization whose mission is "Serving Humanity to Honor God" by improving the physical, mental and spiritual health of those least served in the Southwest Texas conference area of The United Methodist Church. MHM supports policy advocacy and programs that promote wholeness of body, mind and spirit.

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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

The Texas Health Care Primer
Updated March 2011

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

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

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Table of Contents

Suggestions for Further Reading

Another publication by CPPP with the support of Methodist Healthcare Ministries, entitled ***Texas Top Five: Key Steps to Make the Most of Health Reform***, is available online at www.cppp.org/files/3/MHM_shortpaper_4page_new.pdf. This brief report identifies decisions that Texas must make to properly implement health care reform.

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

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

Center for Public Policy Priorities. *What Every Texan Should Know: Health Care Reform Law.* June 2010. www.cppp.org/files/3/2010_09_June_WhatsIntheLaw.pdf

Center for Public Policy Priorities. *What Is a Health Insurance Exchange?* March 2, 2011. www.cppp.org/files/3/HealthFactSheet_InsExchange_Cove_0227.pdf

Institute of Medicine, National Academy of Sciences. *Insuring America's Health: Principles and Recommendations.* 2004. www.iom.edu/Reports/2004/Insuring-Americas-Health-Principles-and-Recommendations.aspx

Institute of Medicine, National Academy of Sciences. *America's Uninsured Crisis: Consequences for Health and Health Care.* 2009. www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx

Medicaid and CHIP Payment and Access Commission. *Report to the Congress on Medicaid and CHIP.* March 2011. www.macpac.gov/reports

Conclusion

This primer presents a brief but broad picture of health care in Texas to enable readers 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 job-based benefit and consumer out-of-pocket expense; and a major fiscal challenge for taxpayers and all levels of government serving 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.

Nationally, signs of progress can be seen, even just one year after the enactment of national health care reform. But this update comes in the middle of a legislative session during which Texas is still reeling from the effects of a global economic recession. In the face of an historically large revenue shortfall of at least 27%, legislators are considering massive cuts in 2012 and 2013 to Medicaid, CHIP, and other public health programs which would severely harm Texans' access to health services and leave billions of federal dollars for health care unspent.

These state cuts to health care are being considered even though Texas already ranks very low on almost any measure of state or local government per capita health spending, and also ranks poorly on indicators such as the share of uninsured residents or residents living in poverty. But even if some of the worst cuts to Medicaid or CHIP are reduced or avoided entirely, 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.

The picture painted by this primer should help you to understand the full implications of health care access 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.

Foreword

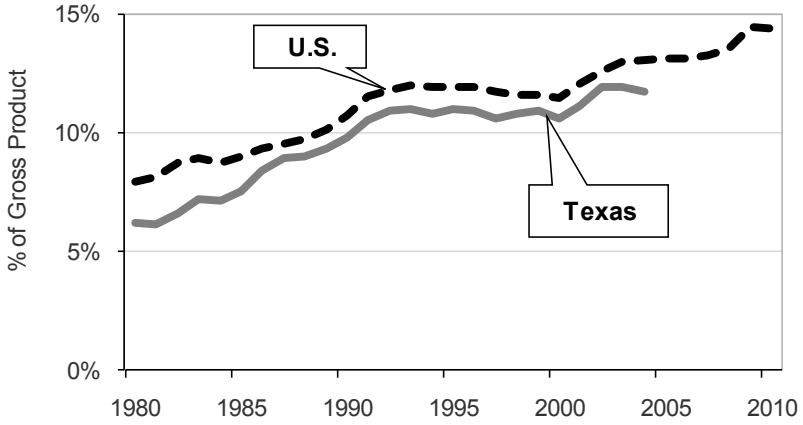
The Center for Public Policy Priorities (CPPP) and Methodist Healthcare Ministries (MHM) are pleased to release another update of our *Texas Health Care Primer*. The primer was first issued in 2003 and has been reprinted and distributed electronically to thousands of readers. As two nonprofits working 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.

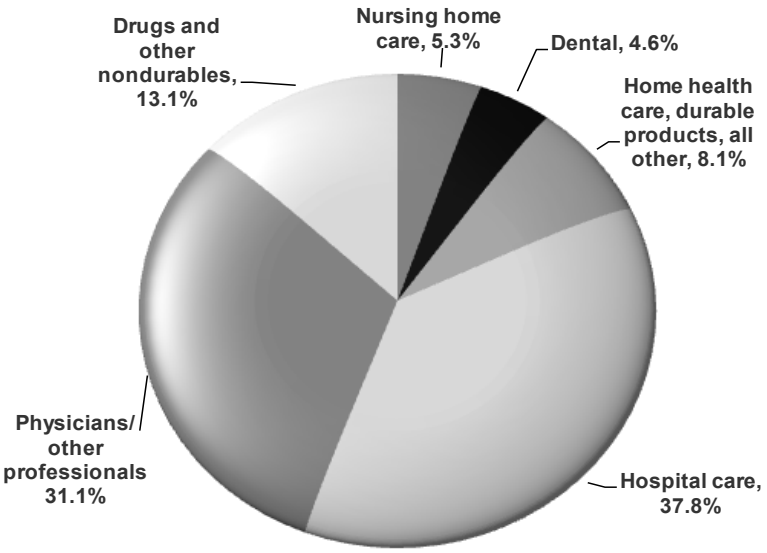
Another goal of this primer is to paint a picture beyond the numbers and facts conveyed. Knowledge brings responsibility. We hope that the knowledge in this primer will prompt readers to reach into their hearts and not only find compassion, but ask: Is this the kind of society in which I want to live? 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.

Personal Health Care Expenditures as a Percent of the Economy, 1980 to 2010



What is Bought with Texas Health Care Dollars, 2004: $105.5 billion total



SOURCE: U.S. projections for 2009-10 are from September 2010 estimates. State Health Accounts data, February 2007, Centers for Medicare and Medicaid Services.

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 2003 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 Dr. Perryman include higher health insurance premiums and other health care costs, and decreases in retail sales and other private-sector economic activity.

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 public programs) 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.

Health Care: The Economic Context

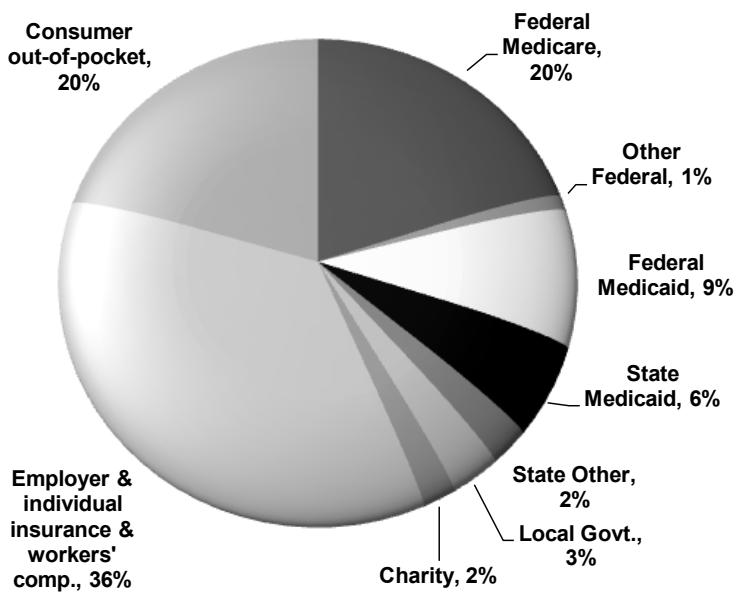
In 2004, the $105.5 billion spent on personal health care in Texas accounted for 11.7% of the Gross State Product (GSP). As shown in the top chart, health care spending became a much larger part of the Texas economy during the 1980s. It stabilized in 1993-95 at 11.0% of GSP and decreased slightly after 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 would therefore not only reduce the need for local government funding of indigent care programs, it would also increase the economic impact of the health care industry.

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

Estimated Sources of Funding for Texas Health Care in 2004: $105.5 billion total



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.

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. Families USA estimates that annually, almost 2,150 working-age Texans die prematurely due to a lack of health coverage.
- When hospitalized, the uninsured get fewer and substandard services than those provided to the insured. They are also often charged more than 2.5 times what people with insurance (and therefore, negotiated discounts) are billed for hospital services.

One study estimated that in 2007, almost two-thirds (62%) of bankruptcies were due to medical bills, unaffordable mortgages to pay for health-related debt, and income loss due to illness or injury. 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.

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.

How is Health Care Paid For in Texas?

Personal health care spending in Texas totaled $105.5 billion in 2004, the latest year for which estimates are available. Private and public employers (36% of health care spending) and individual consumers (20%) combined paid 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.

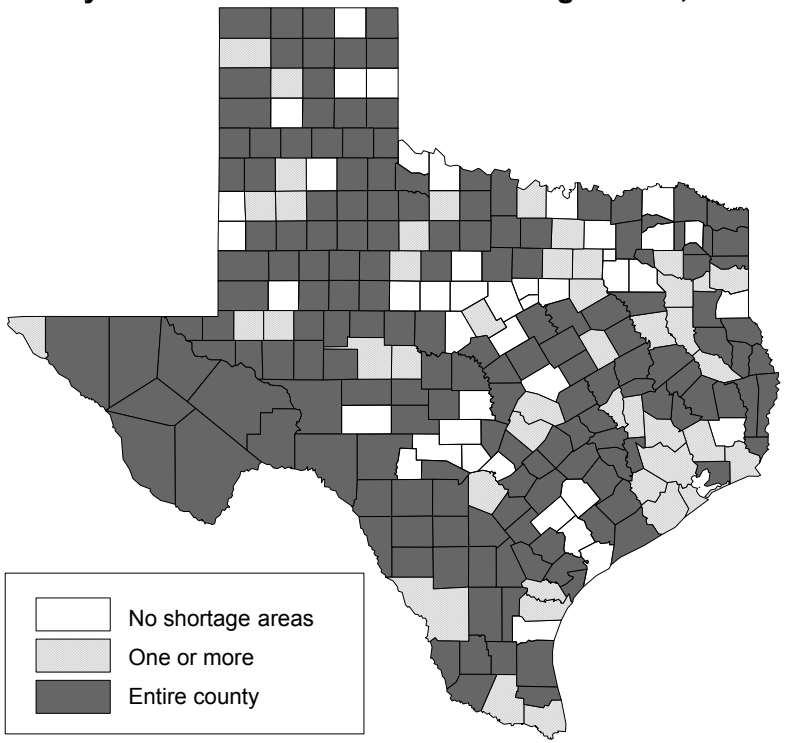
"Charity" consists of public and private hospital charity care; physician charity and bad debt; pharmaceutical companies' charity programs; and medical services funded by nonprofit groups. It is not the same as all health care spending for the uninsured. According to a survey by the Texas Department 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, 2008	250	270	27th
EMTs and paramedics, 2009	56	71	39th
Physicians, 2008	246	326	40th
Registered nurses, 2009	678	840	44th
Dentists, 2008	53	77	45th
Dental hygienists, 2009	42	57	46th

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

Primary Care Health Professional Shortage Areas, 2010

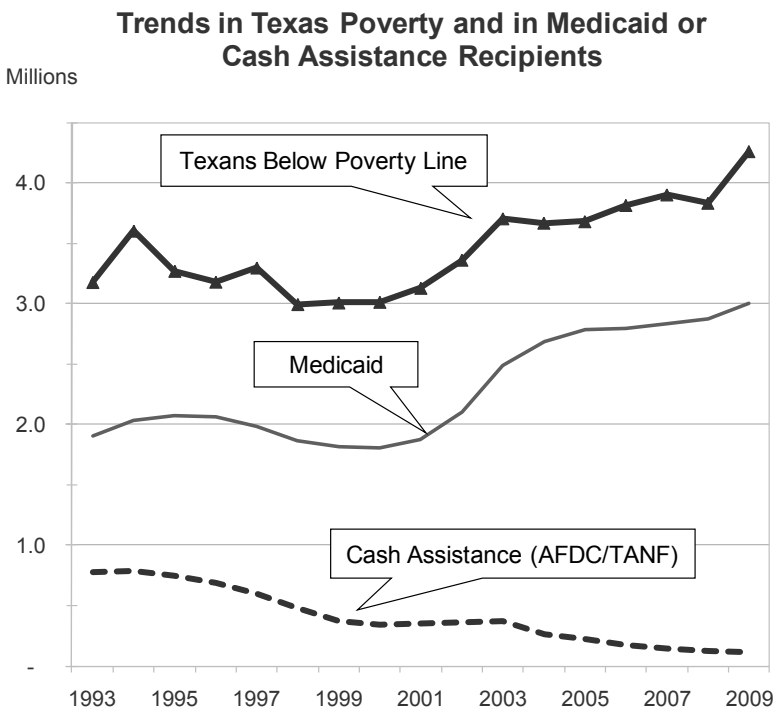


Health Care Access Issues for Children and Adults Receiving and Leaving Cash Assistance

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.

While Texas Medicaid enrollment has grown since 2001, AFDC/TANF cash assistance caseloads have plummeted since 1994. In November 2010, of the Texas Medicaid caseload of 3.2 million people, fewer than 1% were adults on TANF, and fewer than 4% were children on TANF. Another 66% were other low-income children, 1% were foster children, 9% were elderly, 16% were adults or children with a disability, 4% were pregnant women, and fewer than 1% 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 2010, Texas' average monthly managed care cost for a Medicaid disabled/blind recipient was $684, over four times the cost for nondisabled Medicaid children ($165 per month), and more than twice the cost for TANF parents ($311 per month).



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.

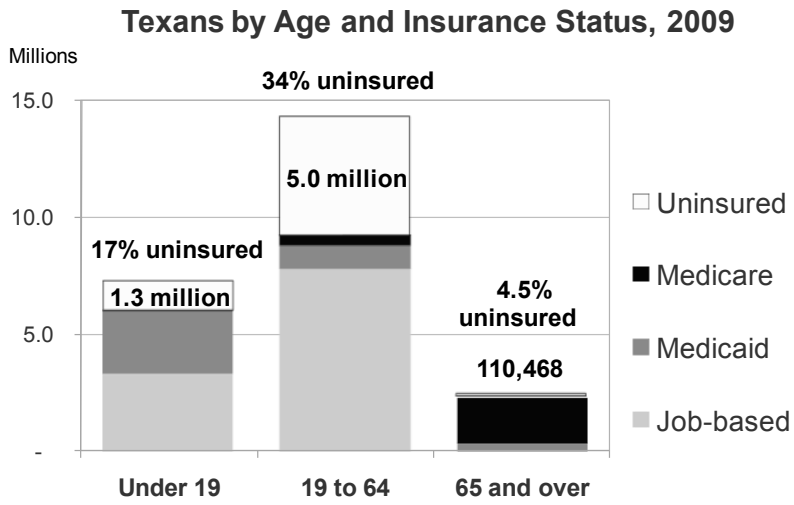
How does the State's Health Care Infrastructure Compare to Other States?

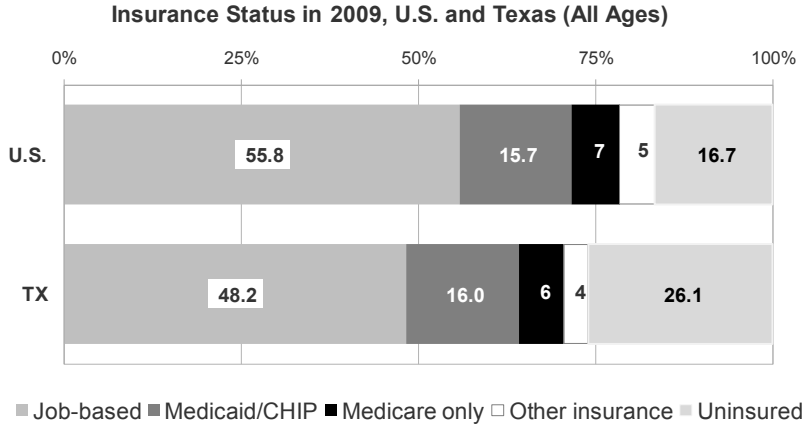
Compared to other states, Texas has a relative scarcity of certain kinds of health care professionals. The table at left shows Texas ranking in the bottom third of states when the number of physicians, nurses, dentists, and other health care personnel is adjusted for the total population of the state.

Even with the lower rates of health care personnel, however, health care jobs are an important part of the state economy. Private-sector health care services employed almost 1,116,000 Texans in 2009, with combined annual earnings of $62 billion. Health services' share of Texas' private-sector earnings is 10.2%, slightly higher than their share of private-sector jobs (9.4%). Texas state and local governments employed another 128,800 health and hospital workers in 2009, with an estimated annual payroll of $6 billion.

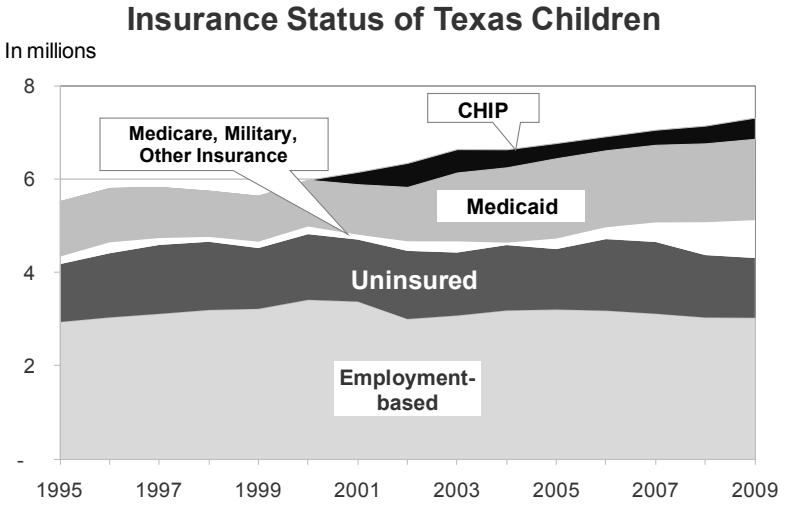
Analyzing the state's health care infrastructure requires looking below the state-level data to the local availability of health care professionals. Federal designations such as "Medically Underserved Area" or "Health Professional Shortage Area" are used to identify regions where health professionals are in short supply. In November 2010, 66% of Texas counties, or 168, were wholly designated as primary medical care shortage areas; 109 counties were dental care shortage areas; and 194 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 November 2010. ("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, 2010. Top chart does not show the small amount of people covered by federal military health care or non-employer-based private insurance, shown in the bottom chart as "other insurance." Top chart includes CHIP coverage in the "Medicaid" category for Texans under 19.



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.

SOURCES: U.S. Census Bureau, Annual Social and Economic Supplement 1995-2010; Texas Health and Human Services Commission.

Public Health Safety Net Finally Begins to Work Again for Children: Despite growth in the total number of uninsured Texans between 2008 and 2009, the number of uninsured children in Texas actually declined from 1.331 million to 1.275 million. Like adults, children continued to lose coverage through employer-sponsored insurance, but increased coverage through CHIP and Medicaid have more than made up for that loss.

A combination of higher recession-driven eligibility and notable improvements in state eligibility and enrollment systems have yielded a substantial increase in children's Medicaid and CHIP enrollment. In the last half of 2009, Texas' enrollment system reduced delays, errors, and backlogs, allowing the children's insurance safety net to perform as it should and helping families in need during hard economic times.

Health Care Access Issues Specific to Children

Children make up a larger share of Texas' population than they do of most other states. In 2009, 28% of Texans were under 18, compared to the U.S. average of 24%, giving Texas the second youngest population. Children in Texas are also much more likely to be poor and uninsured. Texas had the 7th highest child poverty rate in 2009, at 24.4%, and the highest share of children (under 19) uninsured in 2008-09, at 18%—well above the U.S. average of 10%.

In absolute terms, employer-based insurance coverage for Texas children peaked in 2000 at 3.4 million. By 2009, 383,000 fewer children had employer-based coverage, compared to the coverage levels seen before the 2001 economic recession.

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, child enrollment had reached 1.82 million. However, it fell to 1.72 million by October 2006 because of problems with the eligibility determination system, and remained relatively flat for two years. In October 2008, as the effects of the Great Recession began to be felt in Texas, children's Medicaid enrollment began a steady climb, reaching 2.3 million in Fall 2010. Almost 3 million children are projected to be enrolled by 2013.

Changes made by the 2003 Texas Legislature to the Children's Health Insurance Program (CHIP) reduced the number of children served and the benefits package. CHIP enrollment began in Texas in May 2000 and climbed rapidly, peaking at about 529,000 in May 2002. 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. Starting in September 2007, CHIP enrollment resumed steady growth, reaching the pre-2003 levels by November 2010 (527,4300 enrolled).

Who is Insured?

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

Three-fourths of Texans do have health insurance, primarily through their employer or a government program—Medicare or Medicaid. **Residents aged 65 or over** are the most likely to be insured. In 2009, 91.2% of Texans 65 and over were covered by Medicare; only 4.5% of senior Texans lacked insurance of any kind in 2009.

Among **working-age Texans (19 to 64)**, the primary source of coverage is employment-based insurance, covering 52% of these adults. But because Medicaid and Medicare coverage for working-age adults is low (7% and 3%, respectively), Texans in this age group are the most likely to be uninsured (34% in 2009). Among Texas **children**, 45% were covered because a family member had employment-based insurance, and the remainder had Medicaid or CHIP coverage (37%) or no insurance at all (17%) in 2009.

Nearly two-thirds of Texas uninsured children have incomes below the CHIP income limit of 200% of the federal poverty line. Adjusting for undocumented immigrant children who are excluded from Medicaid and CHIP, this means roughly half of Texas uninsured children qualify for these programs but are not enrolled.

Texas has the highest uninsured rate—26.1% in 2009—in the nation. The U.S. average is 16.7%, or almost 50.7 million uninsured nationwide. Over 6.4 million Texans were uninsured in 2009.

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

For example, a March 2009 Families USA study estimates that nationally, 33% of nonelderly Americans—86.7 million people—were uninsured for all or part of 2007 and 2008. Of these uninsured people, three-fourths (74.5%) went without coverage for 6 or more months. One-fourth (25.3%) of the 86.7 million were uninsured for the entire 24-month period. Persons who go for longer periods without insurance tend to have lower incomes, be in fair or poor health, or be middle-aged (who have higher rates of chronic disease).

For Texas, Families USA estimated that about 9.3 million nonelderly individuals—44% of all residents under 65, the highest rate in the U.S.—were uninsured for some or all of 2007 and 2008. Almost 81%, or 7.5 million, of these Texans went without coverage for 6 months or more. Most (83%) were part of family with one or more workers.

The 9.3 million nonelderly Texans who experienced a spell of being uninsured over a 24-month period in the Families USA study is much larger than the state's 6.3 million nonelderly uninsured in the 2010 Current Population Survey, because the pool of Texans with no insurance includes people who remain uninsured for long periods of time, as well as others who regain coverage at some point. But, while some Texans uninsured in 2007 regained coverage in 2008, a new group of different individuals lost coverage in 2008. To sum up: Texans are at higher risk than other Americans of being uninsured for both short and longer periods.

Within Texas (see chart at right), the estimated percentage of non-elderly residents with no health insurance is highest in communities along the U.S.-Mexico border, and in the metro areas of Houston, Dallas, and Fort Worth. Border-area economies are more likely to lack the type 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).

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

State Policy Debates: Bills filed during Texas' most recent legislative sessions have 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's business community support comprehensive immigration reform. While it is clear, based on bills already filed for the 2011 session, that debate of these issues will continue to take place, it is not clear whether any significant changes in state 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. (Prior to that date, legal immigrants already had to provide their official immigration documents to enroll in Medicaid.)

The 2007 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.

Provisions in the 2009 federal reauthorization of the Children's Health Insurance Program allow states to use the federal Social Security Administration database to electronically verify U.S. citizenship. The Texas Health and Human Services Commission was slated to begin using this in February 2011.

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

The Children's Health Insurance Program Reauthorization Act of 2009 gave states the choice to provide Medicaid and CHIP to legal immigrant children *without* a five-year delay, triggering language in Texas law directing the state to take the federal funding should it become available. Texas expects to fully implement the shift to covering lawfully present children in Medicaid and CHIP with full federal match in 2011.

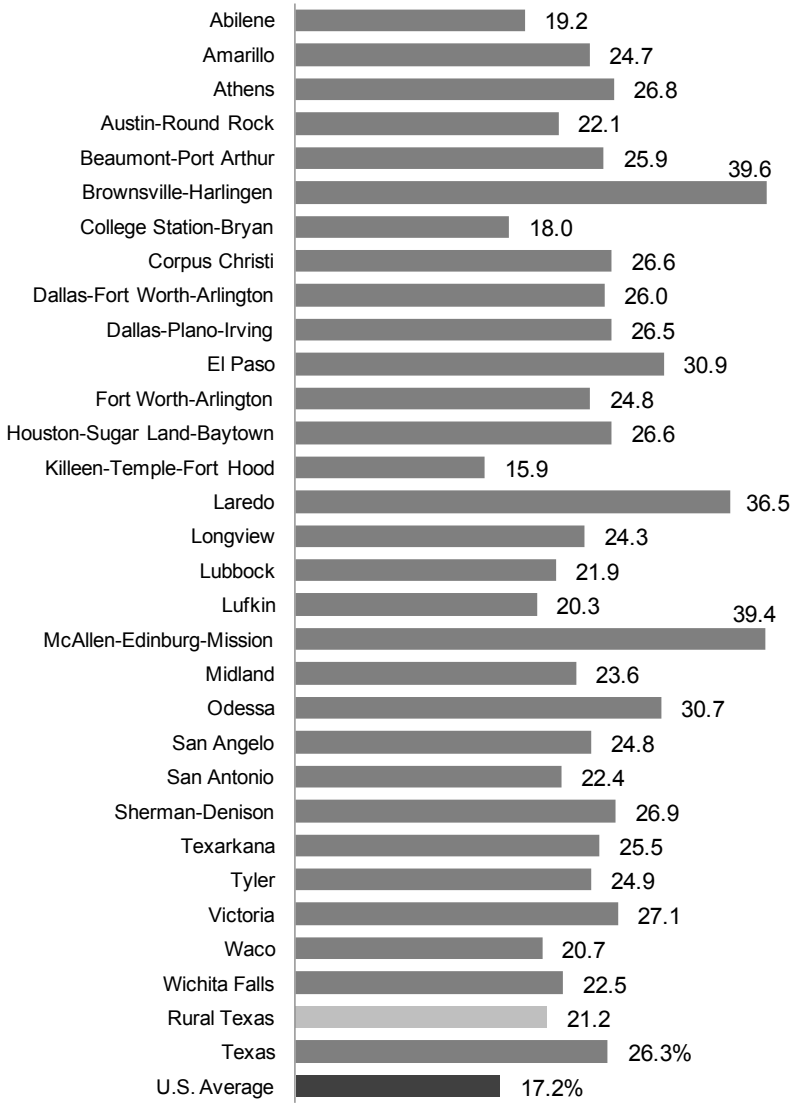
Undocumented Immigrants: The estimated 1.45 million to 1.75 million undocumented immigrants living in Texas face numerous barriers to health care access. Undocumented immigrants have never been eligible for Medicaid or CHIP, and in 1996, federal welfare reform further restricted undocumented immigrants' access to certain other federal public benefits.

National health reform under the Affordable Care Act of 2010 does not provide for any additional access to public or private health insurance coverage for undocumented immigrants.

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."

Nonelderly Residents With No Health Insurance, 2009



SOURCES: U.S. Census Bureau; 2009 American Community Survey. Uninsured rates are shown for the under-age-65 population by Texas micro– and metropolitan statistical area or division.

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, 2009	9.4%	10.5%
Workers represented by a union, 2009	5.1%	13.6%
Private-sector workers in a union, 2009	3.1%	7.2%
ASSOCIATED WITH LESS ACCESS		
Involuntary part-time workers as % of part-time labor force, July 2008	14.6%	14.3%
Agriculture/mining jobs as % of all jobs, 2009	2.8%	1.8%
Construction jobs as % of all jobs, 2009	8.8%	6.8%
Percent of workers in low-wage jobs, 2008	24.4%	24.1%
Percent of business employment in 2008 accounted for by firms		
with fewer than 20 employees	22.9%	24.7%
with fewer than 50 employees	39.5%	41.2%

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

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: one-fourth of all Texas children live in "mixed families" (one or more parent is a non-citizen, either legal or undocumented), and one-third of Texas children in low-income families (below 200% of the poverty line) are in mixed families.

Immigrants Not the Cause of Texas' Uninsured Ranking: As mentioned earlier, immigrants, whether legal or unauthorized, are much more likely to be uninsured than are U.S.-citizen residents. But if state estimates are adjusted to remove non-citizens from the equation, Texas still ranks worst in terms of uninsured residents, with 4.7 million children and adults—21.4% of the population—lacking health insurance in 2008-09. In comparison, California's U.S.-citizen uninsured rate is 14.5%; New York's is 11.9%.

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

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

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

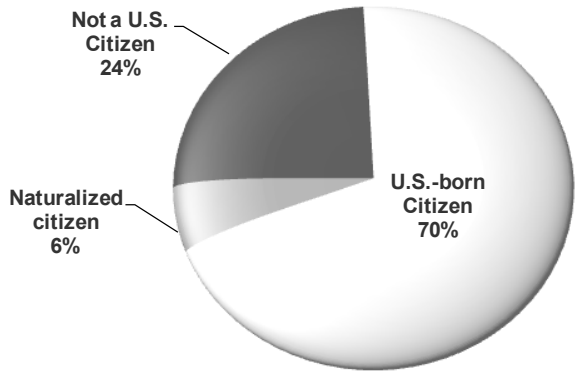
Immigrants in General: Texas has 3.8 million foreign-born residents, the third largest number of immigrant residents (after California and New York) among the states. Immigrants in Texas are much less likely to be insured through Medicaid, Medicare, or any other source of coverage than are native-born residents.

About 1.2 million foreign-born residents of Texas have become naturalized U.S. citizens. They are uninsured at a higher rate (31%) than are U.S.-born residents of Texas (22%).

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

Compared to other large states with similar demographics, Texas has by far the highest percentage (over 32% in 2005) 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

Citizenship Status of Uninsured Texans, 2009
(Total: 6.4 million)



SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.

Who has Employer-Based or Other Private Insurance?

In 2009, 50% 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 59%. (Only New Mexico had a lower rate of employer-based insurance coverage.) Making matters worse, ever since the 2001 economic downturn, the trend has been for a smaller share of Texans to get health insurance through their job. In 1999, 61% of Texans under 65 had employer-based health coverage, compared to 68% of Americans on average.

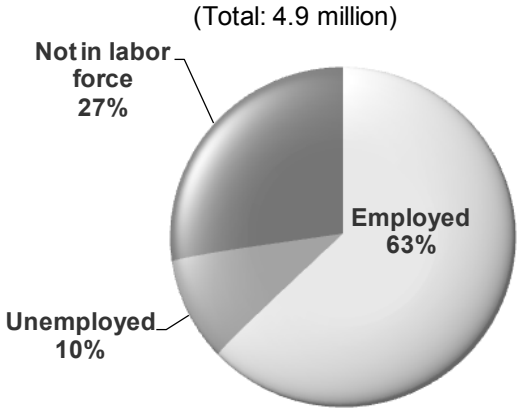
Texans at private firms with up to 24 employees were most likely to lack coverage: 47% of workers at these small employers were uninsured in 2009. At firms with 25 to 99 employees, 36% of workers were uninsured. Even at firms with 100 to 499 employees, though, 27% of workers were uninsured. Thus, Texas' 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.

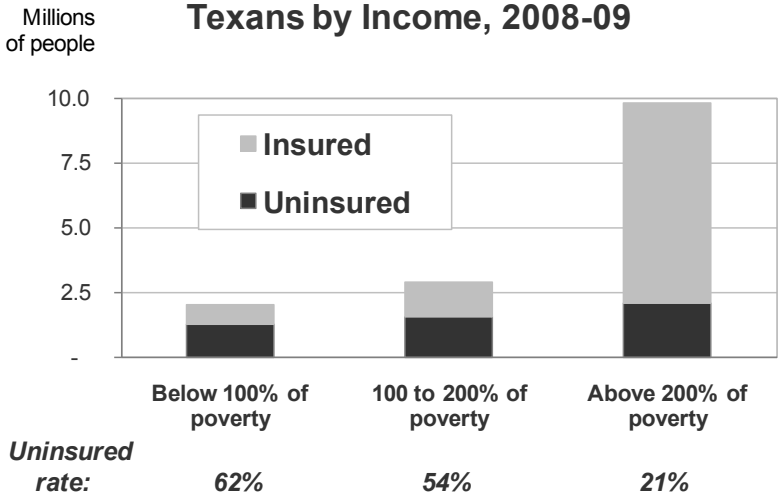
Employers who provide health insurance benefits to their workers, and the workers who receive them, got federal tax subsidies totaling $151 billion in 2009, according to the federal Office of Management and Budget.* In comparison, Medicare outlays in 2009 totaled $437 billion; Medicaid and the Children's Health Insurance Program cost $269 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.

Working-Age Texans with No Health Insurance in 2008-09



Insurance Status of Working-Age Texans by Income, 2008-09



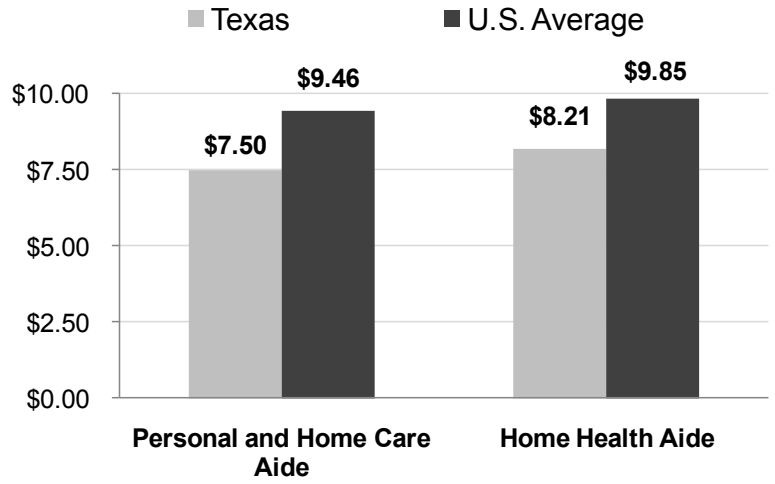
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement 2009 and 2010. "Working-Age" is defined as 19 to 64 years old, so these charts exclude workers who are under 19, or 65 and over.

Texans 65 and over have a poverty rate of almost 12%, compared to 9% for elderly Americans on average, in 2008-09. Texans aged 65 and over were also 1.2 times as likely as senior citizens nationwide in 2009 to have a self-care difficulty, ambulatory difficulty, or cognitive difficulty.

Finally, quality of care is an issue in Texas, which has median wages for personal and home care aides and for home health aides that are not much higher than the federal minimum wage ($7.25 an hour in July 2009).

SOURCES: AARP Public Policy Institute; U.S. Census Bureau, American Community Survey and Current Population Survey, Annual Social and Economic Supplement 2009 and 2010.

Median Hourly Wages of Home Care Workers, 2009



SOURCE: U.S. Bureau of Labor Statistics, Occupational Employment Survey May 2009.

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, helping many seniors but creating the "donut hole" problem for others. This is a gap in coverage that beneficiaries with high drug costs face. The Affordable Care Act of 2010 began closing the "donut hole" in 2010 and will completely eliminate it by 2020.

Remaining policy challenges include out-of-pocket costs that grow faster than retirees' fixed incomes; the impact that federal deficits may have on the Medicare program; and access to affordable and quality long-term care. 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 medical costs; otherwise, they have to find another way to pay for their medical bills. The Affordable Health Care Act may also help some adults who become disabled by creating a voluntary long-term care insurance program by October 2012.

Various indicators point to unmet needs in Texas for health care for the elderly, and for the elderly and disabled, than in the U.S. on average. For example, Census Bureau data show that in 2008-09, only 90% of 62–to-74-year old Texans were insured, compared to the U.S. average of 95% for this age group.

Who is Working and Uninsured?

A popular misconception is that only people who are jobless lack health insurance. It is true that 57% of **unemployed** working-age Texans in 2008-09 were uninsured, versus 29% of **employed** Texans who were uninsured. However, being employed still leaves working-age Texans with a 29% chance of being uninsured. Another way to look at the same statistics: the employed account for almost two out of three uninsured working-age Texans (see top chart at left).

Several factors explain why so many working Texans are uninsured. One is that limits on Medicaid eligibility in federal law have excluded 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 have further limited 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 state income requirements for adults. Texas Medicaid only covers parents with incomes below 20% of poverty, or $308/month for a working parent with two children. At the minimum hourly wage of $7.25, working even 11 hours a week would disqualify a parent from continuing to receive Texas Medicaid.

In 2009, when statewide unemployment averaged 7.6%, one-third of Texas adults under 65 were low-income (below 200% of poverty, or $36,620 for a family of three). Most low-income workers have earnings that are not low enough to fall below the Medicaid adult income cap, but not high enough to enable workers to buy health insurance for themselves or their dependents, even if their employer is willing and able to share the cost. Half (54%) of working-age Texans between 100 to 200% of poverty were uninsured in 2008-09, compared to 62% of those below 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 (2.0 million) than among the poor (1.25 million) or other low-income (1.6 million uninsured). In 2008-09, 21% of working-age Texans above 200% of poverty had no health insurance.

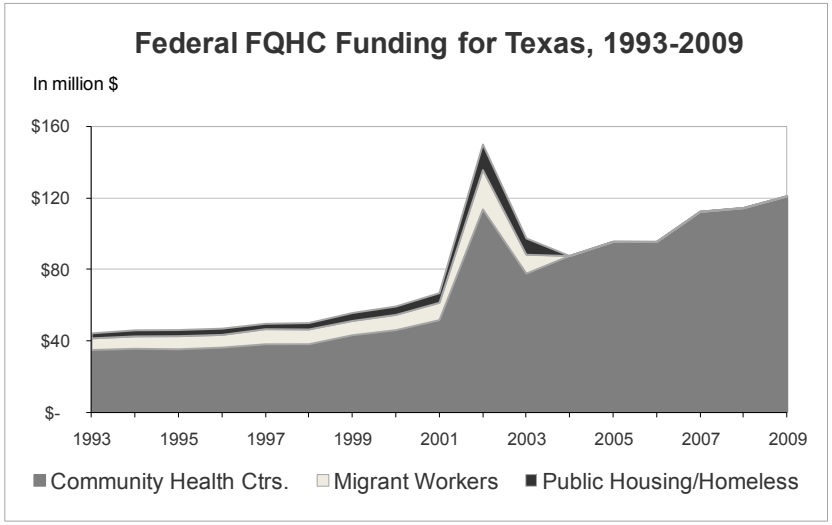
Monthly Household Budget, Two Parents/One Child, 2007

	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.

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

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



How FQHCs were Funded, 2009

(% from each source)	Texas	U.S. Average
Federal Grants	28.0%	21.9%
Medicaid	25.5	37.1
Medicare	4.5	5.9
Other Public Insurance	3.1	2.9
Private Insurance	3.5	7.3
Patient Self-Pay/Fees	9.4	6.0
Foundation/Private Grants/Contracts	6.6	3.9
State/Local Grants/Contracts	16.9	12.1
Other Revenue	2.5	2.9

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

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 are cited often as a key part of federal plans 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 received federal funds through various programs created over the years: Community or Migrant Health Centers; Health Care for the Homeless; Public Housing Primary Care; and Healthy Schools, Healthy Communities. These were consolidated into one "cluster" which brought $121 million to Texas in 2009. This is a significant increase from $44 million in 1993, but federal FQHC grants are still only 0.1% of Texas health care spending.

In 2009, 65 FQHC grantees served almost 904,000 Texans throughout the state. About 56% 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 government grants, 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 September 2010, Texas FQHCs could be found in 102 counties.

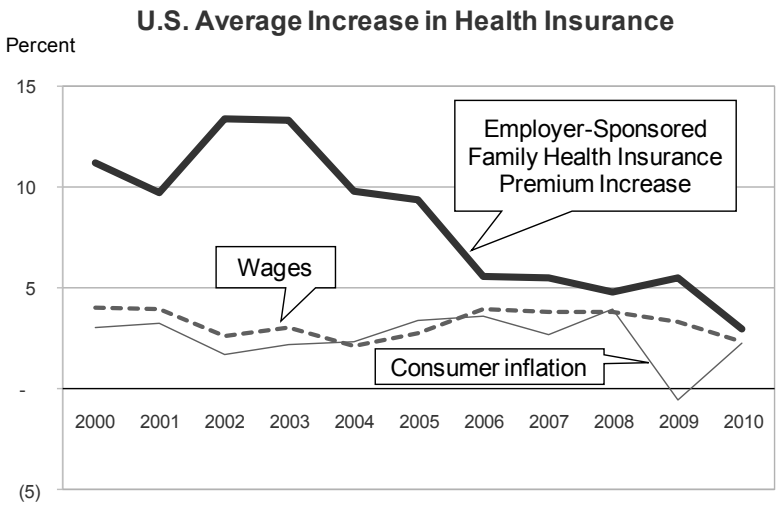
Why More People Don't Buy Health Insurance on Their Own

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

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

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

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



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

	Monthly	Yearly	Increase from Prior Year (percent)
2002	$ 663	$7,954	12.8%
2003	756	9,068	14.0
2004	829	9,950	9.7
2005	907	10,880	9.3
2006	957	11,480	5.5
2007	1,009	12,106	5.5
2008	1,057	12,680	4.7
2009	1,115	13,375	5.5
2010	1,148	13,770	3.0

SOURCE: Kaiser Family Foundation/HRET Surveys of Employer Sponsored Benefits, 1999-2010.

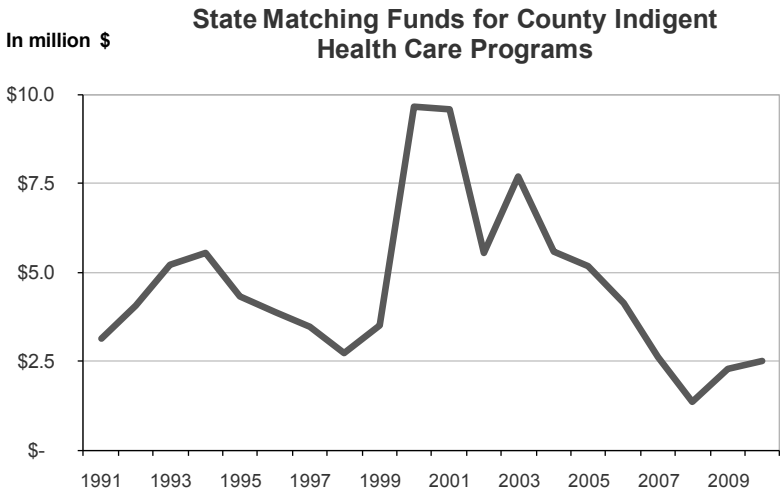
What is the Counties' Role in Providing Health Care?

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 a car) and with an income below 21% of the poverty line. In 2011, this means an ***annual*** income of less than $2,287 for one person, or $3,891 for a family of three. The household's countable resources cannot exceed $3,000 if an elderly relative or someone with a disability lives in the home, or $2,000 for all other households.

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

Depending on which option they choose and who is served, counties may also receive state and federal funding for their indigent care services. Counties with indigent health care programs can qualify for state assistance if they spend more than 8% of their general tax revenue on state-approved basic and optional health services that are medically necessary. However, the state assistance fund has never been large enough to reimburse all counties' eligible spending, and has provided even less help since 2000-01 because of state budget cuts. In fiscal 2010, the state assistance fund made only $2.5 million in grants to 11 Texas counties, down from the highest, but still inadequate, level of $9.6 million in fiscal 2000. The 2007 legislature reduced the total amount of state aid that any one county can receive, from 20% to 10% of appropriated funding.

As of November 2009, 19 public hospitals and 136 hospital districts were providing county indigent care, and 143 counties administered a County Indigent Health Care Program.



SOURCES: Legislative Budget Board and Texas Department of State Health Services. Funding does not include indigent health care reimbursement to the University of Texas Medical Branch at Galveston.

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 rising cost of premiums. Even with cost growth slowing in recent years, businesses surveyed by the Kaiser Family Foundation and the Health Research and Educational Trust continue to cite high cost as "the most important reason" they don't offer health benefits, including 54% of small firms (fewer than 200 employees).

To help address this problem, the Affordable Care Act authorizes tax credits for tax year 2010 of up to 35% of an employer's cost of coverage to help eligible small businesses afford insurance. In Texas, 249,000 small businesses, or 81% of small businesses, are eligible for tax credits in 2010.

Nationally, family premiums for employer-based health coverage averaged $1,148 per month in 2010. For Texas firms, single and family premium costs in the late 1990s and in 2004-06 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.

Kaiser Family Foundation/HRET research shows that from 2009 to 2010, family health insurance premiums rose an average of 3.0% for all employers, and by 4.4% for employers with 3 to 199 workers. As was the case from 2004 to 2008, 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.

Medicare Rankings

	Texas	U.S. Average	Texas Rank
Medicare payments per enrollee, 2008	$9,769	$8,649	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, 2010	19.8%	23.6%	24th
Elderly (aged 65 and over) enrolled in Medicare, 2008-09	91.7%	93.5%	39th
Social Security disability insurance (SSDI) beneficiaries as a percent of age 18-to-64 population, Dec. 2009	3.5%	4.3%	41st

SOURCES: CQ's *State Rankings 2010*; Centers for Medicaid and Medicare, 2009 Data Compendium and 2010 Medicare and Medicaid Statistical Supplement; Kaiser Family Foundation; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Who is Served by Local Public Health Care Spending?

Local governments in Texas and other states fund or directly operate a variety of health care programs and services, such as hospitals, clinics, and community centers serving the uninsured or underinsured; public health campaigns such as mosquito control, immunizations, and HIV prevention; and Emergency Medical Services (EMS) and trauma care. Local public hospitals account for one-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 Census Bureau data on state and local government spending. The table at left shows that Texas local governments' public health spending—although still well below the U.S. average—is higher than state government spending on public health. Hospital spending by Texas local governments is higher than the U.S. average. State government hospital spending is closer to the U.S. average than is its spending on public health; this is because Texas funds health science centers and other hospitals associated with universities.

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

Texas hospitals (public, for-profit, and nonprofit) reported a total of $7.2 billion in charity care for 2008, or $3.7 billion when adjusted for the differences in hospitals' charges and what they receive in payments (the "cost-to-charge" ratio). Public hospitals accounted for almost 60%, or $2.1 billion, of this adjusted charity care amount. Local public hospitals reported $1.7 billion in adjusted charity care, and state hospitals accounted for the remaining $379 million in adjusted charity care in 2008.

Local Government Health Care Spending

	Texas	U.S. Average	Texas Spending as a Percent of U.S. Average Spending
Per-capita spending on **public health**, 2008			
By local government only	$74	$130	57%
By state government only	$69	$132	52%
State and local government combined	$143	$262	55%
Per-capita spending on **hospitals**, 2008			
By local government only	$291	$253	115%
By state government only	$120	$171	70%
State and local government combined	$411	$423	97%

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

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 2.9 million Texans in 2009, or one out of seven insured Texans. About 83% of Texas Medicare enrollees are aged 65 and over and can be of any income level; the other 17% are under 65 but disabled or with end-stage renal disease. Almost 2.9 million Texans had Part A coverage, for in-patient hospital expenses; 2.7 million Texans opted for supplemental Part B, which covers outpatient costs such as doctors' fees.

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

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

Congress added a prescription drug benefit (Rx/Part D) to Medicare, effective January 1, 2006. By February 2009, about 2.4 million Texans, or 86% of the state's Medicare beneficiaries, had drug coverage through a stand-alone plan, Medicare Advantage, employer or union plans, or dual-eligibility coverage. The national average was also 86%.

Medicaid Rankings

	Texas	U.S. Average	Texas Rank
Nursing home residents with Medicaid as primary payer, 2008	63%	64%	23rd
Medicaid payments per disabled enrollee, 2007	$12,936	$14,194	32nd
Medicaid spending as a percent of total personal health care spending, 2004	14.5%	17.4%	34th
Medicaid payments per enrolled child, 2007	$1,851	$1,951	36th
Percent of Medicaid enrollees in managed care, June 2009*	64.6%	71.7%	39th
Medicaid payments per aged enrollee, 2007	$11,003	$14,141	43rd
Medicaid recipients as a percent of poverty population, 2009**	72.7%	107.7%	47th
Medicaid nursing facility expenditures per person served, 2005	$19,471	$26,096	49th

* 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: Centers for Medicaid and Medicare; Kaiser Family Foundation; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; AARP Public Policy Institute.

How will Health Care Reform Change the Delivery of Health Care in Texas?

The Affordable Care Act was passed by Congress and signed by the President in March 2010, changing the health care landscape in Texas and nationally. With 26% of Texans lacking health insurance, Texas stands to gain more than any other state from the new law: by 2014, about 5 million of the 6.4 million currently uninsured Texans could gain coverage through reform.

Though Texans' opinions of the new health care reform law cover the full spectrum from approval to those who would have preferred different approaches, the new law is an important tool that states can use to achieve their own health policy goals, such as increasing coverage, improving transparency and quality, and controlling costs.

The new law provides substantial federal funding to support fundamental improvements in Texas' health care system, but leaves many of the key policy decisions and much of the heavy lifting to implement national health reform up to the states. Ultimately, decisions made at the state level—by the Texas Legislature and state agencies including the Health and Human Services Commission and the Texas Department of Insurance—will determine how successful Texas is at expanding health insurance coverage, improving quality, and controlling health care costs.

For more information, see *Texas Health Reform Checklist: Key Steps to Make the Most of Reform*, at www.cppp.org/files/3/MHM_HealthReformChecklist_final.pdf. This report explains key reform provisions, identifies imminent decisions that must be made at the state level, and explains what is at stake for Texas as health care reform is implemented. More details on how private insurance consumers and Medicare clients in Texas are benefitting from the Affordable Care Act can be found in *What Every Texan Should Know: Health Care Reform Law*, June 2010, www.cppp.org/files/3/2010_09_June_WhatsIntheLaw.pdf.

Health Reform Timeline

2010
- Several major insurance reforms began: coverage for dependent children through age 26, no lifetime limits, no pre-existing condition denials for children, premium increase oversight; minimum standards for share of premiums that plans must pay out for health care;
- Pre-existing condition insurance plan started;
- Medicare started closing the prescription drug "donut hole."

2011
- Medicare adds preventive care with no out-of-pocket costs.

2010 to 2013
- Building/expanding systems needed to support covering large numbers of uninsured people in 2014;

2014
- Expansion for Medicaid coverage to adults under 133% of the federal poverty level;
- Health exchanges begin offering coverage to small firms, uninsured, and those who lack employer coverage, with a sliding scale for those below 400% of poverty.

2017
- First year Texas state budget has costs for new adult Medicaid group (5% share).

2020
- Medicare prescription drug plan "donut hole" is fully eliminated;
- Texas reaches maximum share of costs (10%) for new adult Medicaid coverage.

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 November 2010, Texas had 3.2 million Medicaid enrollees; 2.3 million (74%) of them were under the age of 19. The state budget anticipates a Medicaid caseload of 3.2 million in 2011.

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

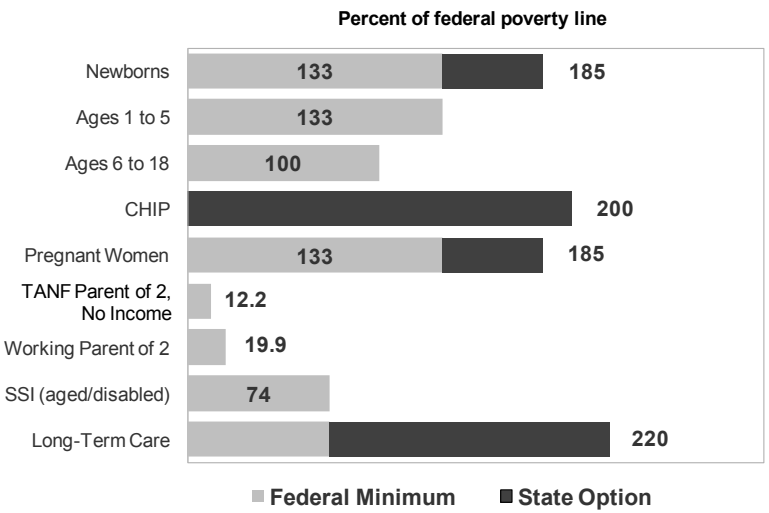
After meeting minimum federal standards for Medicaid coverage, states can set their own guidelines beyond the minimum for the different categories of low-income people eligible for Medicaid. States also decide how much to pay providers of Medicaid services. The combined effect of Texas' restrictive eligibility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

What Happens to Medicaid under Health Care Reform?

The following pages describe how Texas Medicaid coverage is currently limited to children in low-income families; low-income seniors; individuals with disabilities; and pregnant women. National health reform expands Medicaid eligibility in 2014 to all U.S. citizens up to 133% of poverty ($14,484 for one person, or $29,726 for a family of four, in 2011). In Texas, the main expansion beneficiaries will be over 1 million currently uninsured low-income parents and adults without children.

The Medicaid expansion gives Texas two primary roles: (1) the state must enroll eligible adults and administer their benefits, and (2) the state will eventually pay part of the cost for those new adults. Federal dollars will pay 100% of the costs of this new coverage for the first three years (2014 to 2016). Texas will begin to pick up a 5% share starting in 2017, and topping out at 10% in 2020, meaning Texas will get 9 federal dollars for every 1 dollar the state budget contributes. The benefit package can be either the regular Medicaid package or a less comprehensive one, comparable to employer-sponsored health insurance "benchmark" coverage.

Income Caps for Texas Medicaid & CHIP, 2011*



Eligibility Category	Annual Income Limit, 2011*
Children	
Medicaid for Newborns	$34,281
Medicaid, ages 1 to 5	24,645
Medicaid, ages 6 to 18**	18,530
CHIP, ages 0 to 18	37,060
Adult or Disabled	
Medicaid for Pregnant Women	34,281
Medicaid for TANF Parent of 2, No Income	2,256
Medicaid for a Working Parent of 2	3,696
SSI (Aged or Disabled)	8,059
Long-Term Care	23,958

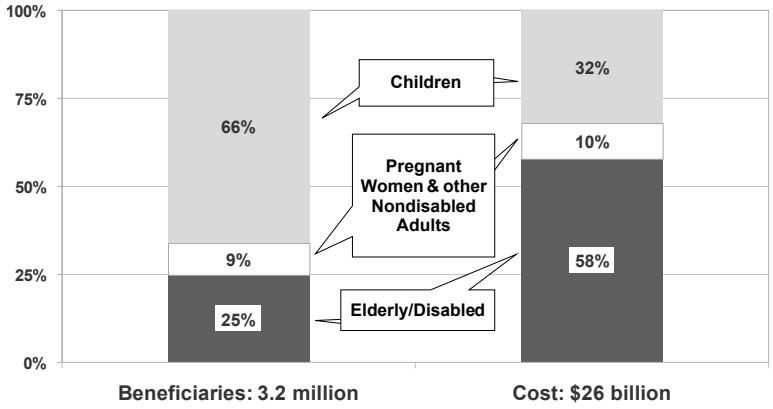
* Annual income limit is for a family of three for child and parent categories. For SSI and Long-Term Care, income cap is for one person.

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

NOTE: Not shown above are the eligibility criteria for the Women's Health Program, the CHIP Perinatal Program, or Medicaid for certain current or former foster care youth. See text for details.

fourths (75%) of Texas Medicaid clients in 2010, but well below half (42%) of Medicaid spending was for these clients. Elderly clients and clients with a disability, in contrast, were one-fourth (25%) of the caseload and three-fifths (58%) of Texas Medicaid spending.

Texas Medicaid Beneficiaries & Expenditures, 2010



SOURCE: Texas Health and Human Services Commission, Medicaid Overview Presentation, February 2011.

	Medicaid Spending, State Fiscal 2009	Share of Texas total
Harris	$3.1 billion	15.6%
Dallas	1.8 billion	9.2
Bexar	1.7 billion	8.3
Hidalgo	1.3 billion	6.7
Tarrant	1.1 billion	5.3
Travis	752 million	3.8
El Paso	728 million	3.6
All other	$9.5 billion	47.6
Texas	**$20.0 billion**	**100.0%**

SOURCE: Texas Health and Human Services Commission, Sept. 2009.

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 18,358 newborns and 34,129 pregnant women in October 2010. 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 about 106,300 women in November 2010.

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. This is a program for people who have disabilities and want to work or continue working, but are concerned about losing their health coverage when their income level exceeds Medicaid eligibility limits. At the end of October 2010, the Texas Buy-In Program had 202 active enrollees.

Eligibility Determination Problems. Since 2006, the enrollment system for Texas Medicaid and other public benefits has undergone a performance crisis from which it has only recently begun to recover. In the worst months, fewer than half of Medicaid applications were processed in the 45 days required by law, and more than a third of applicants waited more than 90 days to have eligibility determined. Since September 2009, the Health and Human Services Commission has gained nearly 850 eligibility workers, who along with system and training improvements have brought the percentage of cases processed on time up to 94.1% in July 2010, compared to 75.4% in September 2010.

At this juncture, it is critical that the Medicaid enrollment system continue to modernize, improve, and expand capacity to prepare for the 2014 Medicaid expansion. This will not be achieved unless Texas sustains and builds upon these staffing and system improvements between now and 2014.

Medicaid Caseloads versus Costs

In Texas, as in 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-

Medicaid and CHIP Income Eligibility Comparisons

Children's Medicaid. When comparing states' coverage of children, both Medicaid and CHIP (Children's Health Insurance Program) 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.* Nineteen states including Texas operate separate CHIP programs; another six use CHIP funds to expand children's Medicaid, and 26 states have both expanded children's Medicaid and have a separate CHIP program.

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. Thirteen 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; 15 states cover newborns at a lower level than Texas. (Federal law prohibits states from lowering Medicaid or CHIP eligibility levels, unless they do not receive any federal Medicaid and CHIP funding). Hawaii, Maryland, Missouri, Vermont, and Wisconsin have the highest child Medicaid caps, at 300% of the poverty line.

CHIP. Texas CHIP coverage begins where children's Medicaid coverage ends, and goes up to 200% of the federal poverty line. Under the federal Affordable Care Act of 2010 (health reform), in

NOTE: For the most up-to-date comparison of state Medicaid and CHIP eligibility policies and enrollment procedures, see the Kaiser Family Foundation's **statehealthfacts.org**, "Medicaid & CHIP."

*Congress has extended federal funding for the CHIP block grant through September 2015, and requires states to maintain CHIP eligibility levels through 2019. Block grant reauthorization will be required to fund CHIP beyond September 2015.
**This includes many states that chose the Medicaid expansion option for CHIP.

2014 children in CHIP who are between 100% and 133% of poverty would move to Medicaid, while children in Medicaid who are above 133% of poverty would move to CHIP, eliminating Texas' current "stair-step" eligibility.

Twenty-one states currently have CHIP income limits that go beyond 200% of poverty. New York has the highest CHIP income cap at 400% of the poverty line. Thirteen states currently have no upper income limit for CHIP, and allow buy-in for children at incomes higher than their upper subsidy limit.

Only two states, Idaho and North Dakota, set the CHIP cap below 200% of poverty.

Medicaid Maternity Coverage. Texas is one of 15 states offering maternity coverage up to 185% of poverty. Another 15 states go beyond that to cover women up to 200% of poverty. Finally, another 8 states and the District of Columbia cover women above 200% of poverty. Of these, Wisconsin has the most generous income cap, at 300% of the federal poverty line.

Parents' Medicaid. Texas has the sixth lowest income cap for Medicaid coverage of parents with dependent children, after Alabama, Arkansas, Indiana, Louisiana, and Missouri. A Texas working parent of two children who earns more than $4,000 a year loses Medicaid coverage, because the Texas legislature has not increased that cap since 1985. On the other end of the spectrum, eight 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—$674 per month for an individual in 2011). Two 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. Twenty-eight 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—38 states including Texas set it at this level for nursing home care. In Texas, this is also the income limit for community care "waivers" designed to keep people out of institutions, but states can set this limit higher or lower than their Medicaid nursing home cap.

Recent Eligibility Changes. The 2009 Legislature created a new Medicaid buy-in program for children with disabilities. Starting in January 2011, children in families with incomes up to 300% of the poverty line will have an option to purchase Medicaid coverage on a sliding scale. The state expects to cover 2,000 to 3,000 children when the program is fully implemented.

The 2007 Legislature extended Medicaid coverage for young adults formerly in foster care. That coverage, which used to end at age 21, was extended to the 23rd birthday for young adults enrolled in higher education. In November 2010, almost 32,300 current or former foster care children were enrolled in Medicaid.

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