

Texas Health Care 2008:

What Has Happened and What Work Remains



Center for Public Policy Priorities

FOREWORD

As this report goes to press in 2008, the latest Census reports show that more Texans than ever lack insurance, and fewer than ever get coverage through their jobs. The growing uncertainty of our access to health care jeopardizes the financial security and prosperity of all Texas families. Those of us with insurance don't know how much longer we will have it, and find that our insurance policies cover less every year. Insured Texas families pay \$1,500 more per year in premiums than we would otherwise due to the uncompensated care costs of uninsured Texans. Those without health insurance know they are one serious illness or injury away from bankruptcy.

Access to affordable health care for all Americans can be achieved in any number of different ways, as demonstrated by the diverse successful models in the other industrialized democratic nations. A good reform model should:

- Cover every person who wants it;
- Be affordable by people at every income level, including when life circumstances change;
- Give us the health care we really need, instead of just “shrinking the benefits”; and
- Protect against loss of coverage due to changes in income or health status.

Many can agree on these broad principles. Less clear is whether, in order to be fiscally sound, a system that guarantees affordable care to every American should require that everyone obtain health coverage.

Our American health care system also faces other challenges—cost-effectiveness, quality, safety, and access barriers (due to factors other than cost). No single reform will “fix” all these problems. The steps we take to make sure every American can afford decent health care coverage will differ from those taken to control the cost or improve the quality of care. Nonetheless, we could better tackle the tough challenges of cost and quality once our health care system no longer carries the huge burden of uncompensated care.

Achieving affordable care for every American will also relieve much of the need that drives Texas government health care spending. Much—though certainly not all—of our health and human service needs result directly from Texas' high uninsured rate. This report explains where we are today and what work remains ahead to ensure affordable care to all. We hope you will join us in working toward that goal.

Center for Public Policy Priorities

INTRODUCTION

The Center for Public Policy Priorities (CPPP) is pleased to publish this update on how health care fared in the 2007 Legislative Session and the work that remains, funded with the generous support of Methodist Healthcare Ministries (MHM).

Texas faces sobering health care challenges:

- Texas has the highest percentage of people without health insurance in the nation. As of 2007, one in four Texans (5.96 million) was uninsured. That's the equivalent of every man, woman, and child in the entire Houston metropolitan area.
- Lack of insurance extends beyond the very poor or unemployed. In fact, more than two out of three uninsured Texans aged 18 to 64 work, and nearly three-quarters of them have incomes above the poverty line.
- That's due in part to the fact that Texans are far less likely to receive health insurance through their jobs than workers in other states (50% of Texans, compared to 59% of all Americans).
- Another 3.4 million Texans would lack insurance if not for two federal-state programs: Medicaid and the Children's Health Insurance Program (CHIP).
- Despite the fact that Texas struggles with poor immunization rates and high rates of infectious and heart diseases, diabetes, obesity, and late entry into prenatal care, the state spends among the least on health care in the nation. Texas ranks 33rd in Medicaid spending per child enrolled, 46th in Medicaid spending per elderly enrollee, and 48th in the proportion of poor Texans who receive Medicaid.
- Medicaid provides the largest source of federal funds in Texas' state budget: nearly four times as much as federal highway funds and nearly three times as much as federal public education funding.
- In state dollars, Medicaid spending ranks number three in the state budget after public education and higher education, costing about one-third as much as total K-12 education spending.
- In 2007, Texas state government spent \$2,141 per Texan in non-federal state revenue, versus a national average of \$3,508 in 2007. This ranks Texas 50th in the nation in state-dollar spending per resident. Put another way, in order to just "be average" among states, Texas must spend \$1,367 more per person in state funds—a 64% increase, or about \$32 billion in new spending per year.
- We are not last in investment in public structures because we are a poor state, however. In 2007 Texas was 21st in per capita personal income and 18th in gross domestic product per Texan.
- While the private sector plays a major role in the health care system, our state government also has an indispensable role in creating a level playing field for health care access. Texas needs greater engagement and investment in health care, so that every Texan gets the best health possible and be the strongest community member possible.

This report explains the Legislature's 2007 health care funding decisions, highlights problems in the Texas' health care system, and identifies next steps to improve access to care.

The Basics: Which Texans Get Medicaid and CHIP Coverage?

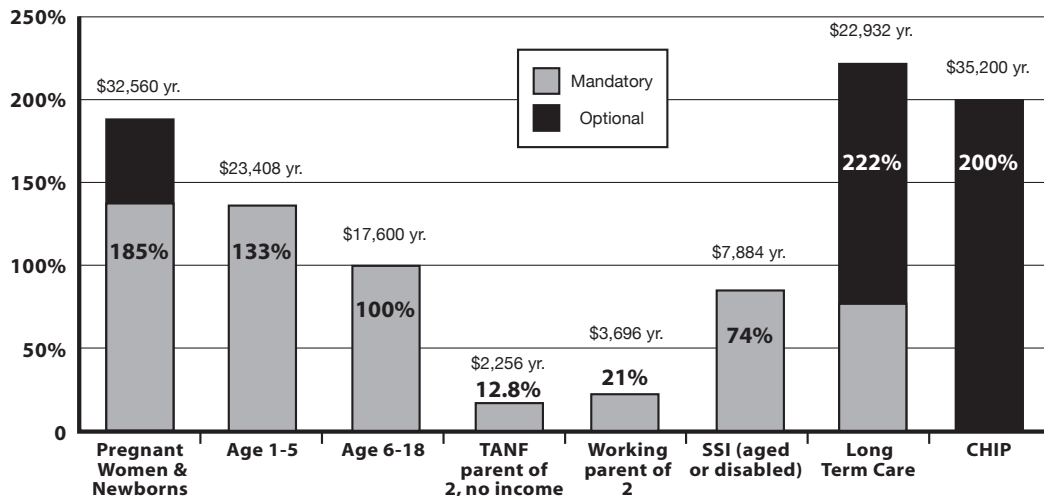
Medicaid is a federal-state program that is the bedrock of health care for some of the poorest Texans. Medicaid primarily covers poor children, elderly, and people with disabilities. As of July 2008, nearly 2.9 million Texans—including 1.9 million children—relied on Medicaid for health insurance. The Children’s Health Insurance Program, or CHIP, provides health care to Texas children (464,000 in July 2008) whose parents earn more than the Medicaid limits, but still can’t afford private insurance. Texas CHIP eligibility stops at two times the poverty line, or \$35,200 a year for a family of three. The Texas Health and Human Services Commission (HHSC) oversees Medicaid and CHIP.

Low-income pregnant women are also eligible for Medicaid prenatal care and delivery coverage. In fact, because so many young adult women lack insurance, Medicaid covers about half of all births in Texas and takes care of those babies for the first year of their lives.

More than 75% of adults on Texas Medicaid are elderly or disabled. Because only parents with extremely low incomes (less than \$308 per month, or \$3,696 annual income, for a working parent of two children) qualify for Medicaid under Texas rules, fewer than 100,000 parents are enrolled. In contrast, the U.S. median Medicaid income limit for working parents is nearly three times Texas’ limit, at \$10,850 per year for a family of three.¹ Not only that, but in Texas, poor uninsured adults without dependent children cannot currently receive Medicaid at all (unless they are also disabled, pregnant, or elderly), due to federal restrictions. For these reasons, many uninsured Texans living in poverty do not qualify for Medicaid.

Most Low-Income Texas Children Could Get Medicaid & CHIP, But Very Few Adults Can

INCOME CAPS FOR TEXAS MEDICAID AND CHIP, 2008



Income limit is shown as a percentage of federal poverty income. Annual income in dollars is for a family of three, except that individual incomes are shown for Supplemental Security Income and Long Term Care.

Source: Texas Health and Human Services Commission.

WHAT HAPPENED TO CHILDREN’S HEALTH CARE ACCESS?

About 6.9 million children under age 19 live in Texas, and as of July 2008, more than a third of our children got comprehensive health care from children’s Medicaid or CHIP—(1.9 million in Medicaid, and 464,000 in CHIP). Another 1.53 million Texas children were uninsured in 2007, and more than half of these uninsured children are eligible right now for children’s Medicaid or CHIP, but are not enrolled.² Important developments and unmet needs in children’s Medicaid and CHIP are described in this section.

Children’s Medicaid Improvements: FREW Lawsuit

Federal Medicaid law provisions called “Early and Periodic Screening, Diagnosis, and Treatment” (EPSDT) require states to provide comprehensive health care to children and youth under the age of 21. Texas calls our state program “Texas Health Steps.” States can’t place arbitrary limits on children’s health care benefits coverage in Medicaid (e.g., no limits on days coverage of hospital care, doctor visits, or prescriptions per month). Still, children enrolled in Medicaid sometimes cannot access the care they need.

A lawsuit filed in 1993 alleged that Texas Medicaid failed to ensure children’s access to check-ups and to medically needed follow-up care. The federal court approved a settlement in 1996, but in 1998 the plaintiffs complained that the state was not complying with the agreement. Appeals followed until 2007, when state officials and plaintiffs’ attorneys agreed to a set of court-approved “corrective action plans” designed to improve access to preventive care, treatment, and supportive services for children in Texas Medicaid. The corrective action plans are designed to improve children’s Medicaid through:

- Outreach to parents;
- Monitoring check-up rates and completeness of check-ups;
- Improving medical transportation;
- Studies of care received by children in HMOs (e.g., monitoring how frequent and complete check-ups are, and reporting how many children in Medicaid Managed Care plans get no health care during a 12-month period);
- Speedier services for children of migrant workers;
- Reducing barriers to needed prescriptions and medical supplies;
- Improved customer service on toll-free telephone lines;
- Better access to case managers for children and education of Medicaid health care providers about the availability of this help;
- More study of health outcomes of children on Medicaid and whether they improve over time;
- Better training for health care professionals on the services available for children under Texas Health Steps;
- More accurate lists of providers accepting new patients in Medicaid HMOs; and
- Adequate supply of health care providers.

The 2007 Legislature appropriated over \$700 million in state funds (\$1.8 billion with the federal matching funds) in the 2008-2009 state budget to support these improvements. Most of this amount, about \$512 million, went to increase fees paid to doctors and dentists for care to children, and another \$46 million went to other corrective actions. A “pot” of \$150 million was set aside for special “Strategic Initiatives” designed to improve

access to care. Projects have been funded to increase dental care for infants, create a mobile dental unit, integrate mental health care into primary care, reimburse specialists for telephone consultations, and create referral guidelines for primary care doctors, but as of July 2008 less than \$50 million of this fund had been allocated.

Why Is This Important?

- Many doctors, dentists and other health providers take very few Medicaid and CHIP patients, or do not serve them at all, because they are paid Medicaid fees that are well below Medicare and commercial payment rates, and sometimes do not even cover their costs.
- Texas Medicaid rate cutbacks before 2007 had reduced physicians' fees to 1993 levels for most services. Rate cuts were the largest health care budget cuts the Legislature made in 2003—even larger than the CHIP cuts.
- Even with the new investments in Medicaid doctors' fees for kids, the 25% increase raised a Texas Medicaid regular office visit fee from \$41 to \$53, while Medicare would pay at least \$85. Overall, Texas Medicaid rates average about 73% of what Medicare pays. A full dental exam fee increased from \$18 to \$36, compared to a regional median charge of \$54.
- Texas Medical Association surveys show that doctors in our state taking new Medicaid patients dropped from 75% in 1996 to 39% in 2006.

Challenges That Remain:

- When Texas Medical Association surveyed physicians in 2008, 42% reported accepting new Medicaid patients, a modest increase from the 2006 report.
- Medicaid will not automatically get funding to continue all of the improvements and other corrective action plans in 2010-2011. Instead, HHSC requested special "exceptional item" funding, which can be harder to obtain, to continue some of the *Frew* investments.
- The \$100 million budgeted for Strategic Initiatives that was unspent as of August 2008 may be especially at risk of not being funded again in the next budget. HHSC has asked for another \$150 million for these projects in 2010-2011.
- The important corrective action plans are all in very early stages of operations, so we cannot yet judge their success.

Important CHIP Improvements: HB 109

The 2007 Texas Legislature prioritized the needs of children when it came together across party lines to cut much of the bureaucratic red tape that prevented CHIP-eligible children from enrolling. With the support of every major chamber of commerce, House Bill (HB) 109 passed by overwhelming majorities in both the House and Senate. Major CHIP changes in HB 109 included:

1. **12 months eligibility:** most children must renew coverage once a year, instead of every 6 months.³
2. Parents can again deduct some of their **child care expenses** when calculating income.
3. **Waiving the 90-day waiting period** for uninsured children. Only children whose families drop

private health insurance (and do not qualify for an exception) must wait 90 days for CHIP to start. This restores the waiting period to the original 1999 Texas CHIP law.

4. Requiring CHIP to use a **community-based outreach program**.

5. **Doubling the asset test limit** from \$5,000 to \$10,000.

All of these changes either reversed or improved policies passed by the Legislature in 2003 that were designed to reduce CHIP enrollment. The new policies took effect on September 1, 2007, and as of July 2008, enrollment had grown by nearly 164,000 children. In the period since the 2003 cuts, the greatest increase in CHIP enrollment—over 118,000 children in just 6 months—was the direct result of restoring 12-months continuous eligibility to CHIP.

Why Is This Important?

- The 2003 CHIP cuts, especially the shorter 6-month enrollment period, had caused enrollment to drop by more than 215,000 children at the lowest point—more than 42%.
- As a result of drops in coverage in CHIP and children's Medicaid, Texas' uninsured rate for children got worse from 2004 to 2006, increasing from 20% to 22%.
- Now, CHIP enrollment should reach and grow beyond 2003 levels soon, helping to again reduce Texas' uninsured rate for children.
- Having more children insured means better school attendance for kids and work attendance for parents, fewer E.R. visits, fewer hospitalizations, and lower costs for our local safety nets.

Challenges That Remain:

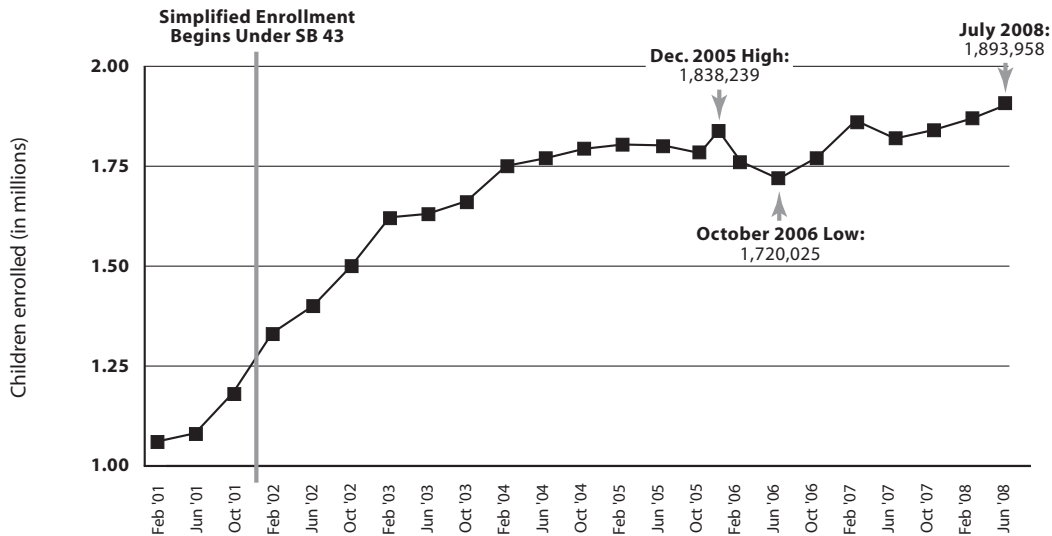
- Despite improved CHIP enrollment, too many parents still report processing errors and lost applications and documents. As a result, some children go without coverage for months despite being fully eligible.
- Children moving between Medicaid and CHIP are especially likely to get dropped from coverage, even though they qualify and are supposed to move directly between programs without any gap.
- Parents whose incomes increase by a small amount can lose CHIP for their kids, but still lack access to decent, affordable coverage for them.

ADDRESSING THE ELIGIBILITY SYSTEM CRISIS: HB 3575

Texas' enrollment systems for Medicaid and CHIP (also the entry point for Food Stamps and Temporary Assistance for Needy Families cash aid) entered a crisis period in 2006 from which they have not yet recovered. In 2006, children enrolled in Medicaid dropped by over 99,000 over a 4-month period ending in April. Since then, the number of children covered surged and then dropped repeatedly due to severe state staff shortages,

computer woes, and inadequate performance by private contractors in both Medicaid and CHIP.⁴ It was not until June 2008 that children’s Medicaid rolls climbed back to surpass the May 2006 numbers. Put simply, Texas lost at least two years of “normal” children’s Medicaid growth as a result of the ongoing problems with eligibility systems.

TEXAS CHILD MEDICAID ENROLLMENT
February 2001 - July 2008

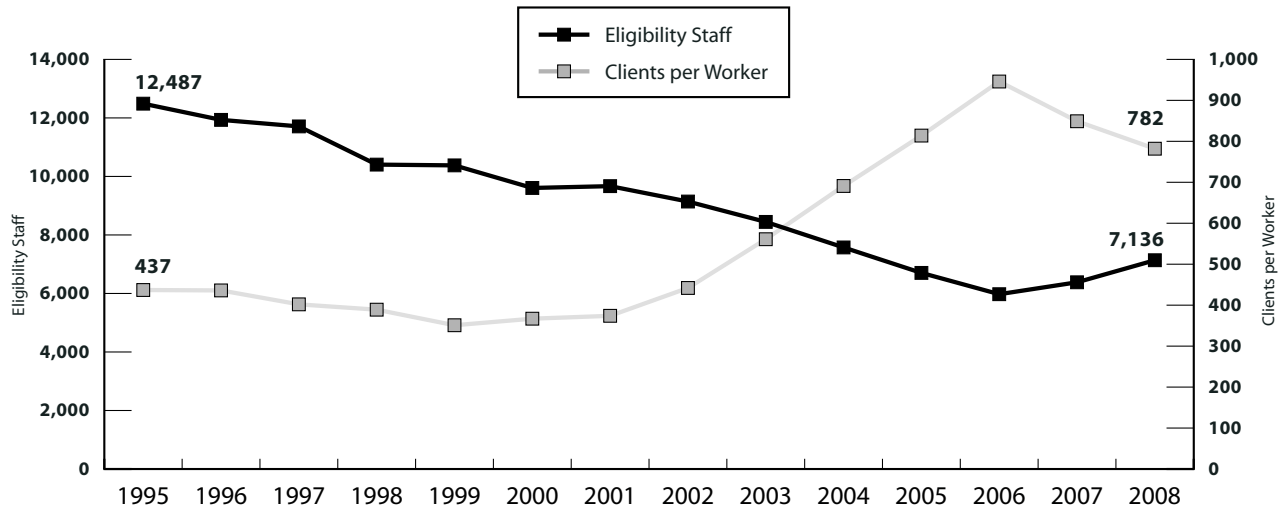


Source: Texas Health and Human Services Commission. January 2007 to present includes newborn CHIP "perinates"; last month is preliminary due to lag.

Texas lacks enough state workers to enroll eligible children. Texas’ Legislature cut state eligibility workers repeatedly—down from 12,500 in 1995 to 7,100 today. Each worker today serves more than twice as many clients as in 2000: 850 per worker in 2007, up from just 370 in 2000. Computer problems are the next big issue: the “new” eligibility computer system, TIERS, is still much slower than the 30-plus-year-old system it is supposed to replace. In 2008, fewer than 63% of TIERS Medicaid applications have been finished in 45 days (required by federal law), compared to almost 95% in the old system.⁵ Still, we continue to add more and more children and adults into TIERS.

The 2007 Legislature responded to the troubled eligibility system with HB 3575, which created a legislative oversight committee for the HHSC eligibility system and set goals to improve customer service, reduce processing time, and meet federal standards. In other actions, the state budget bill called on HHSC to improve CHIP and children’s Medicaid eligibility process to eliminate barriers, delays, and wrongful denials. The budget also gave HHSC permission to add eligibility workers to replace contract workers and to meet federal accuracy and promptness standards.

AVERAGE ELIGIBILITY DETERMINATION STAFFING AND AVERAGE CLIENTS PER WORKER Fiscal Years 1995 to 2008



Source: Texas Health and Human Services Commission, Data Report for HB 3575 Eligibility System Legislative Oversight Committee, April 2008. Fiscal 2008 are targeted amounts.

Why Is This Important?

- HHSC made some progress in 2008 in retaining new state workers and getting more of them trained in the new system to deal with the rapid increase in Texans enrolled in the new system, but the agency will need the authority to hire many more workers for the system to perform well.
- Speed of enrollment in Medicaid and Food Stamps using the new computer system has improved in recent months, but still lags well behind federal requirements.
- Cutting the number of uninsured Texas children in half can only happen with a swift, accurate, and streamlined eligibility system.

Challenges That Remain:

- Far too many parents across Texas struggle to get their kids enrolled in Medicaid and keep them enrolled. Community organizations across the state report that many parents tell them they gave up on Medicaid and CHIP because of repeated enrollment problems even when they follow all instructions correctly.
- HHSC continues to add more children and adults across the state to the new computer system, TIERS, and federal oversight has not slowed this process much. Modest staff growth and training progress are not yet enough to enable workers to keep up with the workload.

- Too often, Texans enrolled through the TIERS system who need help are told that their local office can no longer help them. Instead, they are referred to private call center operators who cannot answer their questions, locate their applications, or resolve their problems. Those who try to call their over-taxed local offices report phones that are not answered, “on hold” times that stretch into hours, and voice messages that are not returned.
- While HHSC took several positive steps to speed up the time it takes (per child) to process an application using the new computer system, it has not yet speeded up enough to let state workers catch up to meet federal standards—let alone common-sense standards of decent public service.
- While children make up two-thirds of Medicaid, these enrollment problems also prevent seniors, adults with disabilities, expectant mothers, and women seeking family planning services from promptly getting the health care and food assistance they need. In these times of high food and fuel costs, our safety net systems need to respond quickly to the needs of all vulnerable Texans.

Congress and Texas CHIP: The Reauthorization Debate

Nationwide, SCHIP (the federal block grant that funds Texas CHIP) has been remarkably successful since enacted by Congress in 1997. The popular program will undoubtedly be reauthorized for another decade—but every federal block grant must periodically be—but only a question of when. In the meantime, state leaders continue to look for ways to move forward in covering America’s children:

- More than half the states took actions in 2007 and 2008 to reach more uninsured children,
- 27 states (plus Washington, DC) cover children in families with incomes above 200% of the federal poverty level (FPL), and
- 19 of these (plus Washington, DC) authorized or implemented coverage for children in families with income 300% FPL or higher.

Congress extended the federal authorization of the SCHIP block grant through March 2009, and Texas has ample federal funds available during that period, even given the recent rapid growth in Texas CHIP. Still, Congress should pass a ten-year reauthorization soon, because temporary extensions hinder states’ ability to make long-term plans and reach more uninsured children.

A controversial August 2007 letter sent by the current federal administration to states hurts states’ progress by limiting CHIP coverage to 250% FPL. States challenged this “directive” in federal court, and Congress may override it, but many states that authorized coverage to 300% of poverty must halt those expansions in the meantime.

Why Is This Important?

- State efforts to reduce the number of uninsured children rely heavily on the federal SCHIP reauthorization process.
- Texas needs federal reauthorization in order to keep serving current children, to help us reach out to unenrolled kids,

and to help us design new, affordable options for moderate-income kids.

- States already providing CHIP above 200% FPL and offering buy-in coverage for kids in higher-income families report that **most new enrollment is among children below 200% FPL, who were already eligible for coverage.** Getting the message out that most or all children qualify for some kind of coverage is one of the most effective ways to reach low-income uninsured children who qualify for Medicaid or CHIP, but not enrolled.

Challenges That Remain:

- Texas lawmakers should understand that our CHIP program will not run out of federal funds immediately.
- At the same time, lawmakers need to know that Texas does need a strong SCHIP reauthorization as much as (or more than) any other state does, because our state needs both adequate funding and flexibility if we are to reach the 750,000-plus uninsured children who qualify for CHIP or Medicaid today but are not enrolled.
- Nationwide, removing the roadblocks to CHIP programs through prompt 2009 reauthorization will help children get and keep the health care they need, especially in an economic downturn.

UNINSURED TEXANS BY AGE GROUP, 2007

Ages 19 to 64:

4.4 million

57% are below 100% of poverty

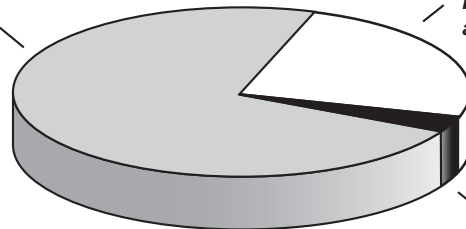
Rate: 30.5% of working-age adults are uninsured

Ages 0 to 18:

1.4 million

64% are below 200% of poverty

Rate: 21.4% of children are uninsured



Age 65+:

100,039

Rate: 4.1% are uninsured

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

WHAT HAPPENED TO ADULTS' HEALTH CARE ACCESS?

Twenty-five percent of Texans lack health insurance, and the biggest reason is that Texans are much less likely to have coverage through their work than other Americans. Texas working-age adults are even more likely to be uninsured than children—30% of Texans between 19 and 64 lacked health care insurance in 2007. This is a bit surprising, since parents (and not children) often have insurance provided with their job. Texas

kids are better covered because low-income kids can get Medicaid and CHIP, while Texas chooses to put tight limits on Medicaid for parents.

Federal law excludes adults without children from Medicaid, unless they are pregnant, are poor seniors, or have serious disabilities. Parents can be covered, but our Texas Legislature last increased the dollar income cap for parents' Medicaid in 1985. This cap has never been updated for inflation and today—just as 23 years ago—remains at \$308 per month for a working parent with two children, or less than 13% of the poverty income for a family of three. As a result, working just 12 hours a week at minimum wage (\$6.55 per hour) will make that Texas mother lose her Medicaid (the national median income cap for the same size family in 2008 is \$904). **Texas chooses this low income limit.** Eighteen states cover parents with incomes at or above the poverty line in Medicaid (\$1,467 per month for a family of 3, compared to \$308 in Texas), and another seven states cover parents above poverty through special waiver programs.⁶

Texas' limited parent coverage, paired with the federal limits on other adults, adds up to little public health coverage help for low-income Texas adults, except during pregnancy. Add to that the low rates of employer-based coverage in our private insurance marketplace, and increasing health insurance among Texas adults must involve solutions for the lowest-income adults and reforms that can make coverage affordable for average Texans with moderate and middle-class incomes.

An Uncertain Vision: SB 10 and Uninsured Low-Income Adults

Senate Bill 10 in the 2007 session included a long list of Medicaid-related changes. It authorized several HHSC **experimental pilot projects** within the existing Medicaid program:

- “Healthy Lifestyles,” rewarding clients for taking steps to improve their health;
- Medicaid health savings accounts (HSAs), allowing clients to directly purchase health services from a special account;
- Tailored benefit packages, designed to provide specialized services to certain groups such as children with special health needs;
- Medicaid “opt-out” (health insurance premium payment, or HIPP), which would allow Medicaid enrollees to be covered by employer health plans with lower benefits and higher out-of-pocket costs than Medicaid; and,
- Co-payments for non-emergency E.R. use, designed to direct patients away from the E.R. for urgent care when alternatives are available.

The law also includes **important protections** both for Texans enrolled in Medicaid, and for Texas taxpayers. For example, the health savings account, Healthy Lifestyles, and E.R. co-pay pilots can only be created in “regular Medicaid” if they are cost-effective. Children's benefits cannot be reduced in the pilots, and only positive incentives are allowed in the Healthy Lifestyles Pilot. Participation in “opt-out” or HSA pilots must be voluntary, and a beneficiary may return to traditional Medicaid upon request. Before adults may opt out of Medicaid—or parents may decide to opt their child out of Medicaid's comprehensive coverage—they must be fully informed.

Just as importantly, SB 10 authorized a “Health Opportunity Pool” (HOP) to be created with funds from several sources, including some funds now paid directly to hospitals to compensate for their care for uninsured Texans and for Medicaid’s low reimbursement rates. How the HOP would be funded and what it would do are described in very general terms in the law, but in April 2008 HHSC submitted a request to federal Medicaid authorities for a “waiver”—special permission for the agency to use federal Medicaid funds for purposes and in ways not usually allowed.

In the waiver request, HHSC estimated there are 2.1 million uninsured Texas adults below 200% of poverty who are the “target population” for the waiver, but did not propose to cover any of these adults before 2011. In 2009, HHSC proposed to use the HOP to extend Medicaid coverage through age 22 for youth leaving foster care who are enrolled in higher education, and to gain federal matching dollars for certain children in CHIP who are currently paid for with state dollars. Another important HHSC proposal was to create a limited “catastrophic” benefit that would pay for selected high-cost hospital bills of low-income adults. HHSC also hoped to use HOP dollars to fund local and regional projects to reduce uncompensated care in 2009.

Why Is This Important?

- The HOP waiver is the Legislature’s first attempt since 1995 to address Texas Medicaid’s lack of adult coverage. However, the April 2008 proposal would not cover any adults before 2011, and it does not indicate how many of the 2.1 million “target” adults would be covered at that time.
- Texas could cover parents to 100% FPL or higher with full Medicaid benefits without a waiver. Instead, this waiver forgoes full comprehensive benefits and federal matching dollars available to Texas. The reasons to cover parents under a waiver rather than regular Medicaid are (1) to avoid putting funds in the state budget to cover these adults, and instead get the funds from local governments and existing programs; (2) to symbolize Texas leadership’s dislike for public coverage programs and their preference for “market-driven” insurance.
- Several Texas urban areas hope to get some level of HOP support—for start-up costs, coverage, or both—for regional “three-share” health care projects aimed at low-income uninsured residents.
- SB 10 also eased access to Medicaid breast and cervical cancer treatment coverage, authorized a needle exchange pilot,⁷ and required studies on several topics including how to increase group health coverage in small businesses.

Challenges That Remain:

- In August 2008, federal Medicaid authorities (Centers for Medicare and Medicaid Services, or CMS) informed HHSC that the waiver could not be approved without additional work.
- HHSC’s proposals assumed that covered adults would get benefits more limited than in “regular” Medicaid. CMS authorities told Texas that to justify bending the federal rules we need to propose a significant coverage expansion that starts sooner. CMS also will not approve a benefit package capped so low at \$25,000. It is not clear how HHSC will develop revised plans to allow the HOP waiver to cover meaningful numbers of adults with decent benefits.

- The “catastrophic” benefit as proposed in the April waiver request would not fully restore the “Medically Needy” benefit the legislature eliminated for Medicaid parents in 2003. It would cover inpatient hospital services only. CMS’ August 2008 guidance indicated that Texas must cover more medical services to those who qualify for the Medically Needy benefit to qualify that benefit for Medicaid matching funds.
- The April waiver proposes co-payments that would charge a mother of two earning \$450 per month exactly the same amount as a mother of two earning \$1,450. This arrangement would favor higher-income adults and be unaffordable for those with the lowest incomes. The proposal also included premiums charges for all covered adults, with incomes from \$0 to 200% of poverty.
- HHSC’s April waiver request asked federal authorities to exempt the HOP program from many Medicaid laws, including appeals of eligibility or benefit denials; consistent access to benefits statewide; state employee determination of eligibility; freedom of access to family planning and Federally Qualified Health Centers; limits on cost-sharing below 100% of poverty; cost-based coverage for FQHCs; and federal marketing standards.
- The regional projects to target the uninsured are a welcome and exciting development. These projects should avoid: (1) using federal Medicaid dollars to provide uninsured Texans in some areas access to good health care while other areas of the state lack access, and (2) using federal Medicaid dollars to support coverage only available to Texans lucky enough to have an employer willing to contribute a share, while other workers lack that coverage.
- Texas should create an ongoing public stakeholder workgroup to build agreement and support for the adult coverage model, a feature that was missing from the SB 10 process and the lead-up to the April waiver submission.

Medicaid Coverage for Breast and Cervical Cancer Treatment

Congress created a Medicaid coverage program for Breast and Cervical Cancer treatment (BCC Medicaid) in 2000, and Texas authorized coverage in 2001. This program provides the same high federal matching funds rate as CHIP. Before September 2007, Texas’ BCC Medicaid had a cruel “catch-22” for some uninsured low-income cancer patients. An uninsured woman could get access to BCC Medicaid only if she was actually screened and/or diagnosed by a clinic funded directly by a separate, sister program, the CDC Breast and Cervical Cancer Early Detection Program. As a result, uninsured low-income Texas women with cancer were denied coverage simply because they were diagnosed by the “wrong” health care provider.

Why Is This Important?

- The results were stark: by using a broader referral policy, Georgia—with less than half of Texas’ population—served roughly 3.5 times as many cancer patients over the same period.
- In 2007, legislation changed the Texas rules so that now any appropriately licensed medical provider can refer a woman for BCC Medicaid coverage, reaching about 1,200 new women every year.

- As of August 2008, there were 979 women receiving cancer treatment through the program, up from 621 in August 2007. More than half of new enrollees come from health care providers excluded under the old rules.
- The new policy conserves limited federal cancer screening funds for women who lack another source of care, takes advantage of the generous enhanced federal matching rate, and eliminates a horrible bureaucratic barrier to desperately needed care.

Challenges That Remain:

- Some CDC cancer screening providers report that support services they provide for the women diagnosed by non-CDC contractor health providers are not adequately reimbursed under “case management” fees. Further evaluation of the costs and work involved in this new role for the CDC contractors in our Texas program makes sense.
- Outreach is needed to let more health care providers and women know about this life-saving program. This outreach can and should be part of a unified strategy to get the word out about all our Texas health care programs.

WHAT HAPPENED TO LONG-TERM CARE IN 2007?

Long-term care for persons with a disability or chronic illness is a crucial—and cost-intensive—component of health care and human services. Neither private health insurance nor Medicare (the federal health program for seniors regardless of income and individuals with disabilities) pay for most long-term care. Long-term care programs serve seniors, adults, and children with disabilities in both community care programs that provide care in an individual’s home or in smaller group homes, and in nursing homes and other “institutional” settings.

In Texas, Medicaid helps pay for the long-term care of nearly 70% of nursing home patients. Community care “waiver” programs have limited budgets and caps on the number of people they can serve, and as a result have waiting lists to receive services. People with the most significant disabilities waiting for programs can wait five to nine years, even after the new funding approved in 2007.

Most Texans using long-term care Medicaid services live in poverty. Some recipients can earn up to about \$22,900 per year for an individual, but they must use their income to pay for a portion of the care they get.

Long-Term Care Gains in 2007

In 2007, HHSC asked for over \$260 million in state funds to allow several community care, mental health, and public health programs to keep up with population growth, and to reduce the number of Texans on waiting and “interest” lists for care. The 2008-2009 budget put \$107 million in state dollars towards reducing those waits, two-thirds of which went to long-term care programs at the Department of Aging and Disability Services. The Legislature also reversed cuts it made in 2003 to payment rates for community care and nursing home providers, and gave them some increases in payments above 2003 levels.

Why Is This Important?

- Medicaid is the #1 source of funding for nursing home care and community care in the United States because Medicare only pays for short-term care after a hospital stay.
- Our budget investments reduced the average waiting time for several community care programs since 2004.
- As with other health care, when rates are too low, providers may choose not to participate in the program, and service quality can suffer.

Challenges That Remain

- While Texas reduced several waiting lists, improvements have been modest or absent in the programs that serve Texans with the most complex disabilities.
- HHSC requested about \$188 million in state funds for 2010-2011 to reduce wait times for long-term care programs at the Department of Aging and Disability Services, with the largest amounts requested for the programs with the longest waiting lists.

WHAT HAPPENED TO PUBLIC HEALTH, SAFETY, MENTAL HEALTH, AND PREVENTION PROGRAMS?

The Department of State Health Services (DSHS) provides a wide range of public health, safety, mental health, and prevention programs; protects Texans from infectious diseases; and regulates the quality and safety of everything from water to X-ray facilities.

Many DSHS programs were cut deeply by the Legislature in 2003. Funding increases in 2005 and 2007 allowed most of these programs to serve more Texans than in 2003, but some programs still serve fewer than in 2003 before the cuts. Major investments in DSHS programs by the 2007 legislature include increased funding for:

- Mental health crisis services in Texas communities (\$82 million in state funds);
- Breast and cervical cancer screening and diagnosis;
- Immunization programs, TB and HIV drug programs, and smoking prevention; and
- Children with Special Health Care Needs, which provides special care (not covered by insurance) needed by seriously ill and medically fragile children. Funding in the 2008-2009 budget allowed DSHS to serve 793 children on the waiting list in September 2007 and another 226 in April 2008.

Programs serving fewer or the same number of Texans than in 2003 (and thus not keeping up with population growth) include:

- **Substance abuse treatment for adults:** The number of Texans served was cut by a quarter in 2003 (dropping by 11,000), and only this year returned to serving the same number of clients as five years ago.

- **Community mental health services for adults:** Texas serves about 4,500 fewer adults today in community mental health programs than in 2003.
- **Primary health care:** Texas serves more than 16,500 fewer Texans in primary health care programs than in 2003, a 17% drop.
- **Maternal health (Title V):** The number of Texan women served through Title V programs dropped by more than 13,000 in 2008 compared to 2003, a drop of nearly 25%.

Why Is This Important?

- The programs serving fewer Texans today—such as community mental health and substance abuse programs—are usually the only source of care for uninsured Texans, especially those with low and moderate incomes.
- Because population and inflation rise every single year, if program funding does not grow, service levels must drop. The Texas population grew by more than 2 million from 2003 to 2008.
- DSHS' traditional public health systems are a fundamental building block of our society which cannot be neglected without serious consequences, including decreased access to clean drinking water, hampered disease control and unsafe food supplies.

Challenges That Remain

- Despite funds added in the 2008-2009 budget, as of the end of July 2008, 950 children were on the waiting list for Children with Special Health Care Needs services.
- Adult access to community mental health and substance abuse services suffered in recent years, and child and youth access grew modestly. While community advocates applaud improved access to crisis services, they also point out that reducing the need for those crisis services will require ongoing mental health care access.

THREE STEPS TOWARD AFFORDABLE HEALTH CARE FOR EVERY TEXAN

The 2007 Legislature's investments in CHIP and the growth in children covered in that program give us hope that Texas' last-place ranking for health insurance need not persist. Still, the number of Texans lacking reliable access to health care remains unacceptably high. In the latest uninsured figures for 2007, Texas was one of ten states whose uninsured rates got worse over the last four years, while the rest of the country stayed the same or improved.

The biggest changes capable of making affordable health care available to every American are likely to come from action in Washington, not Austin. Still, Texans can take steps to connect hundreds of thousands of our uninsured friends and neighbors with decent health care that they can afford. Described below are three concrete steps to improve access to care in Texas in the near term by (1) raising new revenues to support health care, (2) creating affordable coverage for every Texas child, and (3) reforming private health insurance to make it available and affordable for more Texas adults.

Fiscal Facts: Medicaid, CHIP, and Health Insurance

State tax dollars devoted to health care are a good investment. Because Medicaid and CHIP bring such a large federal match, providing health insurance to Texas' working poor through Medicaid and CHIP just makes good economic sense. Higher uninsured numbers drive up health insurance premiums for insured Texans, and raise local taxes for all of us.

- Federal Medicaid and CHIP laws require states to put up state dollars to get federal Medicaid and CHIP matching funds. In 2008, Texas gets \$1.54 for each state dollar spent in Medicaid, and \$2.62 for each state dollar spent in CHIP.
- Medicaid is by far the largest source of federal funds in Texas' state budget, providing nearly four times as much as federal highway funds and nearly three times as much as federal public education funding.
- Because of Medicaid and CHIP's large federal match, Texas economist Ray Perryman estimates that for every \$1 in state tax revenue cut from Medicaid and CHIP, local taxes go up 51 cents, local health care providers lose 53 cents in uncompensated care, state tax revenue falls by 47 cents, and the state loses \$2.81 in federal funds.
- Additional negative effects of program cuts include rises in health insurance premiums and other health care costs and decreases in retail sales and other private-sector economic activity.
- Texans with insurance are estimated to pay more than \$1,500 extra in premiums per family due to the uncompensated care costs of uninsured Texans. This number is projected to grow to more than \$2,700 per insured family in 2010 if the uninsured rate does not improve.⁸

1) PAY FOR A BETTER BUDGET

Funding Texas' health care budget is a struggle largely because our state tax system does not raise enough revenue to keep up with inflation and population growth. Changes in areas seemingly unrelated to health care—school finance, property appraisals, business taxes—will affect the funding of health and human service programs, and even the potential for improved regulation of health insurance. Expanding small-business exemptions to the “margins” tax, tightening the cap on appraisal increases, or changing property appraisals could reduce state dollars available to fund the budget. In short, state policy changes that cut Texas government revenues will hurt access to health care for Texans.

Of course, revenue could also be increased: through mandatory property sales price disclosure, creating a hospital Quality Assurance Fee, “sunsetting” tax exemptions, or imposing “green” taxes (e.g., a tax on coal use, higher fees on highly polluting diesel fuels, or a tax on inefficient energy producers). How those issues are resolved will determine whether the Legislature has the money to support critical public structures necessary to create opportunity and prosperity for Texans—including real progress in health care.

QAF: Targeted Revenues for Health Care

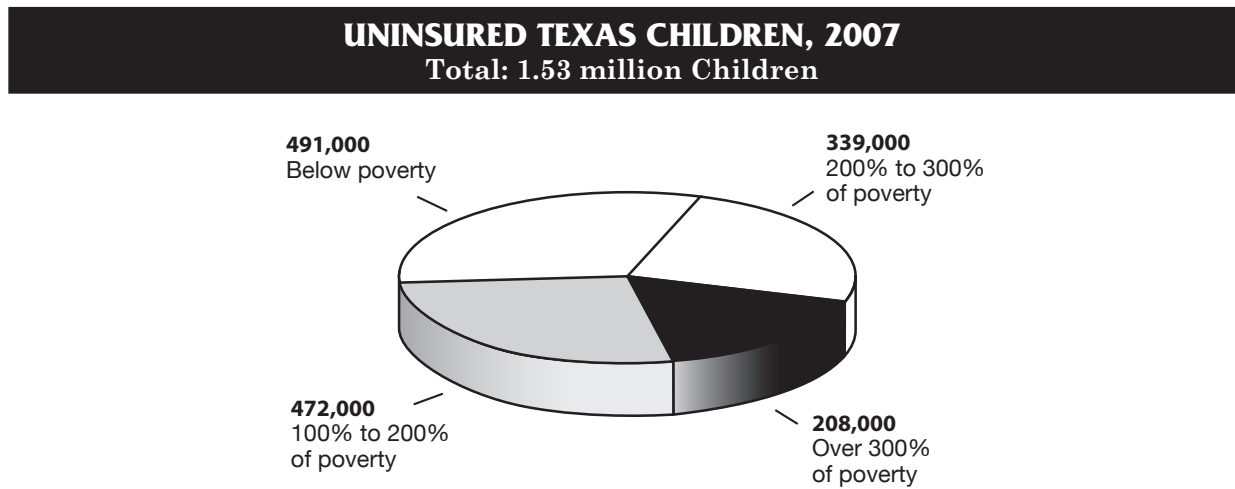
A Quality Assurance Fee (QAF) taxes health providers' revenues so that the state can draw more federal matching funds and increase payments to those providers. QAF proposals to improve Medicaid nursing home

and hospital funding were debated in the 2005 and 2007 legislative sessions, but did not make it into law. Forty-three (43) states have quality assurance fees, and 30 of those states tax more than one kind of provider to generate the state funds necessary to draw down a larger federal Medicaid match. Texas already has a QAF on residential facilities for developmentally disabled persons, and a tax on Medicaid HMOs.

The academic Task Force for Access to Health Care in Texas recommends creating a new QAF on hospitals and surgery centers. As a first step, the 2008 *Code Red* report recommends Texas adopt a 1% QAF on revenues of all hospitals and freestanding surgery centers in Texas, which could generate \$367 million in state funding to draw down an additional \$567 million in federal matching funds. A “sunset date” would be set, and the QAF would continue only if evidence showed that the increased federal Medicaid funding it generated improved access to health care.

2) Finish Line in Sight: Affordable Coverage for Every Texas Child

In 2007, an estimated 5.96 million total Texans were uninsured—people who lacked private or public health insurance coverage. Of these, 1.53 million were kids: 22% of Texas children under age 19 lack insurance.



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

Of these 1.53 million uninsured children:

- 491,000 live in families below the poverty line;
- 472,000 live in families between one and two times the poverty line (100-200% FPL);
- 339,000 uninsured children live in families between two and three times the poverty line (200-300% FPL); and,
- 208,000 uninsured children live in families above three times the poverty line.

Just under two-thirds of uninsured Texas children (64%) are in families below 200% of poverty. However, as many as 250,000 uninsured Texas kids may be undocumented immigrants, who cannot get children's Medicaid or CHIP.⁹

- This means 700,000 to 800,000¹⁰ children—half of our uninsured children—are eligible for Medicaid or CHIP right now, but not enrolled.
- Texas HHSC estimates three-quarters of these are eligible for Medicaid, one-quarter for CHIP.

Two steps are needed to reach as many Texas children as possible.

- **First, we must enroll eligible uninsured kids by eliminating the bureaucratic roadblocks that discourage participation in Medicaid and CHIP.**
- **Next, we must create new affordable coverage options for Texas children whose families are now above the CHIP limits.**

Recommended actions to reach these goals are outlined below.

Reaching “Already-Eligible” Children

To enroll our “uninsured-but-already-eligible” children, Texas must first address ongoing poor performance in the eligibility system. As explained earlier, HHSC **must hire and train more state workers and private CHIP contractor staff**, so that phones are answered promptly, questions answered correctly and problems fixed, and applications and renewals are processed quickly. HHSC must continue to increase the speed of computer systems, so that technological problems do not hinder workers.

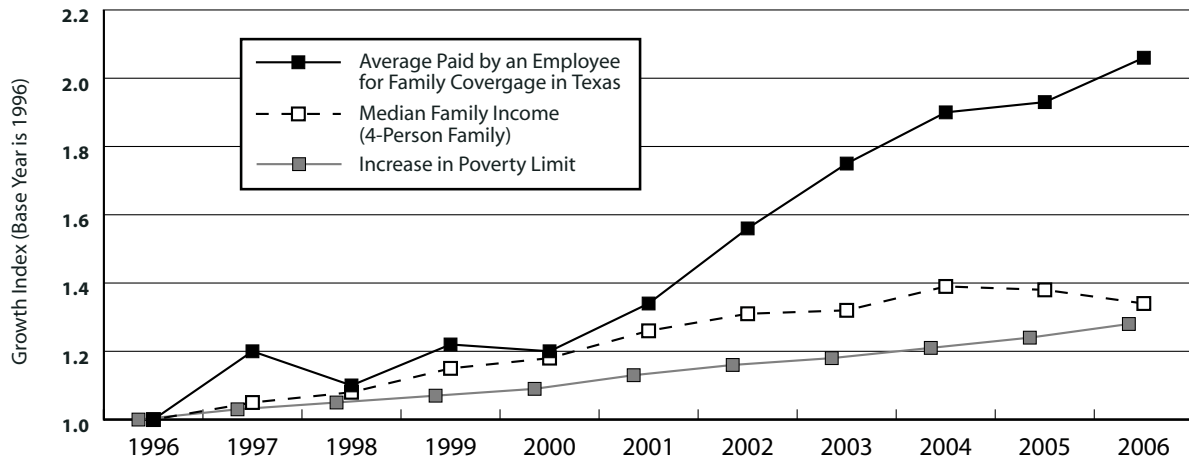
Texas can further reduce the red tape if we **provide 12-month continuous coverage for children's Medicaid**. This step will likely improve enrollment of eligible uninsured children, and at the same time it would dramatically cut the workload for our state eligibility staff and boost their performance. The 2007 legislature eliminated the twice-yearly renewal requirement only for CHIP. The recent surge in Texas CHIP enrollment—more than 118,000 children from March to August 2008—shows the powerful potential of 12-month coverage. Texas and California studies found 12-month coverage reduced hospitalizations and the annual cost per child. As of July 2008, 18 states provided 12-month continuous eligibility for all children in Medicaid, and two other states provide it for younger children.

Our state should also invest in community-based outreach. An army of community-based organizations (CBOs) want to help enroll Texas children in health coverage. Their efforts can be effective if the eligibility system can quickly and accurately handle the applications and renewals CBOs generate when they reach out to families in community settings. CBOs can play a critical role in helping families submit documents correctly the first time, speeding enrollment and eliminating time spent requesting more documents.

However, the state budget short-changes outreach. Texas CBOs must serve twice as many Texans and multiple safety net programs (not just children's health insurance), but the dollars budgeted for their 2008-2009 work are **below** the investment in the first years of CHIP when the target population was much smaller. And, actual spending on CBOs and marketing fail to meet budgeted levels. Texas should at least double the amount allocated for outreach—and make sure those funds are spent!

Better outreach for all of our Texas health care programs will bring better health care outcomes and savings for Texas taxpayers. A robust outreach program would recapture the energy of Texas CHIP start-up years, bringing HHSC contractors, other community-based groups, social service providers, advocates, health care providers, and health plans together as a team. With a strong enough commitment to outreach, we can connect kids early to preventive and primary care; expectant mothers to early prenatal care; new mothers to follow-up care and family planning; women to screening for breast and cervical cancer—and treatment for those who need it; and seniors and Texans with disabilities to the supports they need.

FAMILY INSURANCE PREMIUMS ARE GROWING MUCH FASTER THAN FAMILY INCOMES OR CHIP ELIGIBILITY LIMITS



Source: Georgetown University Center for Children and Families; Medical Expenditure Panel Survey Insurance Component Tables; U.S. Census Bureau; and U.S. Dept. of Health and Human Services.

Reach More Uninsured Kids

Covering children has gotten tougher for working families. The cost of private insurance grows much faster than family incomes and CHIP income limits, fewer employers cover their workers, and families trying to buy kids' coverage directly can be turned down—or charged sky-high premiums.

- Nationwide, more than two-thirds of newly uninsured children in 2006 were in families above 200% FPL, the current limit for Texas CHIP. New census reports for 2007 indicate more Texas children from 200-300% of poverty lack insurance.
- Very few of these children can get insurance through their parents' jobs: fewer than 8% of families between 200-400% of poverty turn down employer-sponsored health coverage.¹²
- Across the U.S., 27 other states' programs make affordable coverage available to children above 200% FPL, and 19 of these cover children above 300% FPL.

In Texas, more than half a million uninsured kids cannot get CHIP and children’s Medicaid because their working parents earn too much to qualify. Texas CHIP cuts off completely at 200% of poverty even if a family earns just a few dollars above that limit, but many parents still earn too little to afford costly private coverage.

To cover more of these children, Texas needs a new approach that gives them access to CHIP and asks their parents to pay a monthly premium that increases as their income increases. Specifically, Texas should:

- **Help families between 200-300% of the federal poverty level:** Working parents earning between \$42,400 and \$63,600 a year (family of four)¹³ should be able to buy CHIP coverage for their uninsured children, paying a “sliding” monthly premium that increases with their income. Federal CHIP guidelines say families should not pay more than 5% of their pre-tax income to insure their kids. A Texas CHIP “buy-in” program with costs under this limit could:
 - ❑ require parents to contribute an increasingly larger share of the full cost of coverage, using a sliding scale that phases out the subsidy at 300% of poverty;
 - ❑ include policies designed to target uninsured kids and discourage dropping employer-based coverage;
 - ❑ require significant family cost-sharing but still be affordable, preparing families to transition to employer-sponsored coverage (or a full-cost buy-in) when their income increases.
- **Provide “Buy-In” to Full-Cost Kid’s Insurance above 300% of poverty:** Working parents earning more than \$63,600 without access to affordable coverage through their jobs would pay a premium that equals the full cost of covering their uninsured children through CHIP.

3) Make Private Health Insurance More Affordable and Accessible

Texas’ relatively unregulated private health insurance market brings in \$22 billion a year in premiums¹⁴ but leaves one in four Texans uninsured, has the some of the highest premiums in the U.S., and produces one of the lowest rates of employer-sponsored insurance in the nation.¹⁵ Many small-business owners in Texas want to provide coverage to their workers, but cannot afford premium quotes as high as \$23,000 a year per employee.¹⁶ Texans must think twice before switching jobs or starting a business for fear that a preexisting condition will prevent them from getting health insurance. A hands-off approach to regulation failed in the Texas health insurance market as it did for sub-prime mortgages. Though every state has uninsured residents, Texas’ lack of regulation is a major cause for our worst-in-the-nation 25% uninsured rate, instead of the national average of 15% uninsured. Sensible market reform options exist—many already enacted by other states—that can help make private health insurance more affordable and accessible in Texas.

The Texas Department of Insurance (TDI) is currently under “Sunset review,” the process in which the Legislature reviews most state agencies every 12 years to consider the agency’s utility and the effectiveness of its structure and functions. TDI’s Sunset process, plus legislative “interim” health insurance studies, can lay the groundwork for insurance reforms to be adopted in the 2009 Legislative session.

Strengthen TDI

Texas is one of just ten states that do not actively review premium rates for group or individual health insurance.¹⁷ With no rate oversight in Texas, how can consumers, much less the Commissioner of Insurance, know that health insurance rates are fair and justified? Most other states use oversight tools to make sure that health insurance rates are fair. To ensure fair rates, Texas can:

- **Authorize TDI to review health insurance premium rates and reject those that are excessive.**
- **Set a minimum amount of each health insurance premium dollar paid by Texans that must be spent on health care,** as opposed to profits and administration.
- **Modify TDI's mission to include helping consumers access quality insurance** and give TDI resources to fulfill that mission.

Expand Access for Small Employers and Individuals

- **Use publicly funded reinsurance to spread risk broadly, lower premiums, and increase access to private coverage for small employers and individuals.** Reinsurance (insurance for insurance companies) spreads risks broadly among insurers and can lead to lower premiums by reducing potential risk for insurers. Publicly funded reinsurance programs, in which a state assumes some of the costs of the reinsured risk, allow premiums to be reduced even more.
- **Restrict insurers' ability to use health status to price individuals or small employers out of the market.** Small employers struggle to afford average premiums, but many small employers do not qualify for the average rate. Many small employers are priced out of the market because health status and age of employees determines premium costs. TDI reports insurers charge some small employers seven times the average premium. Texas could reduce these enormous premium ranges by “tightening” current rate bands to allow much smaller ranges for rating factors such as health status and age, or adopting “adjusted community rating” with a maximum overall premium variation of 2:1.
- **To reduce premium variation and lower premiums overall, the options listed above could be combined with publicly funded reinsurance.**

Fix the High-Risk Pool

The Texas Health Insurance Risk Pool was created by the Texas Legislature to provide health insurance to Texans denied commercial insurance due to medical conditions. Enrollee premiums fund two-thirds of pool coverage and private insurance carriers fund the remainder. Some Texans that need pool coverage cannot get it, because (1) pool premiums are very high, (2) no sliding scale help exists for lower-income Texans, and (3) state law places limits on who can enroll. To make the pool serve Texans better, the state should:

- **Make the pool affordable for more Texans.** Because of high pool premiums (\$600/month on average per person) and deductibles (from \$1,000 to \$7,500 per year), even moderate-income families cannot afford the high cost of pool coverage. Texas should—as several other states have—develop a pool subsidy program that reduces premiums and deductibles on a sliding scale for low- and moderate-income individuals. A pool subsidy program could be funded in part by restructuring the assessments on

insurance companies so they contribute to the pool in a more balanced manner.

- **Reduce the 12-month pre-existing condition exclusion period.** Most state high-risk pools (72%) have exclusion periods of 6 months or less. By definition all pool members have pre-existing conditions serious enough to make them uninsurable in the private market. Texas' long exclusion period inappropriately requires members to pay almost \$600 a month in premiums for up to a full year for insurance that does not even cover treatment of their serious illnesses.
- **Allow access to the pool for individuals offered inadequate health benefits at work.** Today, a Texan with a serious medical condition cannot access the pool if they (or a family member) are employed in full-time work that provides access to employer-sponsored insurance. However, no minimum standard for the employer plans exists, and we lack a way to allow exceptions, so some Texans with inadequate employer coverage are locked out of the high-risk pool.
- **Increase the pool lifetime maximum benefit to \$5 million.** Since 2005, three pool members reached their \$1.5 million lifetime maximum and others are nearing the limit, including seriously ill children in middle-class families who don't qualify for disability-related Medicaid or CHIP, and who are uninsurable in the private individual health insurance market. If they cannot access employer-sponsored coverage, they can get coverage through the pool. But when these children reach their lifetime pool maximum, they lack other coverage options until they turn 18. Likewise, some adults with severe illness may use up their pool benefits long before they qualify for disability-related Medicare.



Endnotes

- ¹ Kaiser Family Foundation, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles*, January 2008, www.kff.org/medicaid/7740.cfm .
- ² See later section entitled “Finish Line in Sight: Affordable Coverage for Every Texas Child” for details on this estimate.
- ³ Children above 185% of the federal poverty line (\$38,203 a year for a family of four) would have their income (not assets) reviewed after six months by HHSC; see *Child Friendly? How Texas’ Policy Choices Affect Whether Children Get Enrolled and Stay Enrolled in Medicaid and CHIP*, Center for Public Policy Priorities (February 2008). www.cppp.org/research.php?aid=639 .
- ⁴ For detailed history, see *Ibid.*, and www.cppp.org.
- ⁵ Unpublished data reported by HHSC to HB 3575 Transition Legislative Oversight Committee, July 2008.
- ⁶ Kaiser Family Foundation, p. 34.
- ⁷ Enactment of this provision has been delayed by legal challenges.
- ⁸ Families, USA, “Paying a Premium: the Added Cost of care for the Uninsured,” Families USA, 2005.
- ⁹ Pew Hispanic Center tabulations of Current Population Survey (CPS) data with immigration status assigned with methods, initially by Passel and Clark (1998); see also Passel, Van Hook, and Bean (2004, 2005). Average of 2003 and 2004 data. Texas CHIP is available to legal immigrant children, so undocumented children below 200% of the FPL are the most significant identifiable group of children who do not qualify for CHIP despite their family income.
- ¹⁰ The Texas Health and Human Services Commission estimated in 2007 (prior to the newest Census data) that there were 850,000 uninsured Texas children eligible for Medicaid or CHIP.
- ¹¹ Georgetown University Health Policy Institute, Center for Children and Families. Note: These data represent the cumulative growth in employee premium contributions for employer-sponsored family coverage and the federal poverty level for a family of three. Source: Agency for Healthcare Research and Quality estimates of 1996-2005 Medical Expenditure Panel Survey Insurance Component Tables, generated using MEPSnet/IC (August 21, 2007); and CCF analysis of 1996-2005 Federal Poverty Guidelines.
- ¹² Center on Budget and Policy Priorities, November 5, 2007, “Martinez Bill Would Weaken Children’s Health Coverage Bill;” Lisa Clemans-Cope, Bowen Garrett, and Catherine Hoffman, “Changes in Employees’ Health Insurance Coverage, 2001-2005,” Kaiser Commission on Medicaid and the Uninsured, October 2006; Linda Blumberg and Genevieve Kenney, “Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Expansion?,” Urban Institute, October 2007.
- ¹³ For a family of four, 2008 federal poverty income guidelines.
- ¹⁴ Texas Department of Insurance, *State Planning Grant Interim Report*, 2005, pg. 18, www.tdi.state.tx.us/reports/life/documents/spgint05.pdf; Texas Department of Insurance, *State Planning Grant Interim Report*, 2006, pg. 22, www.tdi.state.tx.us/reports/life/documents/spgint061.pdf; and Texas Department of Insurance, *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature*, December 2006, www.tdi.state.tx.us/reports/documents/finalbie07.pdf.
- ¹⁵ Between 2001 and 2005, Texas health insurance premiums for family coverage increased 39.7%. This is the third highest premium increase seen in the nation. Nationally, the average increase over this timeframe was 29.5%. State Health Access Data Assistance Center, University of Minnesota, *Squeezed: How Cost for Insuring Families are Outpacing Income*, April 2008, www.rwjf.org/files/research/042508ctuwfinalembargoed.pdf. In Texas, only 50% of people have health insurance coverage through employment, compared to 59% nationally. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.
- ¹⁶ Texas Department of Insurance, *Texas Group Accident and Health Insurance Survey*, 2005.
- ¹⁷ Adele M. Kirk and Deborah Chollet, “State Review of Major Medical Health Insurance Rates,” *Journal of Insurance Regulation*, Summer 2002, pp. 3-18.



Center for Public Policy Priorities

The Center for Public Policy Priorities is a 501(c)(3) nonprofit, nonpartisan research organization committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. We pursue our mission through independent research, policy analysis and development, public education, advocacy, coalition building, and technical assistance.

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