THE TEXAS HEALTH CARE PRIMER

November 2003

METHODIST HEALTHCARE MINISTRIES
OF SOUTH TEXAS, INC.

Center *for* Public Policy Priorities

CPPP is a 501(c)(3) non-partisan, non-profit policy research organization committed to improving public policies and private practices to better the economic and social conditions of low- and moderate-income Texans. CPPP pursues this goal through independent research, policy analysis and development, public education, and technical assistance.

Principal Author:
Eva DeLuna Castro
Senior Budget Analyst
deluna.castro@cppp.org

Anne Dunkelberg
Senior Policy Analyst
dunkelberg@cppp.org

F. Scott McCown
Executive Director
mccown@cppp.org

Methodist Healthcare Ministries of South Texas, Inc.

MHM is a 501(c)(3) non-profit, non-partisan faith-based organization improving the health of those least served in the 72 counties of the Southwest Texas Conference of The United Methodist Church. MHM provides innovative, effective and long-term resources: physical, mental, spiritual to promote healing and wellness, and to nurture wholeness of body, mind and spirit.

Miryam Bujanda
Policy Analyst
mbujanda@mhm.org

Ed Codina
Director, Planning, Research, and Policy
ecodina@mhm.org

Kevin C. Moriarty
C.E.O.
kmoriarty@mhm.org

The Texas Health Care Primer
November 2003

Layout & Production by Chris Pieper
Communications Director, pieper@cppp.org

TABLE OF CONTENTS

Foreword

"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 Center for Public Policy Priorities (CPPP) and Methodist Health Care Ministries (MHM) are pleased to publish this primer. As two non-profits whose mission is to improve life in Texas communities, this partnership was natural. CPPP researches and advocates ways to improve the economic and social conditions of low and moderate-income Texans; MHM, through health services and programs and public policy advocacy, directly touches the lives of those least served.

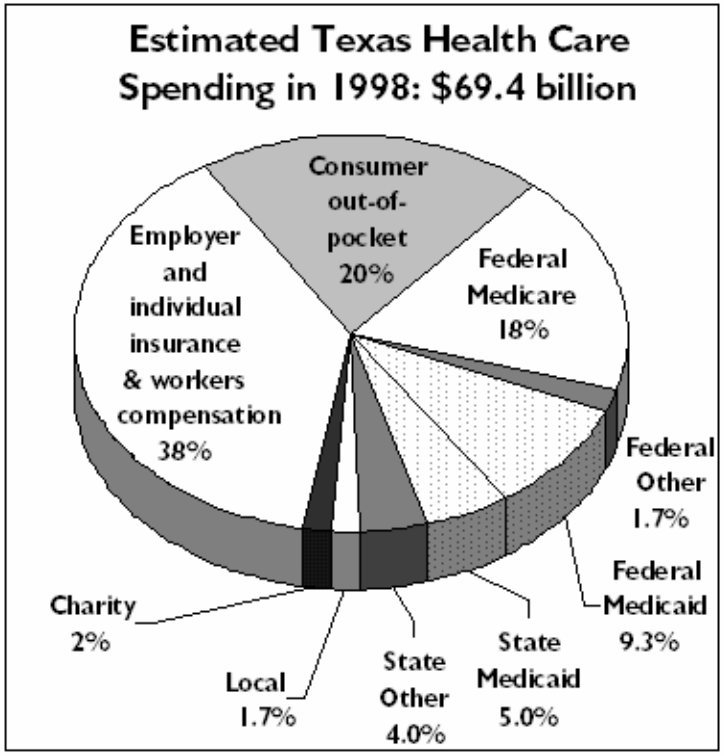
The purpose of this primer is to give readers an introductory overview of factors shaping Texans' access to health care. We define "access" as the ability to obtain health services in a timely manner, to have those services paid for privately or publicly, and to have an adequate infrastructure of health 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.

Perhaps the most well-known, and most alarming, fact about health care access in Texas is that the state has the highest percentages of children and of working-age adults who are uninsured. Recent legislative cuts to the state's Medicaid and Children's Health Insurance Program (CHIP) will further restrict low-income Texans' access to health care.

Beyond the information presented in this primer about the insured, the uninsured, and public programs that make up the health care safety net, our goal is to convey a picture beyond the numbers and facts illustrated. Through this information, we should reach into our hearts—and not only find compassion, but ask ourselves: Is this the kind of society I want to live in? Is it wise that many of the children we will depend on for our future state economic viability are without health care, and thus poorly equipped for the task? Is it fair that a significant number of Texans work hard at full-time jobs, yet do not get the health insurance coverage provided by employers to others?

If public policies reflect our values in action, then we must ensure that our values are heard. For our values to be heard, we must speak out. Methodist Healthcare Ministries and the Center for Public Policy Priorities ask you to stand up and be counted, and to actively engage in the issues that challenge your values so that our society reflects your principles.



SOURCE: Texas Comptroller of Public Accounts, *Texas Health Care Spending* (March 2001), Table 1. Figures do not add to 100% because of rounding.

How is Health Care Paid For in Texas?

The latest estimates of annual personal health care spending in Texas range from $68.4 billion to almost $70 billion in 1998. Private and public employers (38 percent of health care spending) and individual consumers (20 percent) combined pay for well over half (58 percent) of all health care in Texas, according to a study by the Texas 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 payments for health care bills, prescription drugs, and other out-of-pocket costs.

Federal, state, and local government programs combined account for 40 percent of Texas health care spending in the chart at left. Using health care data that are comparable to national-level statistics, however, the public share in Texas was closer to 44 percent in 1998. Compared to the U.S. average of 48 percent, public programs in Texas cover a smaller share of all health care spending. 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.

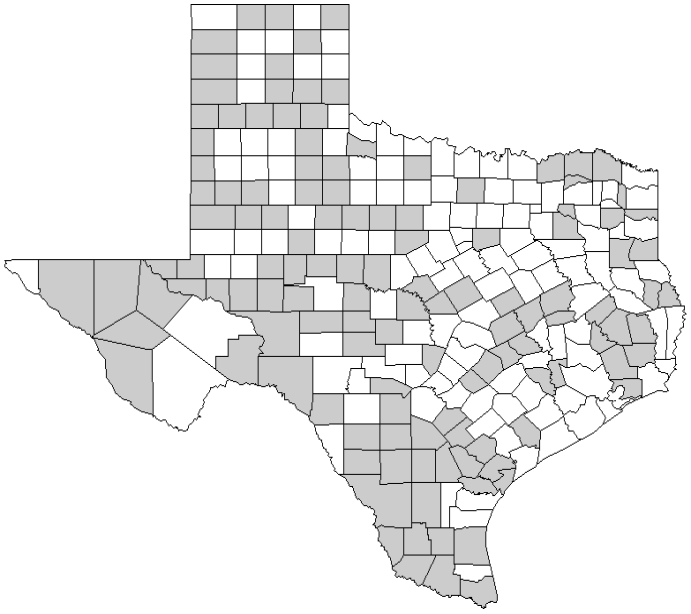
"Charity" consists of public and private hospital charity care; physician charity and bad debt; pharmaceutical companies' charity programs; and medical services funded by nonprofit groups. It is not the same as all health care spending for the uninsured. The Comptroller identified at least $1 billion in unduplicated charitable Texas health care spending in 1998.

Health Care Infrastructure Rankings

Per 100,000 population:	Texas	U.S.	Texas Rank
Physicians, 2000	201	251	38th
Registered nurses, 1999	558	671	45th
Hospital beds, 2000	268	293	32nd
Emergency medical technicians and paramedics, 2001	48.9	59.3	36th
Dental hygenists, 2001	40.8	51.7	39th

SOURCES: *Statistical Abstract of the United States, 2002*; U.S. Dept. of Health and Human Services, Bureau of Health Professions; U.S. Bureau of Labor Statistics. Figures exclude federal physicians and hospitals.

Primary Care Health Professional Shortage Areas, 2003



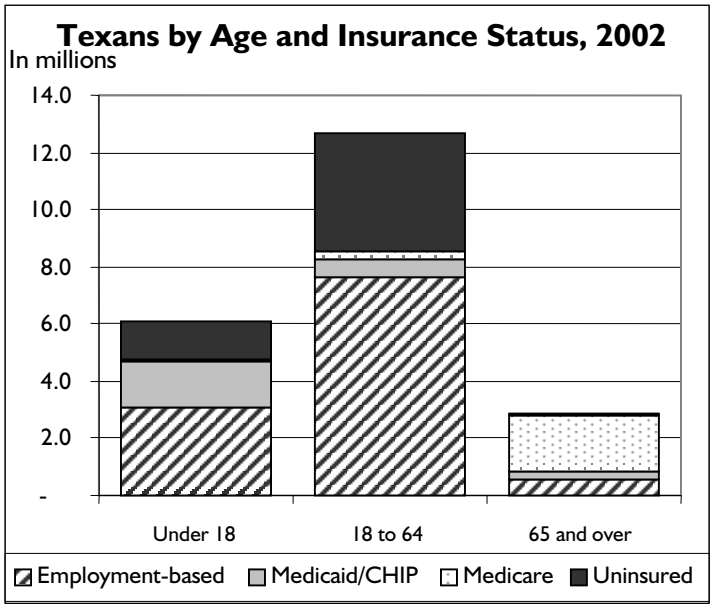
Entire counties shown in gray had a primary care HPSA designation in August 2003. SOURCE: U.S. Dept. of Health and Human Services, Bureau of Health Professions.

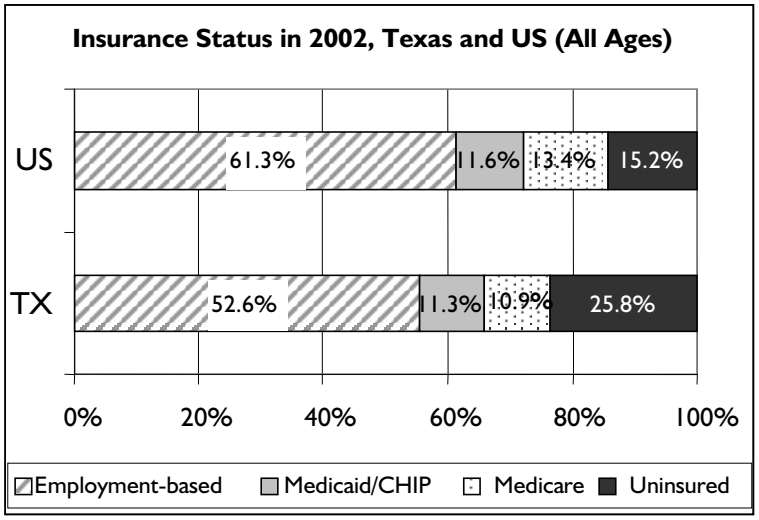
How Does the State's Health Care Infrastructure Compare to Other States?

The latest data show that in Texas, health care spending is 11 percent of the Gross State Product—1 percent lower than the national average. This smaller share may in part be due to the 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 doctors, nurses, other health personnel, and hospital beds is adjusted for the total population of the state.

Even with the lower rates of health care workers, however, health care jobs are an important part of the state economy. Private-sector health care services employed more than 862,000 Texans in 2001, with a combined annual payroll exceeding $32 billion. The health services share of total workers' earnings (7.2 percent) is slightly larger than its share of total jobs (6.9 percent), reflecting the higher-than-average wages paid to high-skilled health care professionals. Texas state and local governments employed another 125,900 health and hospital workers in 2001, with an annual payroll of $3.8 billion.

Analyzing the state's health care infrastructure requires looking below the state-level data to the local availability of health care professionals. Several federal designations, such as Medically Underserved Area or Health Professional Shortage Area (HPSA), are used to identify regions where health professionals are in short supply. In August 2003, half (127) of all Texas counties were entirely designated as primary care HPSAs; 77 counties were dental care HPSAs; and 179 counties were mental health care HPSAs. 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.





SOURCE: U.S. Bureau of the Census, March 2002 Current Population Survey. Charts do not show the small amount of people covered by military health care or non-employment based private insurance.

Who Has Access?

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

Three-fourths of Texans do have health insurance, whether through their employer or through a government program—primarily Medicare or Medicaid. Residents aged 65 or over are the most likely to be insured. In 2002, 94 percent of Texans 65 and over were covered by Medicare; fewer than 2 percent of senior Texans lacked insurance of any kind.

Among **working-age Texans** (18 to 64), the primary source of coverage is employment-based insurance, covering 57 percent of these adults. But because Medicaid and Medicare coverage for working-age adults is low (4.5 and 2.1 percent, respectively), Texans in this age group are the most likely to be uninsured (31 percent in 2002). Among Texas **children**, 51 percent were covered because a family member had employment-based insurance, and the remainder were mostly divided between Medicaid and CHIP (26 percent) or no insurance at all (22 percent) in 2002.

Texas has the highest uninsured rate—25.8 percent in 2002—in the nation. The U.S. average is 15.2 percent, or more than 43.5 million uninsured nationwide. More than 5.5 million Texans had no health insurance in 2002.

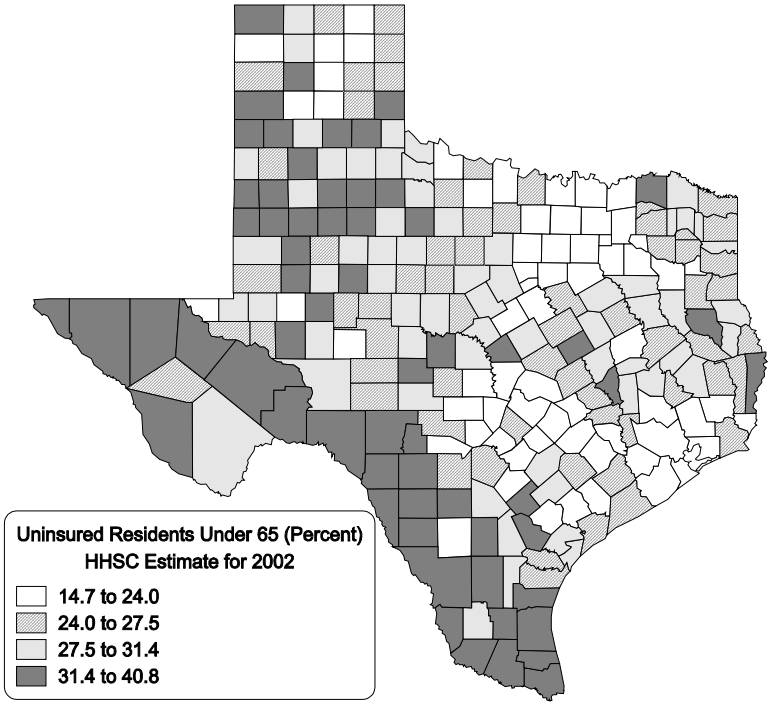
Single-year estimates of uninsured Texans come from the Census Bureau's Current Population Survey (CPS)—the source of the statistics cited above. Other studies reveal that Texans are also more likely to lack insurance for long periods of time. The 1999 National Survey of America's Families found that more than half of the 20.5 percent of Americans uninsured at any time in 1999 went without

coverage for 12 or more months. The same survey showed that 31.2 percent of Texans lacked insurance at some point in 1999; of those, two-thirds were uninsured for a year or more. Persons who go for longer periods without insurance are those with lower incomes, those in fair or poor health, and the middle-aged (who have higher rates of chronic disease).

Between 2001 and 2002, an estimated 7.6 million Texans (40 percent of all Texans under 65, the highest rate in the U.S.) were uninsured for some length of time. Two-thirds of these Texans went without coverage for 6 months or more, and almost one-fourth were uninsured for the entire 2 years.

The 7.6 million Texans who experienced a spell of being uninsured over 24 months is much larger than the 5 million uninsured in the 2001 CPS, 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 2001 regained coverage in 2002, a new group of different individuals lost coverage in 2002. In conclusion, Texans are at higher risk than other Americans of being uninsured both for short and longer periods.

Within Texas (see chart at right), the percentage of residents with no insurance is highest in counties along the U.S.-Mexico border and in rural counties. This is largely because these areas lack the kind of higher-paying jobs that would either offer employer-provided coverage, or pay high enough salaries so that workers could purchase insurance coverage for themselves and their families. These counties are also likely to have much higher than average unemployment rates.



SOURCE: Texas Health and Human Services Commission, Research Department, April 2003.

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

	Texas	U.S. Average
ASSOCIATED WITH MORE ACCESS		
Manufacturing jobs as % of all jobs, 2001	8.7%	10.2%
Workers covered by a union, 2001	6.8%	14.8%
Private-sector union members, 2001	3.6%	9.0%
ASSOCIATED WITH LESS ACCESS		
Involuntary part-time workers as % of all part-time workers, 2000	9.9%	8.7%
Farming jobs as % of all jobs, 2001	2.4%	1.8%
Construction jobs as % of all jobs, 2001	6.7%	5.9%
Workers earning poverty-level wages, 2001	30.4%	23.9%

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

Who Has Employer-Based and Other Private Insurance?

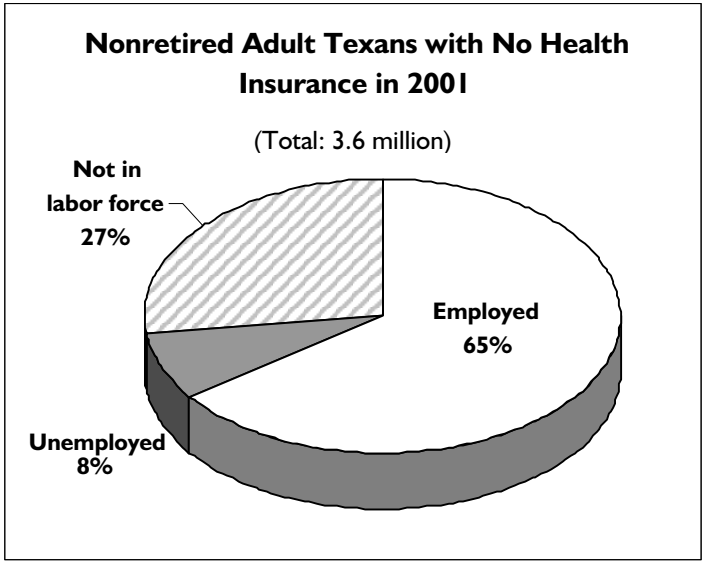
In 2002, 55 percent of Texans under 65 years of age had health insurance through their own or a family member's job—considerably below the U.S. average of 65 percent. What's worse, with the recent economic downturn, the trend is for *fewer* Texans to get health insurance through their job. In 2000, 60 percent of Texans under 65 had employer-provided health insurance.

Texans at firms with up to 24 workers were most likely to lack coverage: 40 percent of workers at these small employers were uninsured in 2001. For firms with 25 to 99 workers, the statistics show 26 percent of workers uninsured. Even at firms with 100 to 499 employees, though, 19 percent 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 statistics are very similar to national averages.)

Factors explaining the lower rate of employer-based coverage are a higher share of workers employed involuntarily at part-time jobs (i.e., they cannot find full-time jobs); a lower share of manufacturing and higher share of construction and farming jobs; and low rates of unionization, all of which make Texas workers less likely to have employer-based health insurance.

Employers who provide health insurance benefits to their workers, and the workers who receive them, get federal tax subsidies amounting to almost $151 billion in 2003, according to the federal Office of Management and Budget.[*] In comparison, federal Medicare outlays in 2003 will total $241 billion; Medicaid and the Children's Health Insurance Program will cost $167 billion in federal funds.

[*] OMB estimates the cost of tax expenditures on health insurance (including medical savings accounts and workers compensation) by determining the amount that would be required to "provide the taxpayer the same after-tax income" as the tax expenditure.



SOURCE: Texas Health & Human Services Commission, "Demographic Profile of the Texas Population Without Health Insurance in 2001."

Who is Working and Uninsured?

A popular misconception is that only people who don't work lack health insurance. It is true that 49 percent of unemployed Texans in 2001 were uninsured, compared to 25 percent of all working-age Texans who had no insurance. However, being employed still leaves working-age Texans with a 25 percent chance of being uninsured. Another way to look at the same statistics: the employed account for 2 of every 3 uninsured working-age Texans in 2001 (see chart).

There are several reasons why working Texans don't have either public or private health insurance. One is that the limits on Medicaid eligibility categories in federal law exclude many adults from that safety net program: namely, childless adults 18 to 65 years old, unless they are pregnant or disabled. Medicaid policy decisions made by Texas further limit the ability of the program to serve working-poor parents. Wages—even from a part-time, low-paying job—make most adults ineligible for Medicaid because of very stringent income requirements for adults. Texas Medicaid only covers parents with incomes below 24% percent of poverty, or $308 per month for a working parent with two children. At the minimum hourly wage of $5.15, working 14 or more hours a week would disqualify a parent from continuing to receive Texas Medicaid.

In 2001, when statewide unemployment averaged only 5 percent, almost one-third of Texas adults under 65 were low-income (below 200% of poverty, or about $29,300 for a family of three in 2001). Most of these workers earn too much to qualify for Medicaid for themselves, but not enough to be able to purchase health insurance for themselves or their dependents, even if their employer is willing to help pay part of those costs. More than a third (37 percent) of Texans with incomes between 100 to 200% of poverty were uninsured in 2001, compared to 43 percent of those with incomes below 100% of poverty.

Texans with incomes above 200% of poverty have a better than average chance of being insured. In 2001, only 15 percent of Texans above 200% of poverty were uninsured.

Estimated Monthly Household Expenses for Two Parents and a Child, 2001

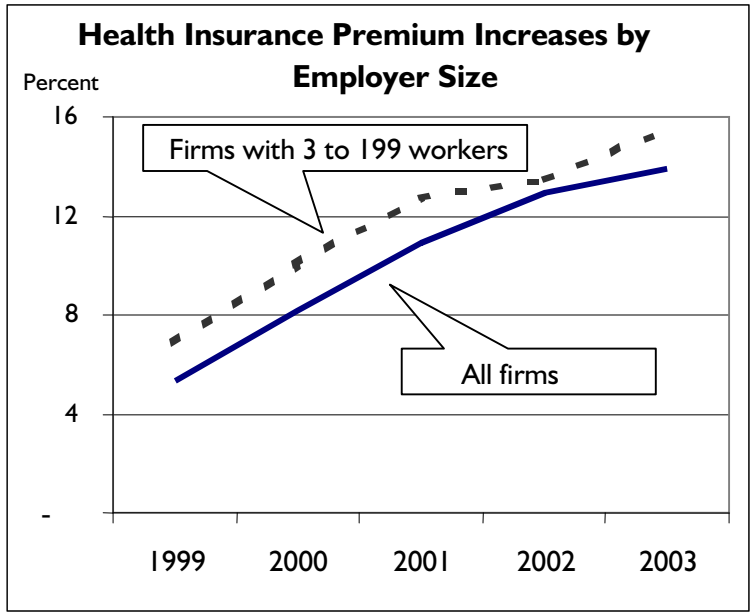
	Housing, Food, Child Care, Transportation, Other Needs	Medical Costs	Increase Needed to Cover Medical Costs
Abilene	$1,735	$769	44.3%
Amarillo	1,727	841	48.7
Austin-San Marcos	2,263	727	32.1
Beaumont-Port Arthur	1,722	841	48.8
Brazoria	1,960	652	33.3
Brownsville-Harlingen-San Benito	1,725	847	49.1
Bryan-College Station	1,879	776	41.3
Corpus Christi	1,867	841	45.0
Dallas	2,215	687	31.0
El Paso	1,773	652	36.8
Fort Worth-Arlington	2,028	687	33.9
Galveston-Texas City	1,918	652	34.0
Houston	2,039	652	32.0
Killeen-Temple	1,775	776	43.7
Laredo	1,775	680	38.3
Longview-Marshall	1,703	847	49.7
Lubbock	1,816	723	39.8
McAllen-Edinburg-Mission	1,695	847	50.0
Odessa-Midland	1,712	777	45.4
San Angelo	1,723	841	48.8
San Antonio	1,904	612	32.1
Sherman-Denison	1,710	847	49.5
Texarkana	1,730	847	49.0
Tyler	1,742	841	48.3
Victoria	1,780	847	47.6
Waco	1,766	776	43.9
Wichita Falls	1,733	847	48.9

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 recent attempt to estimate this is the Family Security Index (FSI), a tool developed by the Center for Public Policy Priorities in 2001.

The FSI uses the cost of family coverage under the Employees Retirement System (ERS) health insurance plan for state employees to model a metro-level cost of comprehensive coverage. ERS is the largest employee group in Texas, so smaller employers and individual purchasers of health insurance would face much higher costs than the amounts used in the FSI. Thus, the figures shown in the chart estimate the minimum, not average, cost of health insurance in 2001.

The FSI data show that if families were to pay health insurance premiums entirely on their own, their monthly expenses would rise an average of 30 percent (in larger urban areas) to 50 percent (in the Border/Valley and smaller cities). A two-parent, one-child family in Abilene, for example, has monthly costs of $485 for housing; $327 for food; $257 for child care; $381 for transportation; and $285 for other necessities (local phone service, clothing, shoes, household supplies, etc.), for a total of $1,735. If $769 for family coverage were added, health care would surpass housing as the largest item in the monthly budget, which would rise to $2,504. Factoring in federal taxes and credits, the family would need a monthly income of $2,821, or $17 an hour, to support the family (one worker employed full-time at that rate, or both parents working for a combined $17 hourly wage).



SOURCE: Kaiser Family Foundation/Health Research and Educational Trust annual surveys of Employer Sponsored Health Benefits, 1999-2003.

Why More Employers Don't Provide Health Insurance

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

Small businesses surveyed by the Texas Department of Insurance identified unaffordable premiums as the main reason they don't offer coverage to their workers.[*] Almost two-thirds (62 percent) of those surveyed had either tried to purchase coverage for workers but found it too expensive, or assumed it was too costly and did not even explore coverage options. Those who did offer health insurance were asked if they were likely to stop offering this benefit: less than 15 percent said this was "almost certain" or "very likely" in the next five years. Another 21 percent said they were "somewhat likely" to drop coverage.

Nationally, premiums for family coverage for employer-sponsored health insurance averaged $756 per month in 2003. For Texas firms, single and family premium costs in the late 1990s were at or above the national average. Texas premiums may be higher because of population characteristics (more obese residents with more diabetes and heart disease problems). Other explanations include a lower usage of HMOs and wider access to provider networks.

From 2002 to 2003, private health insurance premiums rose an average of 13.9 percent for all employers, and by 15.5 percent for employers with 3 to 199 workers. This is the third year in a row that premiums experienced double-digit increases, based on employer surveys done by the Kaiser Family Foundation and the Health Research and Educational Trust.

[*] Texas Department of Insurance, *Texas State Planning Grant [federal Health Resources and Services Administration]: Final Report*, March 2003.

Medicare Program Rankings

	Texas	U.S. Average	Texas Rank
Medicare spending per enrollee, 2001	$7,104	$5,870	5th
Medicare payment per hospital day, 2000	$2,947	$2,694	7th
Medicare spending as a percent of total personal health care spending, 1998	21.2%	20.6%	14th
Medicare+Choice (Managed Care) Enrollees as Percent of All Medicare Beneficiaries, 2002	7.1%	12.5%	19th
Elderly (aged 65 and over) covered by Medicare, 2002	94.0%	95.3%	40th

SOURCES: *CQ's State Fact Finder 2002*; Centers for Medicaid and Medicare; Kaiser Family Foundation; U.S. Bureau of the Census, Current Population Survey, March 2002 Supplement.

Who Gets Medicare?

Medicare is the federal 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. The program served 2.3 million Texans in 2001, or about one out of seven Texans with insurance that year. Most Medicare recipients are retirees aged 65 and over (and can be of any income level), or under 65 but disabled or with end-stage renal disease. Almost 2.3 million Texans had Medicare Part A (insurance covering in-patient hospital expenses). Of these, 2.2 million opted for Part B, which covers outpatient costs, such as doctors' fees.

In Texas, Medicare enrollment relative to the number of residents 65 or older is slightly below the national average, but spending per enrollee is higher (see table at left). 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 next pages.) 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 is currently debating adding a prescription drug benefit to Medicare. Adding prescription drug coverage would provide significant relief to the 38 percent of elderly and disabled Medicare beneficiaries who lack such coverage and must pay for medications themselves.

Medicaid Program Rankings

	Texas	U.S. Average	Texas Rank
Average Medicaid spending per child, 2000	$1,634	$1,744	35th
Medicaid spending as a percent of total personal health care spending, 1998	12.6%	15.7%	37th
Average Medicaid spending per aged/disabled recipient, 2000	$9,211	$11,394	39th
Medicaid managed care enrollees as a percent of all Medicaid enrollees, 2001	42.9%	58.3%	41st
Medicaid recipients as a percent of poverty population, 2001*	63.1%	111.2%	47th

* NOTE: Not all people below the poverty line (100% of poverty) receive Medicaid services. The ratio of Medicaid recipients to residents below the poverty line nationwide is higher than 100% because some Medicaid eligibility categories have income cut-offs that are above 100% of poverty.

SOURCES: *CQ's State Fact Finder 2002*; Centers for Medicaid and Medicare; Kaiser Family Foundation; U.S. Bureau of the Census, Current Population Survey, March Supplement.

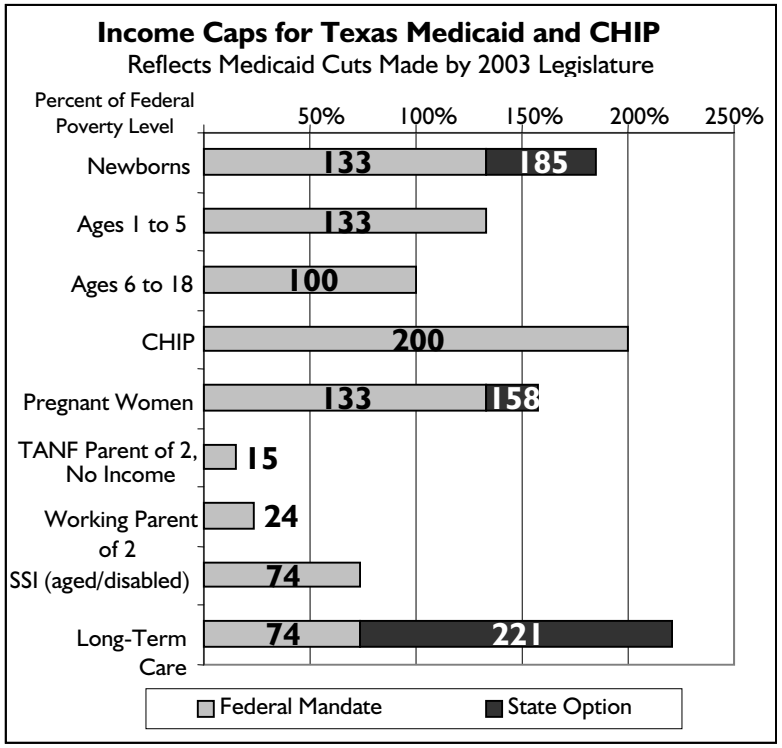
Who Gets Medicaid?

Medicaid is the federal health care program that covers low-income people, as well as some elderly and persons with disabilities. In September 2003, Texas had almost 2.5 million Medicaid enrollees.

To receive or "draw down" federal Medicaid funds, states (and/or local governments) are required to match a portion of these funds with their own 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 has given the state low rankings on Medicaid statistics, as seen at left. These rankings will probably worsen once the 2003 legislative cuts to Medicaid eligibility and benefits take effect.

How Much More in Medicaid Matching Funds Could Texas Get?
Texas receives about $1.50 in federal Medicaid funds for every state dollar invested in the program. In practical terms, the limiting factor on getting more federal funds is the state's willingness to put up its share of Medicaid funding. For example, Texas could (without any special waiver) increase Medicaid coverage of parents with dependent children. Texas has at least 350,000 working poor parents who are uninsured—more than twice the number of parents who currently get Medicaid. If Texas were to cover all these working parents below poverty on Medicaid, the full cost for a year would be roughly $950 million, about $380 million of which the state would have to fund. This would bring about $572 million in federal matching dollars to Texas. Texas could also increase coverage of children and pregnant women if it was willing to provide the state match.



Eligibility Category	Annual Income Limit*
Medicaid for Newborns	$28,231
Medicaid for Children ages 1 to 5	20,296
Medicaid for Children ages 6 to 18	15,260
CHIP for Children ages 0 to 18	30,520
Medicaid for Pregnant Women	24,111
Medicaid for TANF Parent of 2, no income	2,256
Medicaid for a Working Parent of 2	3,696
SSI (Aged or Disabled)	6,624
Long-Term Care	19,872

*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.

Medicaid and CHIP Income Eligibility Comparisons:

The 78th Texas Legislature made these changes to Medicaid eligibility, effective September 1, 2003:

- **Eliminated the Medically Needy Spend-Down Program for Adults.** The Medically Needy "Spend-down" program gave full Medicaid benefits on a month-to-month basis to adults in certain very low-income families with large medical bills. At least 10,000 fewer Texans per month will get Medicaid in 2004-05 due to the legislature's elimination of this program.
- **Reduced Medicaid Maternity Coverage** from 185% of the federal poverty line to 158% of the poverty line. At least 8,300 fewer pregnant women per month will get Medicaid due to this cut.

Children's Medicaid. The federal minimum requirement for children's Medicaid eligibility is 133% of the federal poverty line for kids up to 5 years old, and 100% for children 6 to 18. Texas goes beyond the minimum only in the case of newborns, covering them at up to 185% of poverty. Fourteen states cover all children up to 200% of poverty or higher; another five states cover all children up to 185% of the poverty line (many of these states chose the Medicaid expansion option for CHIP).

The only area of Texas' child Medicaid coverage in which some states do less is newborn coverage; 15 states cover them at a lower level than Texas. (Federal law prohibits Texas from lowering its level, unless it gives up all federal CHIP funding). Missouri and Vermont 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 poverty.

Sixteen states cover children over 200% of poverty: 11 in separate state CHIP and state-funded programs, and five in Medicaid. New Jersey has the highest CHIP income cap at 350% of the poverty line, while Massachusetts covers children between 200% to 400% of poverty in a state-funded program.

Six states set the CHIP cap below 200% of poverty, and another five states which chose the Medicaid expansion option for CHIP have caps below 200% of poverty.

Eligibility policy changes passed by the 2003 legislature are projected by state officials to reduce CHIP enrollment by 160,000 to 169,000 in 2005—a reduction of about one-third from 2003 enrollment. Changes include a new limit on cash and vehicle assets for families at or above 150% of the federal poverty income.

Medicaid Maternity Coverage. After Texas' reduced income cap of 158% of poverty took effect September 2003, only 15 states have lower caps than Texas. Seventeen states offer maternity coverage up to 185% of poverty, and another 16 states cover women up to 200% of poverty or higher. Minnesota has the most generous income cap, at 275% of the federal poverty line.

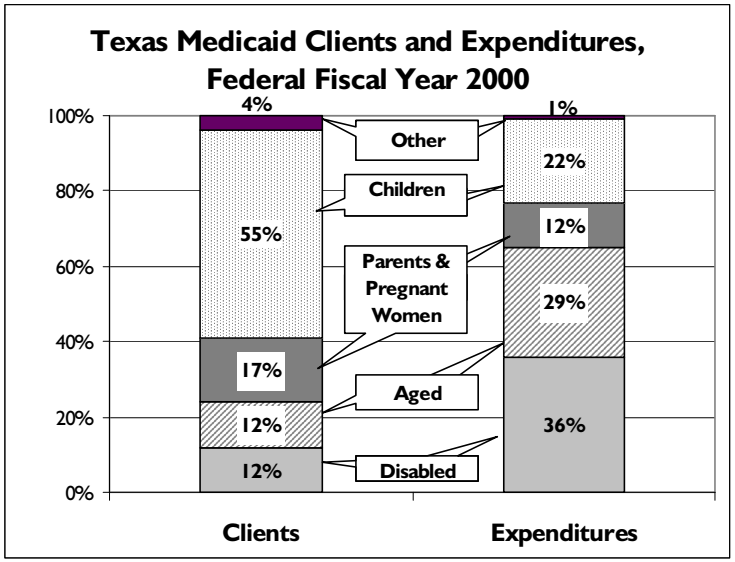
Parents' Medicaid. Only Louisiana has a lower income cap than Texas for Medicaid coverage of parents. On the other end of the spectrum, six states cover parents with dependent children at 185% of poverty or higher.

Medically Needy and Coverage of Aged and Disabled. In September 2003, Texas became the 16th state to offer no Medically Needy "Spend-down" program for adults. All other states and the District of Columbia have these programs, and unlike Texas, their programs are available not only to poor families with children, but also to aged and disabled persons.

All states provide Medicaid to most aged and disabled persons on Supplemental Security Income (SSI—$552 monthly for an individual). Five states set SSI-related Medicaid caps at lower 1972 income levels, but they must allow SSI recipients with medical expenses to "spend down" into Medicaid. Nineteen states set the SSI-related cap above the federal limit, covering more aged and disabled clients with full Medicaid benefits.

All states have some ability for persons above the SSI income to access nursing home care and community-based care. In many states, the medically needy program for aged and disabled persons is one such route. States (including Texas) also may set a "special income limit" for long-term care at as much as three times the SSI cap (e.g., 35 states including Texas set it at this level for nursing home care). In Texas, this is also the income limit for community care "waivers" designed to keep people out of institutions, but states can set this limit either higher or lower than the nursing home cap.

Caseloads versus Costs:
In Texas and other states, children and low-income adults are a large part of the Medicaid caseload, but account for only a small part of Medicaid spending. Children and low-income parents were almost three-fourths (72 percent) of Texas Medicaid clients in 2000, but only one-third (34 percent) of Medicaid spending was for these clients. Aged/disabled clients were one-fourth (24 percent) of the caseload and two-thirds (65 percent) of Medicaid spending.



SOURCE: Texas Health and Human Services Commission. "Other" are mostly long-term care clients. Some children are in "Disabled" category.

Key Local Health Care Program Rankings

	Texas	U.S. Average	Texas compared to U.S.
Local government per-capita spending on **public health,** 2000	$62	$85	73%
State government per-capita spending on public health, 2000	$49	$98	50%
State and local government per-capita spending on public health, 2000	$111	$183	61%
Local government per-capita spending on **hospitals**, 2000	$173	$156	111%
State government per-capita spending on hospitals, 2000	$140	$114	123%
State and local government per-capita spending on hospitals, 2000	$313	$270	116%

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

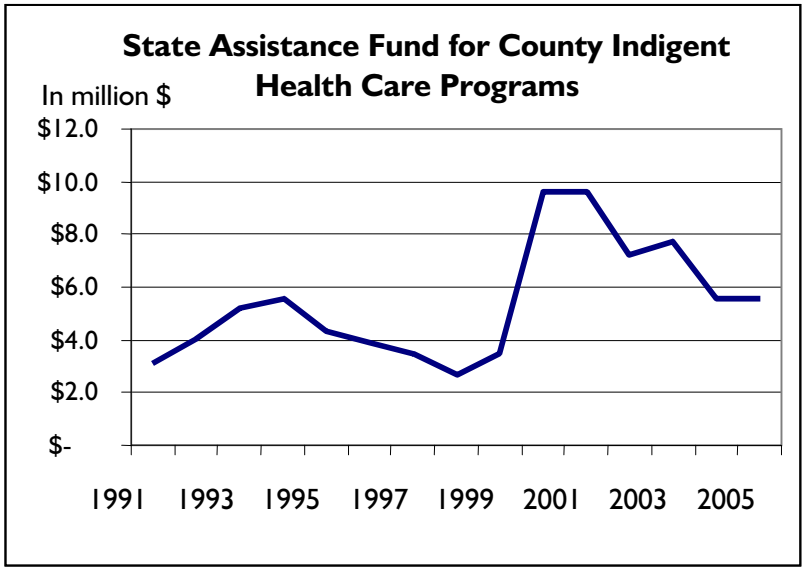
Who Is Served by Local Public Health Care Spending?

Local governments in Texas and other states fund or 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, immunization, and lead poisoning or HIV prevention; and EMS services and trauma care for area residents. Local public hospitals account for about one-third of all hospitals in Texas and almost one-fifth of all staffed hospital beds.

Because of the variety of services, and the diverse types and responsibilities of local governments, the most accurate way to compare Texas local spending is with U.S. Census Bureau data on public health and hospital spending. The table at left shows that Texas local governments' public health spending is considerably closer to the national average than is the state government's spending on public health programs. Hospital spending by Texas local governments is actually higher than the U.S. average for local governments. State government spending on hospitals also surpasses the national average, because the state funds health science centers and other hospitals associated with public universities.

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

Among Texas' local governments, the costs of unreimbursed care fall mainly on hospital districts, based on Texas Department of Health data. In 2001, public hospital districts reported $1.2 billion in unreimbursed care, up 39 percent from 1999. County governments spent $241 million, an increase of 5 percent since 1999. Cities reported $37 million in unreimbursed care, up 31 percent from 1999.



SOURCES: Texas Department of Health and Legislative Budget Board.

What Is the Counties' Role in Providing Health Care?

Texas counties are required by state law to provide certain basic health care services to indigent residents. State law defines "indigent" at a minimum as someone with few or no assets (such as an automobile) and with an income below 21% of the poverty line. In 2003, this means an annual income of less than $1,896 for one person, or $3,216 for a family of three.

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

Depending on which option they choose and who is served, counties may also receive state and federal funding for their indigent care services. Counties with indigent health care programs can qualify for state assistance if they spend more than 8 percent of their general tax revenue on state-approved basic and optional health services that are medically necessary. However, the state assistance fund is not large enough to reimburse all counties' eligible spending, and will provide even less help in the next two years because of state budget cuts. In fiscal 2004 and 2005, the state assistance fund will make only $5.6 million available annually to Texas counties, down from $9.6 million in fiscal 2000 and 2001.

About one-third (87) of the state's counties, home to more than half the state's population, have only a hospital district to provide indigent care. Another 110 counties, where one-third of Texans live, have only a county indigent health program. The remaining counties have chosen either the public hospital option (29 counties, mostly rural), or use a combination of a county program and a hospital district or public hospital to serve residents.

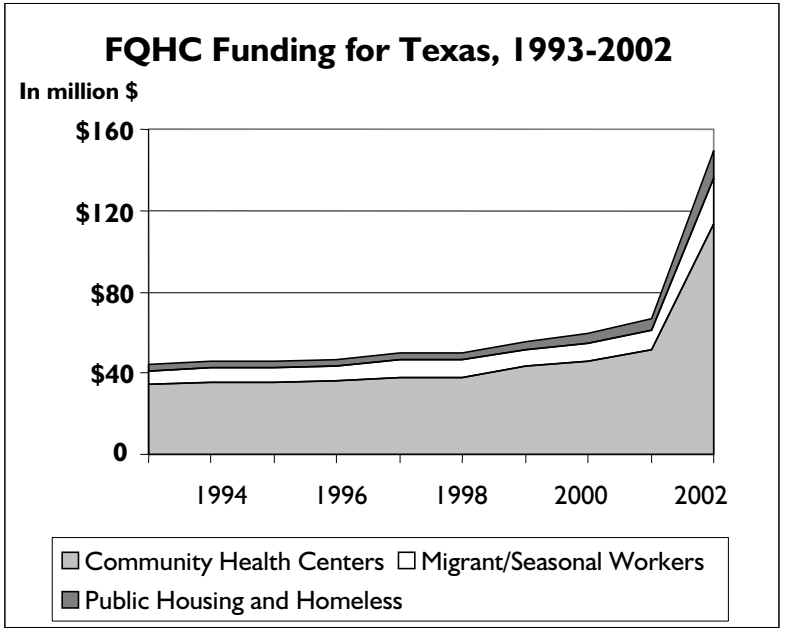
Federally Qualified Health Centers

"Federally Qualified Health Center" (FQHC) is a designation given by the federal Bureau of Primary Health Care to certain public or non-profit primary health clinics serving the uninsured or underserved. FQHCs receive federal funding from various programs created by Congress over the years. The four types of FQHCs are Community or Migrant Health Centers; Health Care for the Homeless Programs; Healthy Schools, Healthy Communities; and Public Housing Primary Care Programs. For all these programs combined, Texas FQHCs received $150 million in 2002. This is up significantly from $44 million in 1993, but FQHC funding is still less than 0.3 percent of Texas health care spending. FQHCs serve almost 484,000 Texans. About 60 percent of Texas FQHC clients are uninsured. FQHCs are also reimbursed from private insurance, Medicare, Medicaid, and CHIP.

Community Health Centers (CHCs) provide comprehensive primary health care for rural and urban residents with financial, geographic, or cultural barriers to care. CHCs also provide transportation, translation, preventive health care, mental health, and dental services. These health centers are public or nonprofit private corporations created by local residents and governed by consumer-majority boards of directors, and thus represent the communities they serve. 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 2003, Texas had 36 FQHCs (two serve homeless persons only), providing services at more than 140 sites in 43 counties. Texas FQHCs are most heavily concentrated along the U.S.-Mexico border and in South and East Texas. While FQHCs serve significant numbers in San Antonio, Austin, and El Paso, their presence in Dallas and Houston is quite limited. Fort Worth has no FQHCs at all. Texas has set up a state-funded incubator grant program to help more communities apply for FQHCs.

Recently, both the federal and state governments have earmarked funds to expand or start new FQHCs. However, while FQHCs provide comprehensive primary care benefits to their clients, they do not provide specialty care or hospital care. Any plan to expand FQHCs as an alternative to providing private or public coverage to the uninsured must also find a way to fund and provide access to specialist and hospital care.



SOURCE: U.S. Bureau of the Census, Consolidated Federal Funds Report.

Selected Statistics About Elderly Texans

	Texas	U.S.
62-74-yr olds with health insurance, 1999-2000:		
Men	95.5%	96.2%
Women	92.9%	95.6%
62 to 74-year olds in poverty, 1998-2000:		
Men	9.7%	7.4%
Women	12.8%	10.7%
Age 65+ with Self-Care Limitations, 2000	10.8%	8.9%
Age 65+ with Mobility Limitations, 2000	19.0%	18.1%
Age 65+ with Cognitive/Mental Limitations, 2000	12.0%	10.2%
Medicaid Beneficiaries 65+ Receiving Skilled Nursing and other Home Health Services, 2000	5.8%	6.4%
Median Wage, Personal & Home Care Aide, 2000	$6.11/hr	$7.81/hr
Median Wage, Home Health Aide, 2000	$6.60/hr	$8.13/hr

SOURCE: AARP Public Policy Institute; Centers for Medicare and Medicaid Services, MSIS Statistical Reports.

Who Is Not Covered by 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 have health insurance and more live in poverty than elderly people in the United States on average.

Probably the most well known health care gap for the elderly is that individuals covered by Medicare lack prescription drug coverage—an issue Congress is trying to resolve in 2003. Some can afford to buy "Medigap" (supplemental health insurance coverage) to pay for medications; others may live in a part of Texas where the Medicare+Choice plan offers prescription drug coverage through an HMO. All others are finding prescription drugs increasingly difficult to afford.

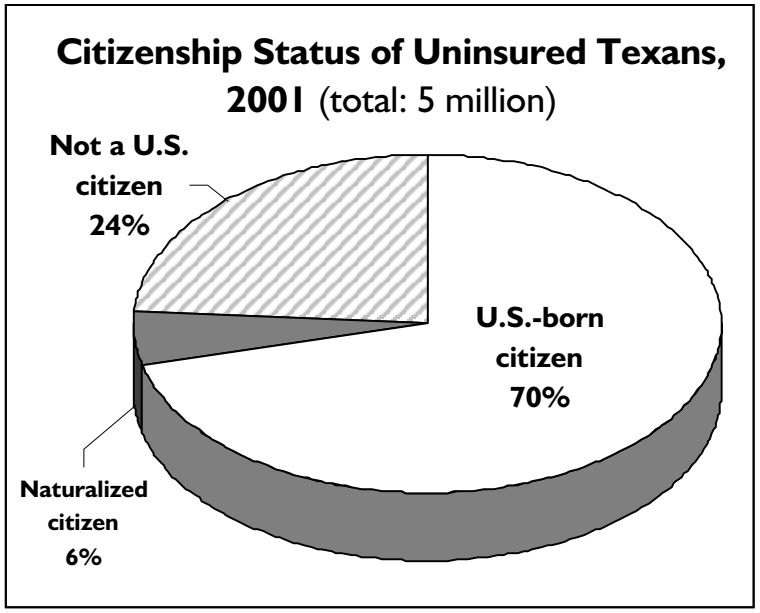
The Medicare nursing home benefit is also very limited and in most cases is not an option for those needing long-term care. Medicare pays for a nursing home only after someone has been hospitalized, and for only 100 days for each incident (or "spell") of illness.

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 a person in this situation has income low enough to qualify them for Supplemental Security Income (SSI), Medicaid can help with their medical costs; otherwise, he or she has to find another way to pay for their medical bills.

The table summarizes indicators that point to a higher need in Texas for health care services for the elderly, and for the elderly and disabled, than in the U.S. on average.

Immigrants in General:
Texas has 2.9 million foreign-born residents, the third largest population (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.

Over 900,000 foreign-born Texas residents have become naturalized U.S. citizens; they are uninsured at higher rates (27 percent) than are U.S.-born residents (18 percent). More than half of the almost 2 million immigrants in Texas who are not U.S. citizens (legal permanent residents, undocumented immigrants, and other foreign-born residents) are uninsured, a rate three times as high as that for native-born residents. Still, as the chart illustrates, non-citizens, both legal and undocumented, are less than one-fourth of Texas' uninsured.



SOURCE: Texas Health and Human Services Commission, "Demographic Profile of the Texas Population Without Health Insurance in 2001."

Compared to other large states with similar demographics, Texas has by far the highest percentage (40 percent) of children of immigrants who are also uninsured. This is true despite the fact that children of immigrants, more often than not, are U.S. citizens and thus eligible for CHIP or Medicaid on the same terms as any other U.S. citizen child. Many Texas children live in families that include U.S. citizens, legal immigrants, and undocumented members; 23 percent of all Texas children live in "mixed families" (one or more parent is a non-citizen, either legal or undocumented), and 34 percent of Texas children in low-income families (below 200% of the poverty line) are in mixed families.

Legal Immigrants:
Federal law lets states choose whether or not to provide Medicaid to legal permanent residents based on when they entered the U.S. 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 currently eligible for Medicaid on the same basis as U.S. citizens.

However, Texas is one of nine 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.

Unlike Medicaid, federal law requires states to include legal immigrant children in their CHIP programs. Thus, legal immigrant children in Texas who came to the U.S. after August 1996 are covered by the Texas CHIP program if they meet the income standards. In addition, under the Texas CHIP statute, state-funded CHIP benefits are provided during the 5-year "bar" on federal funding.

Undocumented Immigrants: The estimated 1.1 million undocumented immigrants living in Texas face numerous barriers to health care access. Undocumented immigrants have never been eligible for Medicaid or CHIP, and in 1996, federal welfare reform further restricted undocumented immigrants' access to certain federal public benefits.

However, services funded through the federal Maternal and Child Health Block Grant (Title V), Family Planning (Title X), the Primary Care Block Grant, and Federally Qualified Health Center funds may not be restricted based on immigration status.

* Alabama, Idaho, Indiana, Mississippi, North Dakota, Ohio, Virginia, and Wyoming are the others.

Federal law also mandates that no restrictions may be placed on federal, state, or local benefits providing emergency care (including labor/delivery and mental health emergencies), immunizations, diagnosis and treatment of communicable illnesses, and "other programs delivered at the community level necessary to protect life or safety."

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

State and Federal Policy Debates: At the state level, the 2003 Texas legislature passed a law permitting local governments to provide health care to their undocumented residents. This new law resolves a debate sparked in 2001 by a Texas Attorney General's opinion that use of local funds to serve the undocumented violated federal law, unless Texas law specifically permitted it. Other efforts to expand health care coverage for immigrants failed, and many of the cuts made in Medicaid, CHIP, and other health programs will also result in reduced care for all low-income immigrants.

There has been little progress at the federal level in removing the restrictions imposed on legal immigrants' eligibility for health care benefits by the 1996 welfare reform law. In mid-2003, Congress was debating extending Medicaid and CHIP benefits to more legal immigrants, through proposals such as the Immigrant Children's Health Improvement Act (ICHIA). ICHIA would give states the option to provide federally funded health benefits to immigrant children and pregnant women without a "5-year bar."

Health Care Access Issues Specific to Children

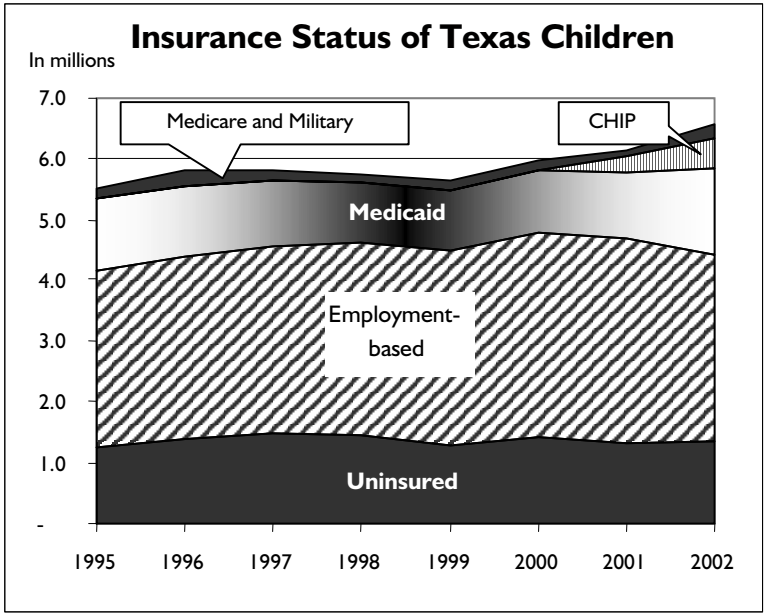
Texas children make up a larger share of the state population than do children in most other states. In 2000, over 28 percent of the Texas population was under 18, compared to the national average of 25.7 percent, giving Texas the 4th youngest population. Unfortunately, children in Texas are also much more likely to be poor and uninsured. Texas had the 10th highest child poverty rate in 2001, at 21.1 percent, and the highest percent of children uninsured in 2002, at 22.4 percent—almost twice the national average of 11.6 percent.

In absolute terms, employment-based coverage for Texas children peaked in 2000 at 3.4 million and has since fallen to just under 3.1 million. More than 300,000 children have lost employer-based coverage primarily because of the economic downturn, particularly the loss in Austin and Dallas-Fort Worth of high-tech and other high-paying jobs with benefits.

Children's Medicaid caseloads 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, caseloads for children's Medicaid started growing again because of a worsening economy, outreach efforts, and simplified eligibility procedures. By August 2002, almost 1.4 million children were served by Texas Medicaid; the latest figures show that Medicaid covers 1.6 million children statewide. Caseloads are expected to continue increasing, although not as much as they would have without legislative changes made in 2003. Various changes to children's Medicaid simplification will keep more than 332,000 children from being added to the Medicaid rolls by fiscal year 2005.

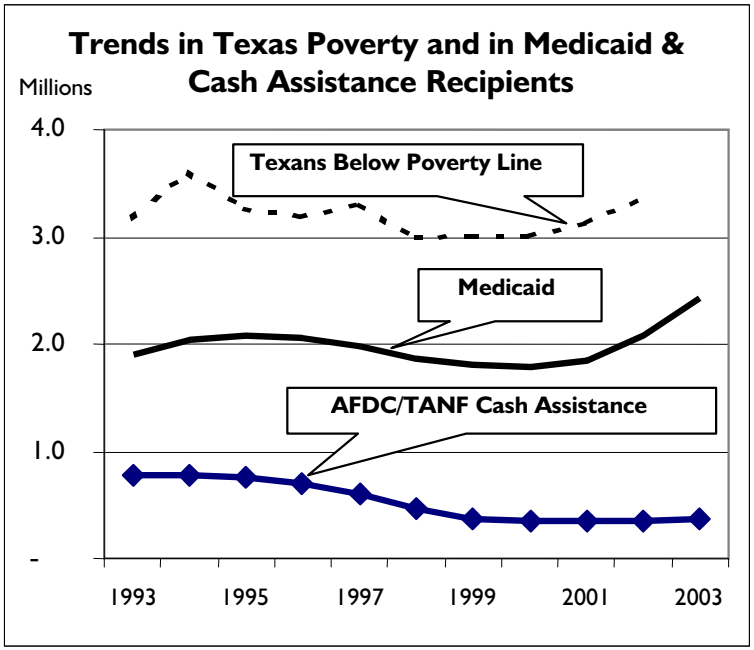
Changes made by the 2003 Texas legislature to the Children's Health Insurance Program (CHIP) will actually reduce the number of children served by this program in 2005 by 169,000 and will also reduce the benefits package. CHIP enrollment began in Texas in May 2000 and climbed rapidly, peaking at about 529,000 in May 2002. Early studies of the program showed that children in CHIP were already benefiting from having a usual source of care. Before enrolling in CHIP, 85 percent of children had a usual source of care,

but for almost 20 percent of those kids, it was the emergency room. For families enrolled in CHIP for three months, those reporting a usual source of care increased to 90 percent, and to 92 percent a year after enrolling. Those citing a doctor's office as the usual source of care increased from less than half before CHIP enrollment, to 62 percent after enrolling in CHIP.



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

SOURCE: U.S. Bureau of the Census, Current Population Survey, March 1995 to 2002; Texas Health and Human Services Commission.



SOURCES: Poverty data from U.S. Bureau of the Census, Current Population Survey March Supplement; caseload data from Texas Health and Human Services Commission and Texas Department of Human Services, average monthly recipients (actual through 2002; budgeted for 2003).

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

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

In September 2003, of the Texas Medicaid caseload of 2.5 million people, only 53,000 (2 percent) were adults receiving TANF, and 204,000 (8 percent) were children receiving TANF. Another 55 percent were other low-income children, 2 percent were disabled children, 14 percent were elderly, 14 percent were adults with a disability, 3 percent were pregnant women, and 6 percent were parents poor enough for TANF, but not receiving cash assistance.

Rising Medicaid caseloads and costs, state revenue shortfalls, and the incorrect assumption that all children on Medicaid are also on cash assistance, have revived support for policies that directly or indirectly attempt to discourage Medicaid participation by children. The 2003 legislature made several policy changes designed to keep more than 332,000 children from being added to the Medicaid rolls by 2005. However, because the cost of covering aged and disabled patients is growing more rapidly, removing children from Medicaid will not change the underlying factors driving long-term growth in Texas Medicaid costs. In 2002, Texas spent $785 per month on average for a Medicaid disabled client (not including long-term care), which was five to ten times the amount spent for the different categories of Medicaid children ($73 to $151 per month), and more than three times the average cost of care for TANF parents ($252 per month).

Health Care Access Issues Specific to Indigent Care

The results of a recent 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 percent said they did not get all of their medications because of an inability to pay.

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

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

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

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

People who support limiting the government's role in providing a health care "safety net" for the uninsured or underinsured often downplay the importance of having coverage, arguing that those who can't pay can always to 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 more likely to end up being hospitalized unnecessarily as a result of an untreated condition.
- Uninsured people with arthritis, heart disease, high blood pressure, and other chronic conditions are less likely to have these conditions cared for through visits to a health provider or medication.
- Uninsured people are sicker and die prematurely compared to those with insurance. When hospitalized, the uninsured get fewer and substandard services than those provided to people with health insurance.

A recent study found that of the 1 million Americans filing for bankruptcy in 1999, more than half cited medical bills and illness or injury as a contributing factor. Being underinsured was more common than being uninsured for those seeking bankruptcy protection. The elderly and women (especially single heads-of-households) were most affected by their inability to pay off medical debt.

Why Inadequate or No Insurance Is a Problem for Employers

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

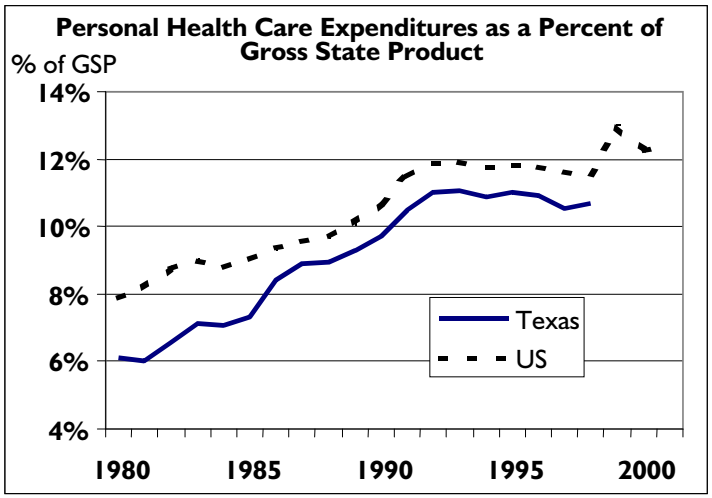
Increasing the availability of employer-provided coverage (or of employer support for universal coverage) will require a better understanding on the part of business leaders and other policy makers of a few key points. First, having insurance means workers are more likely to be in excellent health, to 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.

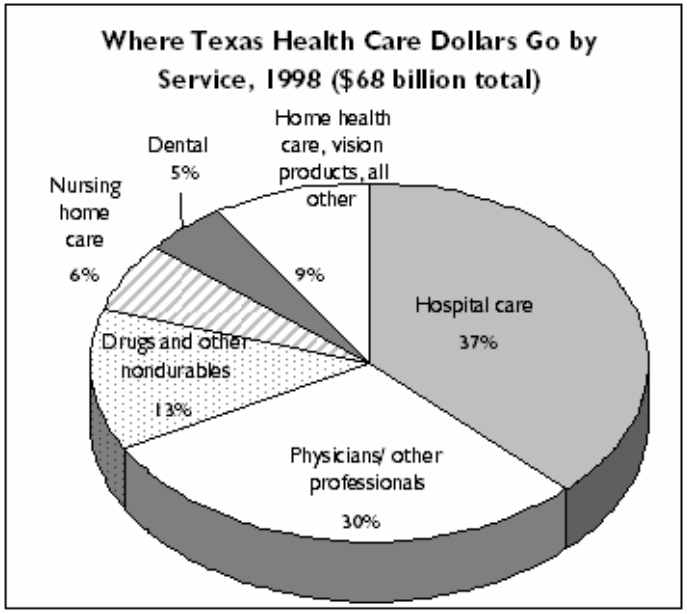
Why Inadequate or No Insurance Is a Problem for State and Local Taxpayers

When uninsured people cannot pay for their own health care, the cost of that care for the most part ends up being covered by local, state, and federal taxes. A recent study estimates that 75 to 85 percent of the cost of uncompensated care is borne annually by taxpayers.

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.

A recent 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 include rises in health insurance premiums and other health care costs, and decreases in retail sales and other private-sector economic activity.





SOURCES: State Health Accounts data, Centers for Medicare and Medicaid Services, and Bureau of Economic Analysis for GSP data.

Health Care: The Economic Context

In 1998, the federally estimated $68 billion spent on personal health care in Texas accounted for 10.7 percent 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 peaked in 1993 at 11.1 percent of GSP and decreased slightly after that. While data are not yet available for more recent years, if Texas follows the national trend, health care spending will once again have grown more rapidly than the economy overall.

The bottom chart shows the different services on which health care dollars are spent. About two-thirds goes to hospitals and to physicians. Texas' health care spending looks similar to the U.S. average, except that only 6 percent of Texas dollars go to nursing home care, compared to 9 percent for the U.S. average.

The Comptroller of Public Accounts estimates 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 not only increase the economic impact of the health care industry; it would also lessen the burden on local taxpayers when health care is instead provided through indigent care programs.

* This lower health care spending estimate by the federal Centers for Medicare and Medicaid Services is used here, rather than the Comptroller's estimate cited on page 8, because the Comptroller's methodology for charity care is different from the one used by the federal government.

Conclusion

Health care access is an extremely complicated and ever-changing policy area, shaped by decisions made at the local, state, and federal levels. Increasing health care costs and the health care needs of Texans make improved access ever more urgent. The public sector and private sector both have a role to play in meeting these needs. We hope this primer is a useful tool as you engage in the growing debate over the future of health care in Texas and nationally.

Suggestions for Further Reading

This primer highlights major health care issues relevant to Texas, but it obviously cannot do them all justice in so short a document. Furthermore, the format and length of this publication do not allow for a discussion of other critically important health care issues such as access to mental health services, dental care, or long-term care. Nor does it provide the more detailed, in-depth policy analysis of Medicaid or other government health care programs that readers may be seeking. Please consult the following for more information:

The Access Project. *Providing Health Care to the Uninsured in Texas: A Guide for County Officials,* September 2000.

Mental Health Association in Texas. *An Overview of the Mental Health System in Texas,* August 2002.

Texas Comptroller of Public Accounts, *Health Care Spending in the Texas State Budget*, August 2002.

Texas Department of Insurance, *Texas State Planning Grant: Final Report*, March 2003. (Grant authorized by the federal Health Resources and Services Administration.)

Texas Health and Human Services Commission, *Texas Medicaid (The "Pink Book")*, Updated April 2002.

Institute of Medicine, National Academy of Sciences, *Hidden Costs, Value Lost: Uninsurance in America*, 2003.

Center for Public Policy Priorities
900 Lydia Street
Austin, TX 78702
(512) 320-0222
(512) 320-0227 (fax)
www.cppp.org

Methodist Healthcare Ministries of South Texas, Inc.
8200 IH-10 West, Suite 610
San Antonio, TX 78230
1-800-959-6673 or (210) 692-0234
(210) 614-7563 (fax)
www.mhm.org