

[CHAPTER ONE]

INTRODUCTION

[INTRODUCTION]

The number of Americans without health insurance coverage has climbed steadily in the past 25 years (Kronick & Gilmer, 1999). According to statistics from the U.S. Census Bureau, there were 46 million uninsured Americans or 15.7 percent of the population in 2004 (U.S. Census Bureau, 2005). If this problem is not addressed, the number of uninsured is predicted to reach 56 million by 2013. Eighty-two million people, one-third of the non-elderly U.S. population, were without health insurance coverage for some or all of 2002-2003 (Stoll, 2004). This increase has occurred regardless of national economic conditions, increasing during both periods of economic expansion and downturns. The social, health and economic consequences of having a relatively large population without health insurance coverage are substantial. For example, uninsured children and adults are unable to access needed medical care, and they experience poorer health outcomes. Many families also face financial risks when one or more family members are uninsured. The quality and availability of health care services are lower in communities with a relatively large uninsured population because local health care systems and providers are affected financially by having to provide uncompensated care (IOM, 2004).

One of the driving forces behind the escalating numbers of the uninsured is health care costs. Employer-sponsored health insurance coverage decreased over the last five years due to double digit health insurance premium increases (Gabel et al., 2004). Nine million fewer Americans under age 65 were covered by employer-sponsored

insurance in 2003 compared to 2001 (Strunk & Reschovsky, 2004).

THE PROBLEM IN TEXAS

Texas leads the nation in the percentage of the population that is uninsured, with 25.1 percent of Texans uninsured in 2004 (U.S. Census Bureau, 2005). Figure 1 shows the percentage of uninsured persons for the five states with the highest rates. This affects all Texans, who pay an estimated \$1,551 annually in higher insurance premiums for a family of four (Families USA, 2005). Furthermore, about 43 percent (8.5 million) of non-elderly Texans were without coverage for all or part of 2002-2003 (Stoll, 2004).

The proportion of the population without health insurance coverage varies substantially across Texas counties and local communities. In 11 counties near Mexico (Cameron, Dimmit, Hidalgo, Kinney, Maverick, Starr, Val Verde, Webb, Willacy, Zapata and Zavala), there is an average uninsured rate of 34.6 percent. Twenty-eight percent of the residents of Houston (the fourth largest city in the United States) residents are uninsured (Machlin, et al., 2000). Harris County (Houston) has the highest proportion of Texas' uninsured, with 17 percent of the total uninsured population located there; Dallas County is next with 11 percent (TDI, 2003).

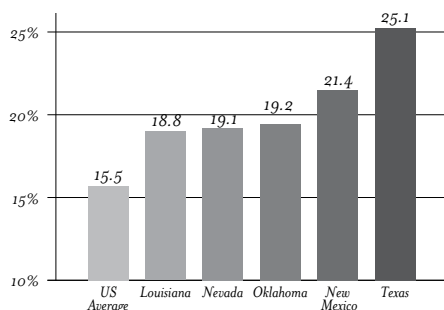
Texas leads the nation in the percentage of uninsured adults, number of uninsured working adults, and the percentage and number of uninsured children. In addition, every major Texas city has a higher uninsured rate than the national average

(State Comptroller, <http://www.window.state.tx.us/specialrpt/uninsured05/>). The characteristics unique to Texas that contribute to the problem are the stringent qualifications for eligibility for state and federal programs (Medicaid and the State Children’s Health Insurance Program – SCHIP), a low rate of coverage in small businesses, and the demographics of the state. Businesses with fewer than 50 employees constitute 73 percent of all business in Texas, and only 37 percent of these small businesses offer health insurance. Furthermore, only 35 percent of employees in small businesses that were offered insurance actually enrolled, compared to 63 percent of employees in large businesses (TDI, 2003). Although some employees who do not take up employer sponsored insurance are insured through spouses or other family members, a significant number of them are uninsured. In addition, Texas has a high percentage of Hispanics* who tend to be young, have low incomes, and have low levels of education, all factors associated with a lack of health insurance (U.S. Census Bureau, 2004).

Given the limited employer-sponsored coverage, Texas relies heavily on local governments to provide a safety net. The resources available to most counties are largely inadequate, and the largest metropolitan public hospitals are disproportionately affected by the uninsured because they find uninsured residents from neighboring counties drifting toward their health care providers. Local demand is met in large part by care delivered by medical residents. Residency programs are fragile nationwide, but Texas is particularly at risk. Texas lags far behind other states in terms of residency positions, with only 5,900, compared to the 14,000 in New York State (ACGME, 2004).

The indigent population of Texas, for the purpose of the county indigent care program, is defined as individuals at or under 21 percent federal poverty line (FPL) (TDSHS, 2005). Texas currently serves its medically indigent population in one of three ways: through hospital districts, public hospitals or county indigent care programs (CIHCP) (Chapter 61 of the Texas Health Code). Hospital districts are special taxing districts created to provide health care within their boundaries. Public hospitals are hospitals owned, operated or leased by a county or municipality. Texas also provides care through state-owned facilities, e.g., The University of Texas System’s five hospitals and a number of specialty institutions. A CIHCP provides health care for some or all of a county’s indigent residents. There are 142 CIHCPs, 131 hospital districts, and 23 public hospitals in Texas (Maberry, 2004). As noted elsewhere in this report, these public hospitals and clinics are currently unable to meet the needs of the uninsured due to limited resources,

Figure 1: States with the Highest Uninsured Rate, 2004



Source: U.S. Census Bureau. (2005). *Income, Poverty, and Health Insurance Coverage in the United States: 2004*. DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee,.

*The terms Hispanic/Latino/Caucasian/Non-Hispanic, White, and African American/Black are used throughout this report depending on the terminology used in the sources of the data.

the magnitude of the uninsured population and the dependence upon expensive, intermittent emergency-room services.

For a county to receive state matching funds, it must spend at least 8 percent of its general revenue tax levy on health care for indigent persons. Only 21 counties had expenditures that exceeded this minimum. Eighteen additional counties spent between 6 percent and 8 percent (Canton, 2000).

CONSEQUENCES OF LACK OF COVERAGE

A lack of adequate health insurance coverage has a major impact on many different aspects of the lives of not only the uninsured, but also the insured. A lack of coverage can affect an individual's physical health, mental health and access to care. It also has an impact on the community by affecting health care service providers, businesses and local economies.

The uninsured receive less preventive care, are diagnosed at more advanced stages of disease, and, once diagnosed, receive less therapeutic care than do the insured (IOM, 2002). Due to this, the uninsured suffer from poorer health and are more likely to die early than are those with coverage. The uninsured may be less able to work, provide for their families and contribute to the state's economy (IOM, 2004). In addition, diagnosis of an illness at a more advanced stage generally leads to higher medical costs. These higher medical costs are cross-subsidized by the insured through higher insurance premiums.

Health insurance coverage makes a substantial difference in the amount and kind of care people are able to afford, where they get health care, and whether they have a regular source of care (Hadley, 2002). The uninsured are more likely to postpone

or forgo needed care. A survey conducted by the Kaiser Family Foundation found that almost half of the uninsured postponed seeking care in the past 12 months because of cost and over one-third did not receive needed care or skipped a prescribed drug or treatment. These gaps are three to four times higher than for those with health insurance (Hadley, 2002).

Texas serves only one-fourth of the individuals currently eligible for mental health services, and many Texans with mental illness have become ineligible for most public mental health services due to recent changes in eligibility rules (MHA Texas, 2005). The consequences of untreated mental illness manifest themselves in poor school performance, juvenile/criminal justice involvement, unemployment, homelessness and suicide (MHNC, 2004). Many individuals with untreated mental illnesses end up in the criminal justice system, at the expense of taxpayers.

The costs of treating the uninsured have had a major impact on Texas urban hospital districts, emergency departments, trauma centers and physicians. Uncompensated care provided by Texas hospitals increased to more than \$7.7 billion in 2003 from \$3 billion in 1993 (Center for Health Statistics, 2004). Emergency department utilization is on the rise nationwide (Seton, 2002). Many people are using emergency rooms to access primary care. For example, at Ben Taub Hospital in Houston, 57 percent of the visits to the emergency room are related to primary-care. Forty-four percent of these visits were from uninsured people. As the number of uninsured increases, compensation decreases, and emergency rooms may be forced to close because of financial difficulties (Bishop & Associates, 2002). In Texas, the number of emergency department visits increased to 8.6 million

in 2003 from 5.5 million in 1992 (THA., 2005). Moreover, the capacity to care for emergency patients diminished in the state; in 2002 as a result of permanent closures, there were 5 percent fewer emergency rooms than there were in 1999. This decrease means that an emergency room might no longer be nearby when it is needed for all patients.

Covering the uninsured will not be sufficient to solve the problem of uncompensated care; the inadequacy of existing coverage needs to be addressed as well. An estimated 16 million insured adults between the ages of 19 and 64 are underinsured, meaning they have limited coverage and face exclusion of major disorders, or high deductibles. More than half of these underinsured adults went without needed medical care services in 2003 (Schoen et al., 2005).

THE NEED FOR CHANGE

Overall, current trends paint a bleak picture for the state of Texas. Based on trends from 1990–2000, the population of Texas is projected to increase to 46 million by 2040, an increase of 117 percent (Murdock et al., 2003). Even if the uninsured population increased only proportionately (which is unlikely), the state of Texas will be overwhelmed by the sheer numbers of the uninsured. Projections show that the number of physicians in Texas is expected to double by the year 2040, but the number of physician visits is expected to triple at the same time (Murdock et al., 2003). Thus, Texas is facing a future with an increasing population with less education and lower incomes, undoubtedly less health insurance, and higher demand for physician services (Murdock et al., 2003). This impacts not only the Texas economy, but also the state budget and funds received from taxes. With the uninsured rate in Texas higher than the national average, this

problem will only be amplified by limited Medicaid eligibility, restrictive or nonexistent employer-sponsored health insurance coverage, and an inadequate number of medical professionals.

The costs of providing uncompensated care are largely borne through higher premiums paid by insured patients and their employers (about two-thirds of the cost) and by local and state taxes (the remaining one-third) (Families USA, 2005). Not only do these higher premiums affect businesses, but there is also increasing pressure to raise taxes. Rising health care costs coupled with uncertain economic conditions and declining profits are causing employees to bear more of the cost of employer-contributions to health insurance premiums through reduced wages or employee numbers and increased co-payments and premiums. Growing numbers of uninsured patients threaten economic stability, economic development, and the infrastructure for health care and prevention in the state.

At the federal level, the response to the growing problem of the uninsured has focused on cutting funding to programs in an effort to balance the budget. In 2006, Congress approved a net \$4.8 billion cut from Medicaid spending over the next 5 years and a net \$26.1 billion reduction over 10 years. This cut will occur at a time when states are facing dramatic enrollment increases in their Medicaid programs (Holahan, 2005). Reducing funding to Medicaid, thereby reducing enrollment, will result in the nation seeing an even greater uninsured population in the future. Reimbursement rates from providers like Medicaid are also decreasing, impacting hospitals that see large numbers of Medicaid and uninsured patients and impacting physicians who increasingly are unable to afford to participate in Medicaid.

Although Americans are now living longer than ever before and population health has increased dramatically over the last century, there are some areas of concern. For instance, an example of a developing health issue is obesity. Obesity has increased 61 percent in a 10-year period and accounts for 27 percent of growth in overall health care spending (Thorpe, et al., 2004). Approximately one out of four adults in Texas is clinically obese (Murdock et al., 2003). In Houston, 23 percent of the population is clinically obese, and 63 percent is overweight (CDC, 2004). The prevalence of diabetes increased 49 percent in the United States between 1990 and 2000 (Mokdad, et al., 2001). Increased health care utilization is one of the factors continually driving up costs, and obesity, diabetes and other chronic conditions are fueling increases in utilization.

Texas not only faces health challenges, but also educational attainment issues as well. Texas has lower rates of high school and college graduates than the national average, and over half of all Hispanics in Texas over the age of 25 do not have a high school diploma (Murdock et al., 2003). This is particularly disturbing because of the predictions for increases in the Hispanic population in the state over the next 15 years. By 2020, Hispanics will be 59 percent of the Texas population, with Caucasians second at 24 percent. Furthermore, school-aged children with conditions such as obesity, asthma and diabetes perform at lower levels on academic measures than their healthy counterparts. It is also believed that education improves an individual's health.

Addressing the problem of the uninsured requires a shared responsibility for the problem and the solutions. The sheer size and complexity of health

care coupled with a lack of standardization across our system will require major contributions from all players to share in reforming our health care system (IOM, 2002). Such shared responsibility includes not only that patients take a more active role in treatment decisions, but also that health care providers ensure that patients understand what is expected of them to improve their health. Federal, state and local governments can help to alleviate the crisis by forming partnerships to reduce redundancy, barriers and cost. This can be accomplished by working collaboratively and across lines of authority to ensure needs are met.

ORGANIZATION OF THIS REPORT

Because of the importance and impending challenges confronting Texas in dealing with the problem of medically indigent individuals, the 10 major academic health institutions in the state sponsored a Task Force to identify strategies for confronting medically indigent care in Texas. These institutions are Baylor College of Medicine, Texas A & M, North Texas, Texas Tech, and the six health institutions of The University of Texas System. The Task Force consisted of individuals selected for their expertise and perspectives with regard to the problem of indigent health care in Texas. Members of the Task Force served as individuals and do not represent any organizations or special interests. Biographies of the members as well as the staff are included in Appendix A of the report.

The Task Force and its staff collected data, much of which was based on previous high-quality analyses of the various issues supplemented by commissioned white papers which are presented in this report as Appendices B through G. The final report was subject to anonymous peer review by

other experts in the field, in order to validate the quality of the analysis from additional sources.

The committee worked diligently to recommend strategies that can work together and that, if implemented, can reduce health care costs over time. Each recommendation addresses aspects along the health care continuum and, therefore, addresses not only the challenges of the uninsured, but also the challenges of rising health care costs, which leads to an increase of uninsured and underinsured individuals. The recommendations, therefore, work in concert to address the circular nature of this problem; if costs are reduced, more businesses, small and large, can offer coverage, and public monies can be leveraged to cover more individuals.

In Chapter Two, we provide an overview of the state of health and the uninsured in Texas as well as discuss the changing demographics of the population of the state and predictions for future populations. In Chapter Three, we describe the consequences of being uninsured, focusing on the consequences for health status, access to care, health service providers and the local economy. Chapter Four explores the current situation of the Medicaid and SCHIP programs in Texas, their financing and future. Chapter Five presents an analysis of reform options developed by other states, summarizing some of the issues and options in health insurance coverage along with innovations by other states to expand coverage to more people. Chapter Six highlights local initiatives undertaken by counties across the nation to expand care and coverage of the uninsured. Various models for expanding care and the lessons learned are presented. Chapter Seven discusses the employer insurance market in the state, state regulation of health insurance and implications for health care access. Chapter Eight describes trauma

care in Texas and the impact of uncompensated care upon the trauma system. Chapter Nine presents the multifaceted relationships between education and health. The evidence on how health affects academic performance and how educational attainment affects health is examined. Chapter Ten describes the Task Force findings from this study and Chapter Eleven describes the Task Force recommendations.

REFERENCES

Accreditation Council for Graduate Medical Education.

(2004). ACGME Resident Physician Population by Specialty and State – Academic Year 2003-2004. Website: http://www.acgme.org/acWebsite/CMS/resPopData_state03-04.pdf.

Bishop & Assoc. (2002). Texas Trauma Economic Assessment and System Survey. *Save Our ERs*. Website: <http://www.saveourers.org/BishopsReport.pdf>.

Canton, F. (2000). Providing Health Care to the Uninsured in Texas: A Guide to County Officials. *The Access Project*. Boston, MA

Center for Health Statistics. (2004). 2003 Annual Survey of Hospitals. in Texas Department of State Health Services. Website: <http://www.tdh.state.tx.us/chs/hospSurv/OnlineReports/char2003.pdf>.

Centers for Disease Control and Prevention. (2004). Chronic Disease Notes and Reports. Special Focus: Heart Disease and Stroke. *Department of Health and Human Services, At A Glance: Centers for Disease Control and Prevention*. Website: <http://www.cdc.gov/nccdphp/cdnr/CDNRfallo4.pdf>.

Families USA. (2005). Paying a Premium: The Added Cost of Care for the Uninsured. Website: http://www.familiesusa.org/site/DocServer/Paying_a_Premium.pdf?docID=9241.

Gabel, J., Claxton, G., Gil, I., Pickreign, J., Whitmore, H., Holve, E., Finder, B., Hawkins, S. and Rowland, D. (2004). Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take their Toll on Coverage. *Health Affairs* 23:5: 200-209.

Hadley, J. (2002). Sicker and poorer: The consequences of being uninsured. A review of the research on the relationship between health insurance, health, work, income, and education. *Kaiser Commission on Medicaid and the Uninsured*: Washington, DC.

Holoahan, J. and Ghosh, A. (2005). Understanding the Recent Growth in Medicaid Spending, 2000-2003. *Health Affairs* Web Exclusive.

Institute of Medicine. (2002). Health Insurance is a Family Matter. *National Academies Press*: Washington, D.C. Website: www.nap.edu.

Institute of Medicine. (2004). Insuring America's Health: Principles and Recommendations. *National Academies Press*: Washington, D.C. Website: www.nap.edu.

Kronick, R. and Gilmer, T. (1999). Explaining the Decline in Health Insurance Coverage, 1979-1995. *Health Affairs* 18:2: 30-47.

Maberry, J. (2004). Program Director, County Indigent Care Program, Texas Department of Health. Email Interview.

Machlin, S.R., Nixon, A.J., and Somers, J.P. (2000). Health Care Expenditures and Percentage Uninsured in 10 Large Metropolitan Areas, 2000. *Center for Studying Health System Change*. Statistical Brief #38. Website: <http://www.meps.ahrq.gov/papers/st38/stat38.pdf>

Mental Health Association in Texas. (2005). Turning the Corner: Toward Balance and Reform in Texas Mental Health Services. Website: <http://www.mhatexas.org/TurningtheCorner.pdf>.

Mental Health Needs Council. (2004). Mental Illness in Harris County: Prevalence, Issues of Concern, Recommendations.

Mokdad A.H., Bowman B.A., Ford E.S., Vinicor, F.M., Marks, J.S., and Koplan, J.P. The Continuing Epidemics of Obesity and Diabetes in the United States. *JAMA* 2001;286(10):1195-1200.

Murdock, S.H., White, S., Hoque, M.N., Pecotte, B. (2003). The New Texas Challenge: Population Change and the Future of Texas. *Texas A&M University Press*: College Station. Website: <http://txsdc.utsa.edu/pubsrep/pubs/txchal.php>.

Schoen, C., Doty, M.M., Collins, S.R. and Holmgren, A.L. (2005). Insured But Not Protected: How Many Adults are Uninsured? *Health Affairs* Web Exclusive.

Seton Healthcare Network. (2002). Out of the Emergency Room: Communicating Healthcare Options to Low Income Texans: Austin, Texas.

Stoll, K. and Jones, K. (2004). One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003. *Families USA*: Washington, D.C. Website: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641.

Strunk, B. and Reschovsky, J. (2004). Trends in U.S. Health Insurance Coverage, 2001-2003. *Center for Studying Health System Change*. Tracking Report No. 9; Website: <http://hschange.org/CONTENT/694/694.pdf>.

Texas Hospital Association. (2005). Texas Hospital Association Legislative Action Alert. Austin, Texas.

Texas Department of Insurance. (2003). Working Together for a Healthy Texas Final Report: Texas State Planning Grant. *Texas Department of Insurance - State Planning Grant Division*. Website: <http://www.tdi.state.tx.us/general/pdf/spgfinalreport.pdf>.

Texas Department of State Health Services. (2005). County Indigent Health Care Program. Website: <http://www.dshs.state.tx.us/cihcp/default.shtm>.

Thorpe, K.E., Florence, C.S., Howard, D. H. and Joski, P. (2004). Trends: The Impact Of Obesity On Rising Medical Spending. *Health Affairs Web Exclusive*.

U.S. Census Bureau. (2005). DeNavas-Walt, C., Proctor, B.D. and Lee, C.H. Income, Poverty, and Health Insurance Coverage in the United States: 2004. in *U.S. Census Bureau, and Current Population Reports*, Washington, D.C.: U.S. Government Printing Office. Website: <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

U.S. Census Bureau. (2004). DeNavas-Walt, C., Proctor, B.D. and Mills, R.J. Income, Poverty, and Health Insurance Coverage in the United States: 2003. in *U.S. Census Bureau, and Current Population Reports*, Washington, D.C.: U.S. Government Printing Office. Website: <http://www.census.gov/prod/2004pubs/p60-226.pdf>.

