

Health Policy for Low-Income People in Texas

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Texas is a large state in terms of geography and population, with many low-income people, high levels of uninsurance, and a substantial number of foreign-born residents. The state takes a minimalist approach to health and social welfare programs, funding little beyond what is required to draw down federal matching payments. Texan culture values independence, and high levels of assistance for the poor are generally thought to be inconsistent with this philosophy. Although health care receives more political support than welfare, Medicaid eligibility is quite restrictive, and the state does not have a general-assistance medical or other state program for the low-income population ineligible for Medicaid. Instead, counties in Texas are constitutionally responsible for providing health care for the indigent. Typically, counties carry out this responsibility through public hospitals supported by local property taxes. Faced with an uninsurance rate approaching one-quarter of the nonelderly population, Texas has relied more on public hospitals to meet the needs of the medically indigent than on expansion of insurance coverage.

State Characteristics

Approximately 19 million Texans live in the state's 262,000 square miles. Of its 254 counties, 196 are considered rural, and 62 of these are considered "frontier," containing six or fewer persons per square mile. Despite this vast territory, 85 percent of the population lives in urban areas. Immigrants, especially from Mexico, are an important part of the Texas population and have been increasing in number.

Although almost a third of the state population is Hispanic, the vast majority are American citizens (table 1).

In the aggregate, Texas's economy has been performing well. The unemployment rate, at 5.6 percent in 1996, was only slightly higher than the national average, and growth in per capita personal income from 1990 to 1995 exceeded the national average. Yet while some areas of the state are bustling and prosperous, others face enormous problems, including high unemployment rates and lack of basic services such as running water and sewage disposal. Moreover, the proportion of the total population and of children below the federal poverty line is considerably higher in Texas than in the country as a whole (table 1).

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Table 1
State Characteristics

	Texas	U. S.
Sociodemographic		
Population (1994–95) (in thousands)	18,732	260,202
Percent under 18 (1994–95)	29.6%	26.8%
Percent 65+ (1994–95)	9.6%	12.1%
Percent Hispanic (1994–95)	31.0%	10.7%
Percent Non-Hispanic Black (1994–95)	12.0%	12.5%
Percent Non-Hispanic White (1994–95)	54.2%	72.6%
Percent Non-Hispanic Other (1994–95)	2.9%	4.2%
Percent Noncitizen Immigrant (1996)*	8.6%	6.4%
Percent Nonmetropolitan (1994–95)	18.8%	21.8%
Population Growth (1990–95)	10.2%	5.6%
Economic		
Per Capita Income (1995)	\$ 21,206	\$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	23.2%	21.2%
Unemployment Rate (1996)	5.6%	5.4%
Percent below Poverty (1994)	17.6%	14.3%
Percent Children below Poverty (1994)	25.8%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	23.9%	15.5%
Percent Medicaid—Nonelderly (1994–95)	12.6%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	58.0%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	5.5%	6.2%
Smokers among Adult Population (1993)	23.8%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	7.0%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	6.6	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	55.0	54.4
Violent Crimes per 100,000 (1995)	663.9	684.6
AIDS Cases Reported per 100,000 (1995)	23.9	27.8
<p><i>Source:</i> Complete list of sources is available in <i>Health Policy for Low-Income People in Texas</i> (The Urban Institute, 1997).</p> <p>* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.</p>		

The lack of health insurance is a major problem in Texas, as 23.9 percent of the nonelderly population was uninsured in 1994–95, compared with 15.5 percent for the nation overall. Limited Medicaid coverage and a low proportion of people with employer-sponsored health insurance compared with the national average (58.0 percent versus 66.1 percent) contribute to this high rate of uninsurance. Texas also has significantly fewer providers than the national average. For example, in 1994, while there were 81 generalist physicians per 100,000 population in the United States, there were only 61 per 100,000 in Texas. In 1995, 112 entire counties and parts of 22

others were designated federal health professional shortage areas.

Political and Budgetary Climate

Overall, Texas is a very politically conservative state, with some liberal pockets in the cities. Republicans control the governorship and the state Senate (although only by one vote in 1996). In contrast, the Democrats have a comfortable majority in the House. There is a substantial amount of bipartisan cooperation.

Structurally, Texas state government is characterized by a weak governor and a strong legislature, despite the

fact that part-time legislators meet for only 90 days every other year. In practice, a great deal of power resides with the Legislative Budget Board, which is chaired by the lieutenant governor and consists of members of the leadership of the House and Senate. This group proposes budgets and is empowered to reallocate funds when the legislature is out of session.

There is a very strong anti-tax environment in Texas. Although local property taxes are relatively high, the state does not levy an income tax. During the 1995–96 biennium, the state enacted major welfare reform and authorized an ambitious Medicaid expansion and managed care demonstration. Authorization for new spending was very limited. For the 1997–98 biennium, the budget was also fairly constrained. Governor George W. Bush made local property tax relief one of his priorities, and the legislature enacted a \$1-billion property tax cut over two years.

Medicaid Expenditures and Enrollment

As in other states, Medicaid is the dominant health care program in Texas, accounting for 11.3 percent of state general-fund spending in 1995. When combined with federal spending, it comprised 21 percent of state expenditures, second only to K–12 education. Between 1990 and 1995, Medicaid was the second-fastest-growing program, following corrections. The program's annual growth rate during this period—20.2 percent—was more than double that of the rate of growth for the total state budget.

Growth in Medicaid expenditures was sharpest between 1990 and 1992, averaging 40.9 percent a year (table 2). Between 1992 and 1995, the annual rate of growth declined to 12.0 percent. In both periods, the growth rate was in excess of the national average. Although the huge increase in 1990–92 is largely explained by state efforts to maximize federal revenues through the disproportionate share hospital (DSH) program, enrollment and expenditures per enrollee also increased significantly during this period. For example, double-digit growth in enrollment occurred among nondis-

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Texas and United States
 (Expenditures in Millions)

	Texas			United States		
	<u>Expenditures</u>	<u>Average Annual Growth</u>		<u>Expenditures</u>	<u>Average Annual Growth</u>	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$9,118.9	40.9%	12.0%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service						
Acute Care	\$7,185.4	24.2%	14.8%	\$133,434.6	18.8%	11.0%
Long-Term Care	5,005.0	29.5%	17.2%	79,438.5	22.1%	13.0%
Benefits by Group	2,180.4	15.6%	10.0%	53,996.1	14.8%	8.3%
Elderly	\$7,185.4	24.2%	14.8%	\$133,434.6	18.8%	11.0%
Acute Care	\$2,142.7	21.5%	11.9%	\$40,087.4	16.7%	8.1%
Long-Term Care	742.2	23.1%	15.2%	9,673.7	18.5%	11.9%
Blind and Disabled	1,400.5	20.7%	10.3%	30,413.7	16.2%	7.0%
Acute Care	\$2,188.5	21.0%	18.3%	\$51,379.4	17.7%	12.9%
Long-Term Care	1,411.7	36.1%	24.7%	29,760.7	22.8%	15.2%
Adults	776.8	8.0%	9.4%	21,618.7	12.3%	10.1%
Children	\$1,267.3	25.8%	12.8%	\$16,556.9	20.4%	9.2%
Disproportionate Share	\$1,587.0	31.8%	16.0%	\$25,410.9	24.3%	13.3%
Hospital Administration	\$1,513.0	1668.6%	0.0%	\$18,988.4	261.5%	2.7%
Hospital Administration	\$420.5	11.2%	23.6%	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

abled adults and children, chiefly because of federally mandated expansions to low-income women and children. Expenditures per enrollee, with the exception of nondisabled adults, were lower than the national average in 1995; however, they generally grew at a rate that outpaced national trends from 1990 to 1995 (table 3). Currently, growth in total expenditures is in the single digits, and enrollment is flat.

Medicaid Policy

Texas Medicaid policies have been driven by a desire to limit state spending while expanding the number of people covered. To that end, the state has pursued a Medicaid research and demonstration (Section 1115) waiver since 1995, with the goals of protecting DSH payments, expanding coverage, and drawing down additional federal funds. Expanding the use of managed care is the centerpiece of this strategy. The state's plan would use local funding for indigent care as the state match to draw down federal funds, so that no additional state spending would be required. Although the initial proposal was never approved

by the Health Care Financing Administration (HCFA), more important to the proposal's demise was the lack of political support by local hospital districts. The hospital districts were concerned about loss of control over their funds and the potential use of their money to fund competing private hospitals through managed care arrangements.

A revised, more modest proposal that focused on low-income children and required newly eligible individuals to receive their care in a health plan organized by public institutions was submitted to HCFA in November 1996. In August 1997, HCFA rejected the second Texas waiver proposal on the grounds that the state needed to include more than one managed care organization in each region in order to provide beneficiaries with some choice of health plans. The passage of the state children's health insurance program (S-CHIP) as part of the Balanced Budget Act of 1997 may make the waiver request largely moot, since the state will be eligible for \$560 million in federal funds in 1998 and \$2.5 billion from 1998 to 2002 to cover this same population.

The impact of Medicaid policies on the health care financing and delivery system in Texas has been and continues to be substantial. First, in recent years, the state has significantly increased Medicaid funding for safety net hospitals by aggressively expanding its Medicaid DSH program, using intergovernmental transfers from local hospital districts to cover the state match. DSH spending now accounts for almost a fifth of total Medicaid expenditures, making federal changes in the program of great concern. Second, Medicaid enrollment in managed care is growing rapidly under a 1915(b) freedom-of-choice waiver, which mandates enrollment for Temporary Assistance for Needy Families recipients and other low-income women and children. At this point, commercial health maintenance organizations (HMOs) are competing actively for the Medicaid business as a way of increasing market share, and the state has not had to rely on Medicaid-only managed care organizations. Savings of about 10 percent compared to the fee-for-service system have been obtained.

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	Texas			United States		
	1995	Average Annual Growth		1995	Average Annual Growth	
		1990-92	1992-95		1990-92	1992-95
Elderly						
Total expenditures on benefits (millions)	\$2,142.7	21.5%	11.9%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	321.3	5.3%	5.6%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$6,669	15.4%	6.0%	\$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	\$2,188.5	21.0%	18.3%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	293.8	12.9%	10.8%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$7,449	7.2%	6.8%	\$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	\$1,267.3	25.8%	12.8%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	600.9	12.1%	6.5%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$2,109	12.3%	5.9%	\$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	\$1,587	31.8%	16.0%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	1,672.4	18.2%	8.1%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$949	11.5%	7.3%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

The Health Care Market

The health care market in Texas is in turmoil. Enrollment in HMOs, which served less than 20 percent of the population in 1995, is growing rapidly. Competition among HMOs is fierce, and a shakeout is widely expected. In addition, there are a number of mergers between hospitals occurring, as well as conversions of nonprofit facilities to for-profit ownership. Texas currently has a high percentage of for-profit hospitals, and additional conversions have raised concerns about for-profit hospitals' willingness to shoulder responsibility for a share of the uncompensated care burden.

The Safety Net

A large number of public hospitals, operated by hospital districts with property taxing authority, play a critical role in providing care for the Medicaid and uninsured populations and partly compensate for the low

level of insurance coverage in the state. Many of these hospitals feel threatened by Medicaid managed care. Although Medicaid requires HMOs to contract with traditional safety net providers for three years, enrollment of Medicaid beneficiaries in managed care plans is likely to reduce utilization of public hospitals. Reductions are likely because HMOs seek to curtail hospital utilization and because patients may be channeled to other hospitals with lower payment rates. Although from the perspective of the Medicaid program this decline in the use of public facilities may result in reduced costs, more consumer choice, and higher-quality care, safety net hospitals will be confronted with fewer paying patients over whom to spread the cost of providing care to uninsured patients. With fewer Medicaid patients, public hospitals may require far larger local contributions, something not likely to occur in the current political environment. As a result, facilities could close or reduce services, diminishing

access to care for the uninsured population. In response, the legislature in 1997 passed a law requiring Medicaid to contract with HMOs formed by public hospital districts. A significant number of community health centers serving a large number of Medicaid and uninsured patients face similar competition for paying patients but have not been afforded similar protection by the legislature.

Long-Term Care

Long-term care for the elderly and people with disabilities is a major component of the state's involvement in health care and accounts for about 30 percent of Medicaid spending. Long-term care has been dominated by institutional care. In an effort to alter this, the state's policy initiatives center on expanding the supply of home and community-based services for both the elderly and younger people with disabilities. At the same time, the number of persons in state mental hospitals and intermediate

care facilities for the mentally retarded is declining, and the state has aggressively maximized Medicaid reimbursement for programs previously funded only by the state. The state is also planning a major demonstration project in Houston that will integrate acute and long-term care services through managed care. Beyond system reform, the state has relied heavily on traditional methods of controlling long-term care expenditures, including a moratorium on new nursing home construction and low nursing home reimbursement rates.

Challenges for the Future

Texas's system of restrictive state health program benefits combined with an extensive locally funded health care safety net is both a strength and a problem for the state as it tries to expand coverage and move toward managed care in its Medicaid program. The state is also facing dilemmas related to welfare reform and long-term care.

Although the state is interested in raising Medicaid eligibility levels, it is unwilling to pay any more in state funds. Thus, even the S-CHIP requirement for a much-reduced state match may be problematic in Texas. Because of its reluctance to increase state spending, Texas's strategy depends almost entirely on using intergovernmental transfers from local entities to qualify for additional federal Medicaid dollars. For their part, local hospital districts are concerned about losing control of their funds and having the state use their money to pay providers not supported by the hospital district, as discussed above. Thus, in some cases they have been reluctant to provide the funds necessary to obtain the additional federal Medicaid match.

A closely related dilemma involves the relationship between Medicaid managed care and the public hospitals. Expansion of managed care is key to the state's Medicaid strategy to control costs and improve quality and access. Texas is moving steadily to enroll all of its Medicaid beneficiaries in managed care organizations and is contracting almost exclusively with

commercial HMOs, an approach viewed as a way of mainstreaming Medicaid beneficiaries. Although certain protections for public hospitals are built into the contracting system, these safety net hospitals (and community health centers) are almost certain to be negatively affected by the growth of managed care in most parts of the state, potentially hampering their ability to care for uninsured populations.

The state faces another major policy challenge regarding the impact of welfare reform on insurance coverage. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 separated eligibility for cash assistance and Medicaid. As people lose welfare because they reach the time limits or are sanctioned for failure to meet the work and other requirements, Texas will have to develop systems to ensure that people who remain eligible for Medicaid will enroll. Even more daunting is that Texas must educate people to understand that they may be eligible for Medicaid, even if they are unwilling to accept the various requirements of cash assistance. Welfare reform further raises the possibility of an increase in the number of uninsured: Given the low level of employer-based health insurance coverage in Texas, people working their way off welfare may find themselves without health insurance coverage, placing additional strains on public hospitals. In addition, although Congress in 1997 restored some Medicaid and cash benefits to legal immigrants that were to be ended as a result of welfare reforms enacted in 1996, most new legal immigrants will not be able to obtain Medicaid for five years, again possibly placing stress on the public hospital system.

A final challenge relates to long-term care for the elderly and disabled. As in the rest of the country, the elderly and disabled populations in need of long-term care are increasing. The state is pursuing a strategy of changing the balance of care in the direction of additional home and community-based services, but institutions still dominate funding, and the nursing home industry is particularly influential in determining state policy. The state would like to extend managed

care to include both acute and long-term care services but recognizes that it faces formidable practical, political, and legal barriers in pursuing this policy objective.

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There are two *Highlights* for each state. The *Highlights* that focus on health cover Medicaid, other public insurance programs, the health care marketplace, and the role of public providers. The income support and social services *Highlights* look at basic income support programs, employment and training programs, child care, child support enforcement, and the last-resort safety net. The *Highlights* capture policies in place and planned in 1996 and early 1997. To receive the full-length reports on which the *Highlights* are based, contact the Urban Institute.

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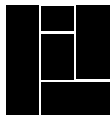
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