

## Recent Changes in Health Policy for Low-Income People in Texas

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### Overview

Texas is a large, diverse state with a substantial low-income population, high levels of uninsurance, and many foreign-born residents, largely from Mexico. Politically, it is very conservative, with minimal health and welfare programs beyond what is required to draw down a federal match. Taxes are low, limiting the funds that are available for health and human service programs. Cash welfare is highly unpopular, but health care is viewed more favorably.

### Political and Budgetary Developments

Texas has new political leadership and is facing a very different fiscal environment than it had during the late 1990s. With the elevation of Governor George W. Bush to president of the United States, the new governor is Rick Perry, a conservative Republican, whose main interests lie outside of health care. Although the state was booming in the late 1990s, the economy deteriorated in 2001, turning a modest surplus into a substantial budget deficit. Despite this, the two-year budget passed by the legislature in the spring included several health care initiatives, including Medicaid eligibility simplification for children, funding for the State Children's Health Insurance Program (SCHIP), increased reimbursement for nursing homes, and establishment of a new system of health insurance for public school teachers and a pharmaceutical assistance program for older people and persons with disabilities (although funding was not provided). To offset some of these increases, the legislature required the Health and

Human Services Commission to find Medicaid expenditure cuts and put off one month of Medicaid funding into the next biennium. The declining economy, which has been exacerbated by the terrorist attacks of September 11, may curtail further expansions and may force reevaluation of the ones enacted in 2001. However, as of January 2002, no major revenue shortfalls or large expenditure overruns are occurring, although both Medicaid and SCHIP are under budget pressure.

### Major State-Funded Health Programs for Low-Income People

Texas has one of the highest rates of uninsurance in the country, partly due to a low rate of private insurance coverage, leaving the state with a large gap to fill with public programs. The Texas Medicaid program is fairly limited in terms of covered services and eligibility for nondisabled adults. Due to the strong economy and welfare reform, Medicaid enrollment fell during the late 1990s, especially for nondisabled adults, although it is rising again and is projected to continue to increase for the next several years. There is strong upward pressure on the Medicaid budget due to increasing enrollment, prescription drug costs, and provider efforts to increase payment rates. A major concern is the very large number of children who are eligible for Medicaid but are not enrolled. In 2001, the legislature enacted an initiative to address this issue by funding outreach and simplifying the application process. The state is not actively pursuing Medicaid options to expand eligibility for adults. The legislature did pass a bill in 2001 that would have sought federal

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*Public programs to meet health care needs are limited in Texas, in part because tax revenues are low and there is strong resistance to funding public programs.*

waivers for a major expansion of eligibility for adults using local funds as the federal match, but the governor vetoed this bill. Smaller demonstrations are being explored.

The Texas SCHIP program took a while to get started but now has enrolled over 400,000 children and is projected to continue to grow. The program is politically popular, and the success of SCHIP inspired the Medicaid eligibility changes for children that were enacted in 2001. The SCHIP application process is simple and the state has invested in outreach. SCHIP eligibility is up to 200 percent of the federal poverty level (FPL). Although there is a small Medicaid expansion component, Texas SCHIP is mostly a separate insurance program using managed care organizations. In part because there are so many uninsured children in the state, Texas has not pursued using SCHIP funds to provide health insurance for adults. The state anticipates using all of its federal SCHIP allotment on children. Substantial rate increases for managed care plans in October 2001 exacerbated some underfunding of the program, leading state officials to consider options to limit enrollment increases.

### *Acute Care Issues for the Low-Income Population*

Texas Medicaid and SCHIP depend heavily on managed care for children and nondisabled adults. Medicaid managed care is in all of the major urban areas, and all SCHIP enrollees are in some form of managed care. Although older people and people with disabilities are not required to join managed care organizations, the state is operating an innovative demonstration in Houston that integrates some acute and long-term care services. State officials believe that managed care has the potential to provide a “medical home” for enrollees, improve quality, and contain costs. Many providers, however, dislike health maintenance organizations (HMOs) and find them to be administratively complicated and burdensome. Medicaid has primarily contracted with commercial HMOs, and while there have been some health plan withdrawals, they have largely been limited to specific markets. Responding to concerns by consumers and providers, the legislature imposed a moratorium on expansion of Medicaid managed care in 1999, which has now been lifted. Despite the ambivalence in the legislature about managed care and the outright opposition by some providers, the 2001 budget includes expansion as one possible strategy for saving money.

Overall, commercial managed care has had a difficult time in Texas, with many HMOs losing money throughout much of the 1990s, leading to some mergers and consolidations. Texas has been a leader in state regulation of HMOs, with laws providing a patients’ bill of rights that includes the ability to sue HMOs.

A major source of health care for the low-income population in major metropolitan areas in Texas is public hospitals, which compensate in part for the low Medicaid eligibility levels for adults. While mostly supported by local property tax assessments, hospitals providing health care to the Medicaid and uninsured populations benefit from the Medicaid Disproportionate Share Hospital (DSH) payment adjustment. Expenditures for these payments accounted for about 14 percent of total Medicaid spending in 1998. While federal law has mandated some cuts, the program has not changed much in recent years. In late 2001, the state proposed to pursue similar strategies—supplemental payments—which are designed to provide facilities with higher-than-normal Medicaid rates, using intergovernmental transfers from large public hospitals as the state match.

The costs of prescription drugs have been increasing for both Medicaid and consumers. In 2001, the state created a limited prescription drug program for low-income elderly and disabled persons, established a discount retail program, and created a bulk purchasing arrangement for state programs. No funding, however, was provided for the prescription drug benefit or the bulk purchasing program.

### *Long-Term Care*

Long-term care, especially nursing home care, is under substantial pressure in Texas. Nursing homes and noninstitutional providers have been affected by a shortage of

TABLE 1. Selected Texas Characteristics

	Texas	United States
<b>Population Characteristics</b>		
Population (2000) (in thousands) <sup>a</sup>	20,852	281,422
Percent under age 18 (1999) <sup>a</sup>	28.2%	25.7%
Percent Hispanic (1999) <sup>b</sup>	32.4%	12.5%
Percent black (1999) <sup>b</sup>	12.1%	12.8%
Percent Asian (1999) <sup>b</sup>	3.9%	4.1%
Percent nonmetropolitan (1999) <sup>b</sup>	14.2%	20.3%
<b>State Economic Characteristics</b>		
Per capita income (2000) <sup>c</sup>	\$27,871	\$29,676
Percent change per capita income (1995–1999) <sup>d</sup>	14.1%	10.8%
Unemployment rate (2001) <sup>e</sup>	4.3%	4.5%
<b>Family Profile</b>		
Percent children in poverty (1998) <sup>f</sup>	23.2%	17.5%
Percent change children in poverty (1996–1998) <sup>f</sup>	–9.0%	–15.0%
Percent adults in poverty (1998) <sup>f</sup>	15.6%	11.2%
Percent change adults in poverty (1996–1998) <sup>f</sup>	–3.1%	–10.4%
<b>Political</b>		
Governor's affiliation (2001) <sup>g</sup>	Republican	NA
Party composition of senate (2001) <sup>h</sup>	15D-16R	NA
Party composition of house (2001) <sup>h</sup>	78D-72R	NA
<b>Percent of Poor Children Covered by Welfare</b>		
1996 (AFDC) <sup>i</sup>	33.7%	59.3%
1998 (TANF) <sup>i</sup>	20.7%	49.9%
<b>Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)</b>		
1996 <sup>i,k</sup>	91%	124%
1998 <sup>i,l</sup>	113%	178%
2000 <sup>i,m</sup>	200%	205%

Table 1 notes begin on page 25.

workers. The state has historically set low levels of Medicaid reimbursement for nursing homes, and the changes to Medicare skilled nursing facility reimbursement enacted as part of the federal Balanced Budget Act of 1997 adversely affected many facilities. In addition, liability insurance costs have skyrocketed, and many facilities have dropped coverage. The nursing home industry contends that the cost pressures make it difficult for them to provide high-quality care. The 2001 legislature partially addressed these issues with a significant rate increase (although only a third of what the industry requested) and with a modest initiative to allow for-profit nursing homes to participate in the state-run high-risk medical liability pool.

Through its Medicaid program, Texas provides a range of home and community-based services, although there are large waiting lists for optional Medicaid waiver services. The state responded to the Supreme Court's *Olmstead* decision, which established a limited right to home- and community-based services, by actively engaging in a planning process to expand services. The changes to the Medicare home health reimbursement system that were part of the Balanced Budget Act of 1997 adversely affected Texas home health agencies.

### Other Issues

Texas policymakers have recently addressed three other health care issues. First, in a highly controversial opinion, the state's attorney general argued that the provision of nonemergency health services to undocumented immigrants is illegal under federal law without explicit new authorization, which he contended has not occurred in Texas. Public hospitals

and consumer advocates strongly dissented from this interpretation of federal law. Second, the state has started an initiative to improve health and human services in the *colonias*, which are areas without basic infrastructure, such as potable water or sewage systems. Third, not all public school teachers in Texas have access to employer-sponsored health insurance, a problem addressed by the legislature in 2001.

The past five years have given states new opportunities in health policy for low-income people but also put new pressures on policy formulation. Many developments increased state flexibility, including welfare reform and delinking of Medicaid from cash assistance, new funding for children's health insurance through SCHIP, repeal of federal minimum standards for nursing home and hospital reimbursement, and increased federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support believed to be abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. The tragedies of September 11, 2001, have accelerated the downturn in the economy that was beginning to affect Texas. The deterioration in the economy will likely accelerate the fiscal problems and may increase the budget pressure on Medicaid and other health programs for the low-income population. Beyond the economy and potentially shifting priorities, political demands to provide coverage for the uninsured, the Supreme Court's *Olmstead* decision, rapid growth in pharmaceutical spending, and the difficulties faced by Medicaid managed care provided additional spending pressure.

To examine how states have responded to both federal constraints and state flexibility during the past half decade, this study of Texas—along with concurrent studies of 12 other states—examines state priority setting and program operations in health policy affecting the low-income population.<sup>1</sup> This report focuses on developments in health care policy in Texas beginning in the late 1990s through 2001, building on an earlier baseline study.<sup>2</sup> Information for this study was obtained from publicly available documents, newspapers, and Web sites and from interviews with state officials, provider organizations, consumer advocates, and other stakeholders. The authors conducted in-person interviews in Austin, Texas, in March 2001. Questions were asked using an open-ended interview protocol. To encourage the respondents to speak freely, they were told that they would not be quoted by name.

## Background

### *Demographics, Economic Indicators, and Health Insurance Coverage*

Texas is a large state, in terms of both population and geography. In 2000, almost 21 million people lived in its 262,000 square miles (see table 1). Despite its vast territory, the majority of people live in urban areas. Immigrants and minorities are an important part of the population and have been increasing in number. Almost one-third of the state's population is of Hispanic origin, reflecting its proximity to Mexico and other Central American countries. Non-Hispanic whites make up only about half of the state's population.

The Texas economy was strong during the late 1990s, with per capita income growing much more quickly from 1995 to 1999 than for the country as a whole. The economy slowed in 2001 and will likely suffer further in the aftermath of the September 11 terrorist attacks. Despite the economic growth of the late 1990s, Texas's per capita income remained below the national average. Moreover, a sizable proportion of Texas's population is low income, with 23.2 percent of children and 15.6 percent of adults living in families with incomes below 100 percent of the FPL in 1998. While these percentages represent a decline from corresponding figures for 1996, the decrease in Texas has occurred at a slower rate than in the rest of the United States.

A substantial portion of Texans lack health insurance, far more than the national average (see table 2). This higher rate is particularly pronounced among children living in families with incomes less than 200 percent of the FPL, where 37 percent of children are uninsured compared to a national average of 22 percent. Similarly, almost half (47 percent) of adults in low-income families are uninsured. The high level of uninsurance is a consequence of the relatively high levels of poverty combined with the low levels of employer-sponsored and Medicaid/SCHIP/other state program coverage.

### *Political Developments*

Texas has traditionally been a conservative state, with a strong distrust of government programs. There is a general lack of support for welfare-type programs, with a common view that people should pull themselves up by their bootstraps. Health care has usually been a low priority for politicians, although it has gained greater prominence in recent years.

Structurally, Texas state government is characterized by a weak governor and a strong legislature. Commissions with staggered appointments run many departments. The legislature is powerful even though it meets for only 140 days every other year. In practice, a great deal of power resides with the Legislative Budget Board, chaired by the lieutenant governor and composed 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.

During the late 1990s, George W. Bush was governor. With his election to the presidency, the lieutenant governor, Rick Perry, a conservative Republican, assumed office in December 2000. In his first state of the state address in January 2001, Governor Perry focused on education, transportation, and crime prevention. Although health care is clearly not a major priority for him, he made brief mention in his speech of improving public health initiatives, such as immunizations, and called for additional outreach to increase enrollment in SCHIP.

For the past several years, Republicans have had control of the state senate, while Democrats have maintained a majority in the house of representatives (see table 1). Despite this, both bodies have worked in a bipartisan manner with each other and the governor, aided by the fact that the Democrats, while more liberal than the Republicans, are fairly conservative. Indeed, Governor Bush's track record of working with Democrats while in Texas was one of the central features of his presidential campaign.

### *Fiscal Circumstances of the State*

**General Fiscal Condition and Budget Priorities.** There is a very strong anti-tax environment in Texas; there is no income tax, although local property taxes are relatively high. In 1999, Texas ranked 48th among the states in total state tax revenue per capita and 48th in taxes as a percent of personal income.<sup>3</sup> Moreover, the tax system is highly regressive, with the lowest income quintile paying 17.6 percent of their income in taxes, while the highest income quintile pays only 5.1 percent of their income in taxes.<sup>4</sup> Consumer advocacy groups contend that the lack of tax revenue cripples the ability of the state to address a variety of human service needs.

The strength of the Texas economy in the late 1990s led to budget surpluses, which Governor Bush and the legislature chose to use to fund large tax cuts and modest growth in public spending. In 1997 and 1999, the state enacted tax cuts that will reduce state revenue by \$2.6 billion in state fiscal year (SFY) 2002–03.<sup>5</sup>

Total government spending in Texas grew from \$37 billion in 1995 to an estimated \$50 billion in 2000, an average annual rate of growth of 6 percent, which is comparable to the national rate of growth (see table 3). General-fund expenditures during this period grew by 4 percent annually in Texas, compared to 5 percent nationally. In 2000, Medicaid was about 14 percent of general-fund expenditures and 21 percent of total (federal and state) spending, in line with the national average. Total Medicaid expenditures increased 7 percent per year from 1995 to 2000, faster than the national average of 4 percent. Spending for

TABLE 2. *Health Insurance Coverage, by Family Income and Type of Insurance, Texas and the United States, 1999*

	Children (Ages 0–18) <sup>a</sup> (%)		Adults (Ages 19–64) <sup>b</sup> (%)	
	Texas	United States	Texas	United States
<b>Below 200% FPL</b>				
Employer-sponsored	<b>32.7</b>	38.7	39.2	41.7
Medicaid/SCHIP/state	<b>28.7</b>	35.2	<b>8.4</b>	14.7
Other coverage	<b>2.0</b>	3.8	<b>5.8</b>	8.8
Uninsured	<b>36.7</b>	22.4	<b>46.6</b>	34.9
<b>Above 200% FPL</b>				
Employer-sponsored	<b>82.2</b>	85.3	<b>80.8</b>	83.7
Medicaid/SCHIP/state	3.7	3.8	<b>0.6</b>	1.1
Other coverage	4.6	4.9	5.0	5.8
Uninsured	<b>9.6</b>	6.0	<b>13.6</b>	9.4
<b>All Incomes</b>				
Employer-sponsored	<b>57.6</b>	66.7	<b>65.1</b>	72.3
Medicaid/SCHIP/state	16.1	16.4	<b>3.6</b>	4.8
Other coverage	<b>3.3</b>	4.5	<b>5.3</b>	6.6
Uninsured	<b>23.0</b>	12.5	<b>26.0</b>	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

FPL = federal poverty level

SCHIP = State Children's Health Insurance Program

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

the Temporary Assistance for Needy Families (TANF) program remained at about 1 percent of total spending between 1995 and 2000, but declined by 12 percent per year.

The year 2001 began with the state projecting a small surplus, but deteriorating economic conditions and other factors quickly changed these projections to a substantial deficit. Layoffs at major technology firms, including Dell, Compaq, and Gateway, have added to the economic problems facing the state. The weakening economy in the aftermath of the September 11 terrorist attacks may complicate the state budget, but so far revenues and expenditures have not resulted in significant imbalances.

Major contributors to the budget deficit were the tax cuts of 1997 and 1999, along with more rapidly rising than expected Medicaid expenditures. Factors in the increasing Medicaid expenditures included higher-than-expected enrollment, skyrocketing prescription drug costs, a slight decline in the federal Medicaid matching rate, and the decision by the legislature in 1999 to fund Medicaid expenditures for only 23 months of the biennium, leaving it to the 2001 legislature to appropriate the balance. Some critics contend that the projected Medicaid expenditures were deliberately lowballed in 1999 and that the one-month short funding of Medicaid was a conscious effort to underfund government programs in order to maximize the tax cut and to help Bush's presidential campaign, a perspective rejected by Governor Bush's administration. Texas lawmakers visited Washington, D.C., in spring 2001 to lobby President Bush and other federal officials for higher Medicaid matching funds for children, greater flexibility on prescription drugs, restoration of Medicaid for legal immigrants, and additional money for states on the border with Mexico.<sup>6</sup> Although federal officials voiced sympathy, they made no promises and no agreements were struck.

The tight fiscal environment in Texas meant that many programs and proposals for added funding were not adopted. Nonetheless, several health care initiatives did well in the budget enacted in spring 2001. The legislature passed and the governor signed bills that simplified Medicaid eligibility for children, provided some additional funding for the SCHIP program, authorized (but did not fund) a small state prescription drug assistance program, created a major new role for the state in providing health insurance for the state's teachers, and provided significant rate increases for the state's financially stressed nursing homes. Some offsetting Medicaid savings were required, and the executive branch was given broad latitude in how that should be achieved. Among the cost-containment options the legislature included are expansion of Medicaid managed care to the entire state and inclusion of the aged and disabled populations, creating a case management program for medically complex Medicaid beneficiaries, establishing a drug pricing formula based on the "best price," and establishing sliding scale copayments. In addition, the budget again funded Medicaid for only 23 months. Although the legislature provided additional funds (from the tobacco settlement) for SCHIP, it was less than requested by the Health and Human Services Commission. This underfunding, combined with larger-than-expected rate increases for managed care plans in October 2001, has led state officials to consider options to control enrollment growth for SCHIP.

However, the governor vetoed a number of health bills passed by the legislature, including an ambitious bill that would have sought Medicaid waivers to expand eligibility and draw down additional federal money using local funds as the state match. Concerned about the continuing economic decline and rising Medicaid expenditures, a legislative panel was established in September 2001 to monitor the impact of Medicaid and SCHIP on the state budget.

**Tobacco Settlement Revenues.** Texas was one of four states to negotiate an independent settlement with the tobacco industry prior to and separate from the multistate agreement. In January 1998, a federal judge approved a \$15.3 billion agreement with the tobacco industry. Through December 2000, the state had received about \$1.6 billion. Annual payments to the state will vary between \$326 and \$580 million. A separate settlement between the state and the tobacco industry awarded \$2.3 billion to counties, hospital districts, and other providers of health care to the indigent. Declining tobacco sales have reduced tobacco settlement payments.

The immediate aftermath of the settlement resulted in a series of conflicts between then-Attorney General Dan Morales and then-Governor Bush and the legislature over the share of the settlement to be spent on lawyers' fees and over who would decide how the proceeds of the settlement would be spent. An initial proposal from the attorney general to directly designate funds from the tobacco settlement toward implementation of an SCHIP plan was rejected on the basis that it undermined the legislature's authority to determine state spending. An agreement was finally reached under which the settlement funds were to be considered general revenue, on the understanding that the legislature would make a good-faith effort to ensure that the money went to children's insurance and other health programs.

In 1999 the legislature established nine separate endowments with most of the first two payments, much of it being earmarked for medical education and related activities. An additional \$180 million was allocated to SCHIP. Only interest from each of these endowments will be available for spending. The Campaign for Tobacco-Free Kids has criticized Texas for spending only about \$9 million a year on tobacco prevention, ranking it 41st out of 46 states that had made allocation decisions by the beginning of 2001.<sup>7</sup>

### Major State-Funded Health Programs for Low-Income People

Medicaid and SCHIP are the major state health programs for low-income people. Eligibility and benefits for Medicaid are limited; after a political struggle, Texas SCHIP covers children in families earning up to 200 percent of the FPL. Lack of program participation by low-income children has been an ongoing issue; the legislature and governor

TABLE 3. Texas Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures <sup>a</sup>				Total Expenditures <sup>b</sup>			
	Actual 1995	Estimated 2000	Annual Growth (%)		Actual 1995	Estimated 2000	Annual Growth (%)	
			TX	U.S.			TX	U.S.
<b>Total</b>	\$22,916	\$27,389	4	5	\$37,003	\$49,641	6	6
<b>Medicaid<sup>c,d</sup></b>	\$2,612	\$3,754	8	5	\$7,713	\$10,584	7	4
% of Total	11%	14%			21%	21%		
<b>K-12 Education</b>	\$8,779	\$11,551	6	7	\$10,505	\$14,257	6	7
% of Total	38%	42%			28%	29%		
<b>Higher Education</b>	\$4,451	\$5,389	4	5	\$4,890	\$5,849	4	5
% of Total	19%	20%			13%	12%		
<b>Public Assistance</b>	\$191	\$131	-7	-6	\$521	\$276	-12	-5
% of Total	1%	0%			1%	1%		
<i>AFDC/TANF</i>	<i>\$191</i>	<i>\$131</i>	<i>-7</i>	<i>-9</i>	<i>\$521</i>	<i>\$276</i>	<i>-12</i>	<i>-7</i>
% of Total	1%	0%			1%	1%		
<b>Corrections</b>	\$2,399	\$2,529	1	6	\$2,749	\$2,873	1	6
% of Total	10%	9%			7%	6%		
<b>Transportation</b>	\$21	\$44	16	5	\$2,961	\$4,560	9	6
% of Total	0%	0%			8%	9%		
<b>All Other<sup>e</sup></b>	\$4,463	\$3,991	-2	5	\$7,664	\$11,242	8	8
% of Total	19%	15%			21%	23%		

Source: National Association of State Budget Officers (NASBO), 1997. *1996 State Expenditure Report*, and 2000. *1999 State Expenditure Report*.

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, and so forth are included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: First, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

adopted new initiatives to address this problem in 2001. There are no active plans to expand either Medicaid or SCHIP to cover low-income parents or other uninsured adults on a large scale. Aside from Medicaid and SCHIP, the state has no major programs designed to provide health insurance to the uninsured.

### Medicaid

As in most states, Medicaid is the dominant program providing health care for the uninsured. Texas's Medicaid program is relatively restrictive in terms of eligibility and covered services. For example, low welfare payment levels make Medicaid eligibility for adults who are not aged or disabled very restrictive; parents of TANF children are eligible only if they earn up to 17 percent of the FPL (although somewhat higher if income disregards are included).<sup>8</sup> In 1998, TANF in Texas covered only 21 percent of poor children, compared to 50 percent in the country at large (see table 1). The state does cover the "medically needy," pregnant women, and infants in families earning up to 185 percent of the FPL, which is above the federal minimum requirement of 133 percent of the FPL. While children are entitled by federal law to virtually any medically necessary service, benefits for adults are limited. For example, Medicaid restricts coverage to 30 days for inpatient hospital stays and three prescriptions per month for noninstitutionalized adults. The state has been sued on



the inadequacy of its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which provides preventive services for children, and has been operating under a consent decree since 1996. In 1998, the plaintiffs sued again, arguing that the state was not complying, and in 2000 the district court agreed, but the state was granted a stay pending an appeal to the Fifth Circuit Court of Appeals.

In 1998, which is the latest year for which detailed national data are available, Texas spent a total of \$10.3 billion on Medicaid (see table 4). Of total Medicaid expenditures, 52 percent was for acute care, 29 percent for long-term care, 14 percent for Disproportionate Share Hospital (DSH) payments, and 5 percent for administration. In 1998, Texas spent \$4,287 per enrollee, less than the national average of \$4,857 (data not shown), mostly because of lower expenditures for elderly and disabled beneficiaries. Between 1995 and 1998, expenditures for medical services grew at an annual average rate of 5.0 percent, just about equal to the national rate of growth of 5.1 percent. Expenditures continued their slow growth of about 4 percent a year in 1999 and 2000, but began increasing more quickly in 2001, when spending increased by an estimated 9.8 percent.<sup>9</sup> According to state officials, prescription drugs, increases in utilization, and nursing home payment rates were the major Medicaid cost drivers in Texas during SFY 2000 and SFY 2001.<sup>10</sup>

Increases in prescription drug expenditures have been especially dramatic, rising from \$826 million in SFY 1998 to \$1.305 billion in SFY 2001, an annual rate of increase of 16.5 percent.<sup>11</sup> The state estimates that the number of prescriptions will increase 3 to 4 percent per year over the next two years and that the cost per prescription will rise by 10.5 to 11.4 percent per year.<sup>12</sup>

The Texas Medicaid program had an average monthly enrollment of 1.9 million beneficiaries in 1998; 56 percent of enrollees were children, 13 percent were nondisabled adults, 15 percent were younger people with disabilities, and 16 percent were older people. Between 1995 and 1998, Texas's Medicaid enrollment fell by an average annual rate of 3.2 percent a year, three times the national rate of decline. Enrollment of children and nondisabled adults fell rapidly during this period, driven by large declines in enrollment by persons receiving cash assistance. For children, increased enrollment in non-cash assistance eligibility categories partly offset the overall rate of decline, but there were no offsetting increases among adults. By 1998, the total number of nondisabled adults enrolled in Medicaid was 27 percent less than in 1995. By contrast, enrollment of older people and younger persons with disabilities rose during this period. Although more recent data indicate that total Medicaid enrollment continued to decline in 1999 and 2000, the total number of beneficiaries increased by 3.3 percent, to an average of 1.8 million persons in 2001, and is projected to continue to increase by 2 to 4 percent a year through 2004.<sup>13</sup>

Although Medicaid is associated with welfare, health care is thought to be different from cash assistance. There is general acceptance of the notion that people ought to be able to obtain needed health care, although Texans are reluctant to pay more in taxes to implement widespread Medicaid expansions or other coverage. From 1995 to 1997 the state unsuccessfully pursued an ambitious Section 1115 Medicaid research and demonstration waiver as a way of expanding eligibility. The waivers were not approved, largely because of the federal government's concern that beneficiaries would not have a choice of health plans, which could adversely affect quality of care. In addition, there were perceived conflict-of-interest issues involving public hospitals. Texas has not pursued use of Section 1931 of the Social Security Act to expand eligibility by changing the definition of income and assets to effectively raise Medicaid income and resources thresholds.

In 2001, the Texas legislature passed two bills designed to expand Medicaid eligibility, one of which Governor Perry vetoed. The bill enacted into law is aimed at simplifying the Medicaid application process for children. One of the major concerns in Texas is that more than 500,000 children financially qualify for Medicaid but are not enrolled. The stark contrast between the simplicity of enrolling in SCHIP and the complexity of applying for Medicaid highlighted the issue of administrative barriers to enrollment. Most SCHIP referrals to Medicaid failed to be enrolled, many for noncompliance with procedural requirements, such as attending an interview or supplying required documentation. Only two

TABLE 4. Medicaid Enrollment and Expenditures in Texas, 1998

	Texas, 1998			Average Annual Growth (%), 1995–1998						
	Total Annual Expenditures (in billions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee		
				Texas	United States	Texas	United States	Texas	United States	
<b>Total Expenditures</b>	\$10.3	-	-	4.0	3.9	-	-	-	-	-
<b>Medical Services</b>										
<b>By Eligible Group</b>	\$8.3	1,939	\$4,287	5.0	5.1	-3.2	-1.0	8.5	6.1	
Elderly	\$2.7	303	\$8,913	8.1	4.3	1.8	0.1	6.2	4.2	
Blind and disabled	\$2.6	295	\$8,718	5.5	8.5	3.3	3.6	2.1	4.7	
Adults	\$1.1	254	\$4,309	-4.8	-1.4	-10.7	-4.4	6.7	3.1	
Cash assistance	\$0.4	123	\$3,102	-10.6	-10.4	-17.3	-14.9	8.2	5.3	
Other enrollees	\$0.7	131	\$5,438	-1.0	7.8	-2.1	9.3	1.1	-1.4	
Children	\$1.9	1,087	\$1,788	7.0	2.7	-4.0	-1.5	11.4	4.3	
Cash assistance	\$0.5	313	\$1,540	-4.0	-8.8	-15.6	-12.2	13.7	3.9	
Other enrollees	\$1.5	774	\$1,888	11.9	12.4	3.0	9.8	8.7	2.4	
<b>By Type of Service</b>	\$8.3	-	-	5.0	5.1	-	-	-	-	
Acute care	\$5.3	-	-	2.1	4.0	-	-	-	-	
Long-term care	\$3.0	-	-	11.1	6.5	-	-	-	-	
<b>DSH</b>	\$1.4	-	-	-1.7	-7.3	-	-	-	-	
<b>Administration</b>	\$0.5	-	-	7.3	8.5	-	-	-	-	

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

states, Texas and Utah, required in-person interviews and asset tests for children's Medicaid.

To simplify the Medicaid enrollment process for children, SB 43 makes four major changes:<sup>14</sup> First, it mandates a single consolidated application and parallel procedures for Medicaid and SCHIP, including a two-page application form. Second, it allows for mail-in application and recertification for Medicaid. Third, it requires the use of the SCHIP self-declared assets test for Medicaid, with no additional documents or proof required. Finally, it phases in continuous eligibility for children through age 19, with 6 months of continuous eligibility by February 2002, and 12 months of continuous eligibility no later than June 2003. These simplifications should increase Medicaid enrollment by 150,000 children by 2003. The law also has provisions to smooth transitions between Medicaid and SCHIP, requires an enrollee orientation to Medicaid, and directs the Department of Health Services to require compliance with Texas Health Steps, the Medicaid program's EPSDT program of prevention and screening for children. The bill had overwhelming bipartisan support, passing the house unanimously.

The other major Medicaid bill to pass the legislature was SB 1156, which was much broader in scope and vetoed by the governor, which surprised and angered many of the bill's supporters. In terms of Medicaid eligibility, the most important provision would have established a large demonstration project, subject to federal approval, that would have served adults in families earning below 200 percent of the FPL using local funds to pay the state share of Medicaid. Subsequent to the bill's veto, a smaller demonstration project is being planned. In addition, some of the bill's other provisions, including proposed demonstrations on provision of psychiatric medications to certain low-income individuals with psychiatric diagnoses, targeted medical services to persons with HIV/AIDS, and preventive and family planning services to women, are going forward despite the veto of the legislation. A major reorganization of Medicaid under the Texas Health and Human Services Commission authorized by the bill is also under way. This reorganization would consolidate administration of the acute care portion of Medicaid under the Texas Health and Human Services Commission; eight agencies have had some involvement in administering the Medicaid program.

In vetoing SB 1156, Governor Perry said that he supported the administrative consolidation of Medicaid, but other provisions would interfere with that effort. According to the governor's office, Perry "generally opposes" expanding health care "to which some people might assume they are entitled."<sup>15</sup> In the aftermath of the veto, a group of lawmakers urged Perry to request federal matching funds for local health expenditures, but the governor has not done so.

### **State Children's Health Insurance Program**

The federal Balanced Budget Act of 1997 established SCHIP, which provided matching grants to states to provide health insurance coverage to children in families with incomes below 200 percent of the FPL. States were given substantial flexibility in how they structure the program. As an incentive for states to participate, the federal matching rate was considerably above that used for Medicaid. In Texas, the SCHIP match rate was 72.4 percent in 2001.

In 1997, before the enactment of the federal SCHIP program, the Texas legislature created the Texas Healthy Kids Corporation, a public-private partnership designed to supplement governmental programs with private funds to help subsidize coverage for children in families with incomes up to 185 percent of the FPL. The Texas Healthy Kids Corporation was modeled after Florida's Healthy Kids program, another state program that predated the passage of SCHIP. After the federal enactment of SCHIP in 1997, the vast majority of Texas Health Kids Corporation's target population qualified for SCHIP, and insurance coverage through the Texas Healthy Kids Corporation was discontinued.

The Texas SCHIP program was implemented in two phases. First, in July 1998, Texas expanded Medicaid coverage to children up to age 19 in families with incomes up to 100

percent of the FPL. This group included older children, ages 15 through 18, who were not already eligible for Medicaid. This Medicaid expansion was an acceleration of a phase-in of already federally mandated coverage and was viewed as a placeholder plan until the state could develop a non-Medicaid approach. Key legislators and state officials believed that Medicaid was a heavily stigmatized welfare program with many problems, and they were unwilling to simply build on what they believed was an inadequate program. In addition, state officials were not interested in expanding Medicaid, because it would have to be run as an entitlement, which would make the state vulnerable to unplanned expenditure increases and was philosophically unpalatable to many state legislators. They wanted a program that was closer to the private insurance that the working population had, including some requirements for premium payments and cost sharing. In their view, SCHIP's success depended on its implementation as a separate program offering non-Medicaid insurance coverage.

Over a year later, in November 1999, Texas received federal approval to offer non-Medicaid coverage to children with family incomes up to 200 percent of FPL (infants, 185–200 percent of FPL; children ages 1 to 5, 133–200 percent of FPL; children ages 6 to 18, 100–200 percent of FPL; and children ages 15 to 18, 100–200 percent of FPL). At 200 percent of FPL, about half of all the children in Texas financially qualify for Medicaid or SCHIP.<sup>16</sup> Texas is one of the few states that has not chosen to use SCHIP to equalize eligibility thresholds across age groups. Because eligibility for Medicaid varies by age of the child, children in the same family can be enrolled in different programs. The choice of maximum income level was a contentious issue, with Governor Bush initially proposing coverage only up to 150 percent of FPL, reportedly because of fears about the potential spillover impact of increased enrollment in Medicaid (with its lower federal matching rate), but the legislature ultimately chose the higher income level. For the non-Medicaid expansion group, the benefit package is somewhat modeled on the coverage offered to state employees, but with added benefits (including dental services and additional rehabilitation services). Within state government, the Health and Human Services Commission administers both SCHIP and Medicaid programs. Enrollment began in April 2000, with coverage beginning in May.

The Texas SCHIP program requires cost-sharing for children in families with incomes above 100 percent of FPL. In families with incomes between 100 and 150 percent of FPL, families pay an annual enrollment fee of \$15. In families with incomes between 151 and 185 percent of FPL, the total premium for children is \$15 per month and there is a \$15 annual enrollment fee. In families with incomes between 186 and 200 percent of the FPL, the total premium for children is \$18 per month, and there is an \$18 annual enrollment fee. Premiums do not vary by the number of children in a family. Some copayments are required on office visits, prescriptions, and emergency rooms visits, but not on preventive services.

The vast majority of enrollees are in managed care; 12 HMOs and one exclusive provider organization participate. HMOs are not available in most rural and smaller urban areas; beneficiaries are enrolled in an exclusive provider organization, which limits enrollees to a broad set of providers. HMOs are available in 85 counties, and the exclusive provider organization provides services in 170 counties. Unlike Medicaid, SCHIP does not offer a Primary Care Case Management (PCCM) option. While SCHIP requires some form of managed care in all parts of the state, Medicaid managed care is operational only in the major cities, although these urban areas account for the vast majority of Medicaid beneficiaries. Half of the SCHIP plans also participate in Medicaid; the rest are SCHIP-only plans. Moreover, not all Medicaid plans participate in SCHIP. Thus, eligibility transitions between Medicaid and SCHIP can mean changes in providers.

Reimbursement has been an issue in the SCHIP program. Texas pays a lower rate for SCHIP enrollees than for Medicaid. SCHIP rates are set based on health plan experience, while Medicaid rates are set administratively based on experience in the fee-for-service

sector. According to industry sources, most SCHIP plans suffered initial losses. In October 2001, SCHIP payment rates were significantly increased. For example, the SCHIP health plan run by Texas Children's Hospital in Houston received a 29 percent rate increase, which the hospital claimed was necessary to keep its losses to a manageable level.<sup>17</sup> In El Paso, some physicians threatened to stop treating Medicaid and SCHIP enrollees, contending that reimbursement levels were too low.<sup>18</sup> However, some observers believe that these are hollow threats because these children account for such a high percentage of paying patients, and that the problems of access in El Paso are systemic ones not limited to Medicaid and SCHIP.

Texas was slow in enacting and implementing SCHIP expansions, in part because the legislature meets only every other year and the federal authorizing statute was enacted after adjournment in 1997. After implementation, however, enrollment in the Texas SCHIP program increased quickly. In June 2000, enrollment was only 39,859 beneficiaries, but by September 2001, it had reached 439,222 children.<sup>19</sup> The Health and Human Services Commission projects continued growth, with enrollment reaching 514,000 in SFY 2004.<sup>20</sup> In part because of the late start and the large number of people eligible for Medicaid who are not enrolled, the state has not pursued expanding SCHIP to adults. Unlike some other states, Texas anticipates using all of its federal SCHIP allotment on providing health insurance to children.

To boost enrollment, the state has modified eligibility rules and eligibility processes. As discussed above, in 2001 the Texas legislature adopted simplified Medicaid eligibility requirements for children modeled after the SCHIP rules and procedures. Starting in January 2002, there will be a two-page joint application for the Medicaid and SCHIP programs, which families will complete without reference to either program. An SCHIP eligibility determination or Medicaid referral will be made based on the information on the application. No face-to-face interview is required for the SCHIP program, and there is no asset test. For SCHIP-eligible children, the "waiting period" of uninsurance before eligibility is 90 days, although there are several exceptions—such as transition from Medicaid and when health insurance premiums are greater than 10 percent of family income—where there is no waiting period.

Texas uses multiple avenues to reach out to potentially eligible children. The state tracks application and enrollment volume at the state, county, and ZIP Code levels. Community groups play a key outreach role, and families can apply through community-based organizations such as churches or schools. State agencies, too, have played an important role in reaching potential enrollees. For example, the state mailed information to more than 80,000 families with children who either had applied for or were receiving food stamps. The state also mailed information to over 25,000 custodial parents with at least one uninsured child who was subject to a medical support order. On the private side, numerous initiatives focus on SCHIP outreach, including donated television advertising time and a partnership with grocery stores where health insurance information was printed on grocery bags. Surveys have found that 40 percent of new enrollees heard about the program through family or friends, which state officials interpret as a positive response to the program by enrollees.<sup>21</sup> Because of some underfunding of SCHIP in the budget enacted in 2001 and the greater-than-planned rate increases, state officials are considering mechanisms to slow the rate of increase in enrollment, including postponing the start of coverage for one or more months from the date of enrollment, guaranteeing eligibility for only 6 rather than 12 months, establishing an open enrollment period, and capping enrollment.

The state also operates two small SCHIP-like programs designed to increase health insurance coverage for children in special groups. The State Kids Insurance Program (SKIP) is a unique program designed to ensure that children of low-income state and higher education employees who are eligible for the state's health insurance program are cov-

ered; about 6,000 children are enrolled.<sup>23</sup> The other program is aimed at children who are legal aliens and are subject to the federally imposed five-year waiting period for benefits; about 8,000 children are enrolled.

### Acute Care Issues

Texas policymakers face a number of issues related to acute care, including Medicaid managed care, commercial managed care and insurance regulation, Medicaid disproportionate share hospital payments, and pharmaceutical assistance for older people and younger persons with disabilities.

#### *Medicaid Managed Care*

Texas began moving Medicaid beneficiaries into managed care starting in 1992. In 1995, a major expansion of managed care was tied to obtaining a major increase in Medicaid coverage through a Section 1115 research and demonstration waiver. However, when the federal government did not grant approval of the waiver, the state moved forward with the managed care expansion despite opposition by public hospitals and consumer advocates. State officials stress the potential of managed care to improve access and to provide a “medical home” to Medicaid beneficiaries, as well as to save a modest amount of money.

By 2001, most Medicaid beneficiaries were in HMOs or PCCM arrangements in the major urban areas, including Austin, Fort Worth, San Antonio, Lubbock, Houston, and, more recently, Dallas and El Paso. Under its managed care program, TANF beneficiaries and related populations (children and pregnant women) must enroll in managed care. Persons with disabilities may enroll in managed care voluntarily, but dually eligible (Medicare and Medicaid) beneficiaries are excluded due to the administrative complexities of coordinating between the two programs. The exception to this exclusion is the STAR+PLUS program in the Houston area, which covers acute and long-term care services. Medically needy beneficiaries are also prohibited from enrolling because of administrative complexity. A private contractor acts as an enrollment broker. As of July 2001, 593,324 Medicaid beneficiaries were enrolled in managed care programs, 60 percent in HMOs and 40 percent with PCCM providers.<sup>24</sup> A high rate of beneficiaries, over 80 percent, voluntarily choose a plan rather than being autoassigned.

Managed care plans must cover most Medicaid-defined services, including special services for children. The fee-for-service system provides dental services and long-term care. Plans that offer benefits beyond those normally covered by the state are favored during the selection process. In particular, plans receive extra points for innovative coverage of behavioral health services. Beneficiaries enrolled in HMOs and PCCMs have coverage for unlimited prescriptions, whereas fee-for-service Medicaid has a three-per-month prescription limit for noninstitutionalized adults. In addition, HMOs must cover a wellness exam and may not limit inpatient coverage to 30 days per spell of illness, as is the case under Medicaid fee-for-service.

A major initiative to expand Medicaid managed care to the aged and disabled population is the STAR+PLUS project, which is designed to integrate delivery of acute and long-term care services through managed care systems.<sup>24</sup> As of July 1, 2001, STAR+PLUS had about 56,000 enrollees in the Houston area.<sup>25</sup> By integrating care, the state hopes to provide higher quality care and save money. Aged and disabled participants may choose from two managed care organizations; certain participants have a PCCM option in addition to the three HMO choices. Services include a range of home- and community-based services and, until 2001, a modest amount of nursing home care, which was dropped due to opposition by nursing homes. The project is one of the few in the country that combines a Medicaid freedom of choice waiver with a Medicaid home- and community-based services waiver.

Except for the PCCM program, the state will contract only with state-licensed HMOs. While the state contracts with Medicaid-only plans, it sees commercial HMOs as a way of mainstreaming Medicaid and SCHIP beneficiaries. Under the PCCM system, providers receive a case management fee of \$3 per member per month. State oversight of the pro-

gram has been hampered by large numbers of staff vacancies and by difficulty in recruiting and retaining qualified personnel, problems which the Texas Health and Human Services Commission is actively trying to address.

Despite the state's commitment to Medicaid managed care, other stakeholders have found it to be problematic. Consumers Union of the Southwest Region identified problems with access to prenatal care and specialists, continuity of care, and delays in the eligibility and enrollment process.<sup>26</sup> In 1999, dissatisfaction from providers and consumer advocates led the legislature to pass and then-Governor Bush to sign a bill placing a temporary moratorium on expansion of Medicaid managed care until problems could be addressed and cost savings demonstrated. By 2001, the moratorium had ended, and the budget passed that year directs the Health and Human Services Commission to explore expanding Medicaid managed care to the rest of the state as a means of saving money. State and local advisory panels have been established to work out problems.

State officials generally contend that Medicaid managed care has been successful, both financially and from a care delivery perspective. Based on an analysis by William M. Mercer, Inc., the state believes that it realized savings of almost \$93 million for SFY 1997 to 1999.<sup>27</sup> According to a Health and Human Services Commission report, "under Medicaid managed care, the [s]tate has a structure for improved program monitoring, oversight, accountability, and outcomes that did not exist in the traditional Medicaid program."<sup>28</sup> According to the state, managed care members are systematically linked with a usual source of care, unlike traditional Medicaid, where use of emergency rooms is frequent.

The state has developed a number of structures and processes for quality improvement, including detailed contract standards and incentives, establishment of advisory groups and quality forums, and enhanced data collection.<sup>29</sup> Texas has defined quality indicators and is tracking them over time, although encounter data remain a major problem. The state also contracts with an external quality review organization, the Texas Health Quality Alliance, that assists the state in a systematic approach to quality improvement. It reports high levels of member satisfaction with health plans and quality of care.

Providers in Texas have been exceptionally hostile to managed care in general, and the Medicaid efforts to expand enrollment have met with resistance. Providers are less opposed to PCCMs than to HMOs. Relationships between providers and health plans are often poor. The state contends that provider dissatisfaction mostly concerns administrative and payment issues.<sup>30</sup> According to some stakeholders, however, primary care providers complain about access to specialists. Some observers contend that the initial rollouts of Medicaid managed care were "fraught with logistical snafus," with children in the same families being assigned to different providers, pregnant women assigned to pediatricians, and young boys assigned to OB-GYNs.<sup>31</sup>

The state concedes that Medicaid managed care is more administratively complex for providers than the traditional Medicaid program. There are multiple claims processes and payers instead of one set of claims processes and one claims payer, as was the case under the traditional program. Variations in requirements for referrals to specialists and prior authorization add to the complexity. Timeliness of payment by managed care plans is a major issue for providers. Among hospitals, there is considerable support for reducing the number of participating plans.

Reflecting the rocky financial performance of HMOs in the state, Texas has experienced some turbulence in Medicaid plan participation. The Harris County (Houston) Hospital District–sponsored HMO, Community Health Choice, initially failed to win a contract and was only admitted to the program following state legislation requiring the Medicaid program to contract with hospital district–sponsored plans. Failure to win a contract could have had a major negative impact on the county-run hospital. Since its inception, the plan has struggled and initially failed to attract sufficient numbers of beneficiaries to make it financially viable.<sup>32</sup> After almost selling the plan, the Harris County Hospital District discontinued its small commercial enrollment and has expanded its Medicaid business.

Other plans have also had financial difficulties, although overall their financial status seems to be improving. Plan withdrawals, however, are mostly confined to certain geographic areas. In March 1999, Blue Cross and Blue Shield of Texas withdrew from participation in Dallas and El Paso, due to projected losses.<sup>33</sup> In 1999, Harris Methodist Health Plan withdrew from the Fort Worth area, forcing 13,000 beneficiaries to obtain coverage from other plans.<sup>34</sup> And in 2000, one of the two contractors in the NorthSTAR program, a managed mental health and chemical dependency program in the Dallas area, withdrew in response to rising pharmaceutical costs.<sup>35</sup> PCA/Humana also withdrew from several markets.

### **Commercial Managed Care and Insurance Regulation**

The health care market is changing rapidly in Texas. Enrollment in HMOs and preferred provider organizations has grown at the expense of indemnity coverage. The vast majority of HMOs in the state are for-profit organizations. The financial status of HMOs in the state was poor through much of the 1990s, with many health plans losing money, leading to intense competition and some consolidations.

Negative publicity about quality of care, combined with hostility from hospitals and physicians, has translated into fairly strict regulation of managed care in Texas. The Texas Medical Association strongly opposes managed care and has fought for rules to make operating an HMO in the state less attractive. Although a “patient protection act” promoted by the state medical society was vetoed by Governor Bush in 1995 as being too tilted toward providers, he did order that many patient and provider protections be instituted by regulation. These regulations address emergency room services, continuity of care, out-of-network referrals, balance billing, and member information. Additional legislation required the state to collect extensive patient care and quality data from HMOs.

In 1997, Texas enacted several other laws that regulate managed care, including banning gag clauses in physician contracts, requiring a “prudent layperson” standard for emergency room use, and allowing direct access to OB-GYNs for specified services. In addition, Governor Bush allowed a bill to become law without his signature that permitted patients to sue HMOs for malpractice. As president, Bush has strongly opposed these provisions. After enactment, Aetna sued the state, arguing that this provision violated the federal Employee Retirement Income Security Act of 1974 (ERISA). The court ruled that enrollees could bring suits over “failure to exercise ordinary care” or quality of care, but invalidated the state’s independent appeals process. Contrary to insurers’ fears, there have been only a modest number of lawsuits filed—5 in 1999 and 15 in 2000. The court also invalidated the ban on “gag clauses” on the grounds that ERISA preempts state law in this area. The state has also been active in preventing health plans from providing financial incentives to providers, especially physicians, to withhold care, suing seven major HMOs over the practice.<sup>36</sup>

Prompt payment of claims by insurers, especially HMOs, has been a major issue. In 2000, the Texas Department of Insurance received more than 10,000 complaints from providers about slow payments. In 2001, the legislature passed and Governor Perry vetoed legislation that would have strengthened the state’s rules requiring health insurers to pay claims promptly. Arguing that Texas already had an adequate law on the books and that he did not want to add to litigation in the state, Perry nonetheless warned insurers that he would not tolerate payment delays.<sup>37</sup> Soon after the governor’s veto, the Texas Department of Insurance fined seven insurance companies over \$9 million for failing to pay providers on time.<sup>38</sup>

As in much of the rest of the country, HMOs in Texas lost substantial sums of money during most of the late 1990s. In 1999, HMOs posted a record loss of \$400 million, despite increasing enrollment and premiums. Industry observers attributed the recent losses to a variety of factors but said that a rise in pharmaceutical costs played a major role. Not surprisingly, then, the HMO industry in Texas has been consolidating, with a series of mergers and takeovers that have involved Aetna, US Healthcare, NYLCare, Kaiser Permanente,



Sierra Health Services, Blue Cross and Blue Shield of Texas, and Harris Methodist Health Plan.

In a major move, Blue Cross and Blue Shield of Texas merged with Blue Cross and Blue Shield of Illinois, creating one of the largest Blue Cross and Blue Shield plans in the country, with 4.8 million enrollees, nearly 11,000 employees, and almost \$8 billion in revenues. The merger was approved in 1998 by the Texas Department of Insurance. The state attorney general opposed the merger because he believed it violated a state law that non-profits can merge only with other non-profits and that it would illegally transfer the assets of the Texas plan out of state. The attorney general dropped his opposition after losing in court and obtaining promises from Blue Cross that they would make payments to the Texas Healthy Kids Corporation.<sup>39</sup> Consumer groups, including Consumers Union, continued to be unhappy about the merger, which was widely thought to be a first step to Blue Cross and Blue Shield becoming a for-profit company.

### *Hospitals and Medicaid Disproportionate Share Hospital Payments*

In 1999, Texas had 408 hospitals, with 53,570 beds (excluding separate nursing home units).<sup>40</sup> About 30 percent of Texas hospitals have 50 beds or less. The hospital market is mixed, with some facilities doing well, but with reportedly about a third facing serious financial difficulties. Like hospitals nationwide, Texas's hospitals were adversely affected by Medicare reimbursement rate cuts in the federal Balanced Budget Act of 1997, that have not been completely offset by the increases in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000. The Columbia-HCA chain, which was a major provider in Texas, has been broken up into six different companies in response to charges of fraud and abuse.

Although Medicaid eligibility levels for adults are low, Texas has a large number of public hospitals—funded by local property taxes—that provide care to low-income patients. Many of these hospitals feel threatened by Medicaid managed care because patients may be siphoned off to private hospitals and because managed care may reduce overall inpatient stays. Reduced Medicaid revenues could make it difficult for public hospitals to continue serving the uninsured without larger local subsidies. Dallas, Amarillo, Houston, Austin, and El Paso have recently raised taxes, cut services, or sold assets in response to fiscal pressures caused by rising numbers of uninsured, Medicaid managed care, and higher health care costs. Some public hospital districts have formed HMOs in order to maintain their Medicaid patient base, a strategy made easier by a 1997 state law that requires that Medicaid contract with these HMOs.

Most hospitals, except children's specialty hospitals and psychiatric hospitals, are paid by Texas Medicaid on the basis of diagnosis-related groups (DRGs). The state makes a flat payment based on a patient's diagnostic category, regardless of the actual length of stay (up to an outlier threshold, after which there is an additional payment). In an effort to save money under Medicaid, the state introduced a selective contracting system in 24 metropolitan areas for nonspecialty hospitals that were not state owned. Almost all hospitals were selected to participate. Medicaid HMOs generally pay Medicaid rates, although they have sought—largely unsuccessfully—additional discounts.

Federal law requires state Medicaid programs to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs, a mandate known as the disproportionate share hospital (DSH) payment adjustment. As expenditures for this program have grown, the federal government has been strongly critical of some states' "abuse" of the DSH program, arguing that they have used it to increase federal payments without incurring much, if any, additional state expense.<sup>41</sup>

Begun in 1986, the Texas Medicaid DSH payment program is now very large, totaling \$1.4 billion, or 14 percent of total Medicaid expenditures, in 1998. These payments are largely funded by intergovernmental transfers by the large public hospitals. Unlike some DSH programs in others states, where federal funds have been diverted to the state treasury, the DSH program in Texas has been used primarily to provide additional financial

support to local hospitals serving a large number of Medicaid and uninsured patients. Distribution of DSH funds among the 150 community hospitals and 12 state hospitals that receive funds is contentious, with strong splits between urban and rural and between public and private hospitals. The Balanced Budget Act of 1997 placed new restrictions on DSH funds and reduced maximum payments. Further changes to the DSH rules in the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 eliminated the 2001–2002 DSH cutbacks mandated by the Balanced Budget Act of 1997. In addition, for two years, it allowed states to pay public hospitals up to 175 percent of their hospital-specific DSH cap rather than the previous maximum of 100 percent.

In late 2001, Texas developed a supplemental payment, or “upper-payment limit,” program that will use intergovernmental transfers to pay hospital providers an enhanced reimbursement rate in order to draw down additional federal payments with no additional state expenditures. This plan will rely on intergovernmental transfers from large public hospitals to make supplemental payments for both inpatient and outpatient care to high Medicaid volume hospitals. Another portion of the funds will be used to fund Medicaid’s graduate medical education payments, which will benefit a large number of additional hospitals. In contrast to upper payment limit programs in some states, the extra money will go to health care providers rather than the state treasury.

### *Prescription Drugs for Older People and Persons with Disabilities*

As in other states, the rising costs of prescription drugs is a major issue in Texas. The 2001 legislature passed and Governor Perry signed several bills related to prescription drugs. The first was a modest new pharmaceutical assistance program for older people and younger persons with disabilities who qualify for Medicare.<sup>42</sup> The upper-income limit for eligibility is to be determined depending on a more thorough analysis of projected costs. The goal is to get the program started and to expand eligibility over time, as state finances permit. The program, which is not an entitlement, will have a formulary and will encourage the use of generic drugs. Although authorized, the program was not funded. Second, the state enacted a program that provides for reduced or discounted retail prices for eligible persons but does not provide a state subsidy for the purchase of prescription drugs. As of this writing, the program features have not been established. Third, an interagency council was established to purchase pharmaceuticals in bulk, giving the state greater leverage in the market to negotiate lower prices. The council will consist of the Department of Health, the Department of Mental Health and Mental Retardation, the Department of Criminal Justice, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and any other agency that purchases drugs.

### **Long-Term Care for Older People and Younger Persons with Disabilities** *Background*

Given its large population and territory, it is not surprising that Texas has a large number of long-term care providers and a sizable, at least in absolute terms, long-term care budget. Texas spent \$3.0 billion on Medicaid long-term care in 1998. The vast majority of expenditures are for institutional care, although expenditure growth in recent years has been much faster for home and community-based services.

The state has a large supply of nursing homes, comparatively more than the national average. In 1998, Texas had 131,172 nursing facility beds (65 beds per 1,000 elderly, compared with the national average of 53 beds per 1,000 elderly).<sup>43</sup> Occupancy rates have historically been among the lowest in the country, and there has been a moratorium on the construction of new nursing homes since 1985, although existing facilities are allowed to add additional beds. In 1999 and 2000, nearly 75 percent of Texas’s nursing facility residents depended on Medicaid to pay for their care, which is above the national average.<sup>44</sup> There were also 14,304 beds in intermediate care facilities for the mentally retarded in 1998, well above the national average (0.72 beds per 1,000 population, compared with 0.47 beds per 1,000 population nationally).

The state has a lower supply of nonmedical residential beds relative to the nation, but it has a large number of home health agencies. In 1998, the state had 29,844 licensed residential care beds (15 beds per 1,000 elderly compared with the national average of 26 beds per 1,000 elderly). The state experienced tremendous growth in the number of home health agencies during the 1990s, but many agencies closed in response to Medicare home health reimbursement changes in the Balanced Budget Act of 1997. In 1998, there were 3,613 licensed home health agencies, but the number is likely to be lower today.

As in much of the rest of the country, Texas's nursing homes and home care agencies are experiencing great difficulty hiring and retaining registered nurses, certified nurse assistants, and home health aides. Annual turnover of certified nurse's aides in Texas nursing homes averages 110 percent a year, which reportedly reflects a combination of low pay and benefits (most nurse's aides lack health insurance) and job stress.<sup>45</sup> In 2001, the legislature provided tuition assistance to nurses who agree to practice in long-term care facilities and provided grants to promote nursing education.<sup>46</sup>

### *Nursing Homes*

The nursing home industry in Texas is under severe financial strain. The state has historically set low levels of Medicaid reimbursement, which has limited its ability to hire staff and perhaps provide high quality care. Many facilities were adversely affected by Medicare skilled nursing facility reimbursement changes enacted in the Balanced Budget Act of 1997, which in some cases were compounded by poor business decisions. About a quarter of Texas nursing homes are in Chapter 11 bankruptcy proceedings. In addition, as a result of some very large jury awards, Texas nursing homes have experienced dramatic increases in their liability insurance premiums, and most insurers no longer write policies in the state.

**Reimbursement.** Medicaid reimburses Texas nursing homes on a case-mix adjusted, flat-rate basis. Each resident is classified into one of 11 categories based on her disabilities and medical conditions. In 1997, the average reimbursement rate was \$72, which was one of the lowest average rates in the country.<sup>47</sup> In a recent innovation, facilities that meet certain staffing requirements receive an enhanced rate.

Medicaid nursing home reimbursement has been a prominent issue over the past several years. Throughout the 1980s and most of the 1990s, the federal Boren amendment required states to pay enough to cover the costs of an economically and efficiently operated facility that met the quality standards. The state was sued twice for violating these standards, and there was one major threat of an additional suit. The Balanced Budget Act of 1997 repealed the Boren amendment, giving states almost total flexibility in setting nursing home reimbursement. According to the nursing home industry, the repeal of the Boren amendment has had a significant impact because the state does not have to fear lawsuits when it sets rates, although the state has been trimming inflation adjustments rather than making major cuts. In 2001, a coalition of small, mostly for-profit nursing homes sued the state in federal court, charging that it had reneged on the 1997 settlement of an earlier lawsuit in which the state committed to reimbursement rate increases. The Texas Health Care Association did not join in the lawsuit due to the uncertainties associated with the potential outcome of the suit and the belief that the current environment required a legislative rather than a legal strategy.<sup>48</sup>

Given the financial pressures on nursing homes, the Texas Health Care Association mounted a major campaign in 2000 and 2001 to raise reimbursement rates, requesting an additional \$778 million in general revenue for fiscal years 2002 and 2003, arguing that doing so was critical to providing higher quality care.<sup>49</sup> A broad coalition that included AARP, the Alzheimer's Association, and the Texas Nurses Association supported rate increases tied to improvements in staffing and quality of care.<sup>50</sup> A bill to increase revenue by charging a new provider tax or "quality assurance fee" of \$5.25 per day per occupied nursing home bed that would then be used to increase nursing home reimbursement rates, with the federal government paying most of the costs, was not enacted. The initiative was criticized on the grounds that it would raise prices for private pay residents, and Governor

Perry strongly opposed any new taxes.<sup>51</sup> The governor also vetoed a bill that would have mandated a study of nursing home reimbursement. In the end, the legislature appropriated about \$180 million in general revenues for nursing home rate increases and acuity adjustments in 2002 and 2003, which was far less than sought by the nursing home industry but still seen as a considerable victory given the state's financial problems.<sup>52</sup>

**Liability Insurance.** Over the past five years, Texas nursing homes have experienced a huge increase in liability insurance costs, with most insurers leaving the state. According to nursing home industry sources, the cost of liability insurance in 2001 is 10 times what it was in 1996. In the past several years, there have been a number of very large jury verdicts against nursing homes and Texas, along with Florida, has a very high rate of liability claims.<sup>53</sup> Reportedly, a third of nursing homes no longer carry liability insurance, causing potential problems for residents and facilities should a claim be filed. The nursing home industry blames the problem on the 1997 legal change that allows plaintiffs to use federal survey and certification results as proof of poor care, abuse by lawyers, and the inapplicability of damage award caps if the plaintiff alleges criminal conduct. Consumers blame the nursing home industry for providing poor quality care.

The state has adopted a few incremental steps to begin to address the problem. In 2000 the state insurance department decided to let Texas's nonprofit nursing homes that cannot find insurance anywhere else purchase liability insurance through a state-sponsored medical malpractice high-risk pool. In 2001, legislation was enacted that allows for-profit facilities to participate as well, and the Texas Department of Insurance appointed a task force to examine the issue.

**Quality of Care.** Quality of care in nursing homes is a major state policy concern and has been the subject of ongoing legislative attention over the past six years. According to a report by the minority staff of the Committee on Government Reform of the U.S. House of Representatives, over 50 percent of nursing homes in Texas had violations that caused actual harm to residents or placed them at risk of death or serious injury.<sup>54</sup> Staffing levels are low, with the state ranking 40th in the nation in total nursing home staffing, and 46th in the nation in staffing by registered nurses.<sup>55</sup> In 1997 and 1998, the state attorney general sued 70 nursing homes for harming residents or violation of safety rules. The state is unusual in that it rates nursing homes according to quality of care and posts the results on the Web. While acknowledging problems of quality of care (and using it as an argument for increased reimbursement), the nursing home industry and some legislators believe that the current regulatory environment is too punitive and that the survey process should be more consultative. In the industry's view, "the pendulum has swung too far and needs to find a middle ground."

Quality of care in nursing homes has been a major focus of the legislature since 1995. In that year, the legislature passed a law that opponents felt significantly weakened the state's ability to regulate nursing homes. Reacting to the political controversy over that legislation, the legislature passed several new laws in 1997 that repealed much of the 1995 law and strengthened nursing home regulation. In 2001, the legislature passed a number of bills designed to improve quality of care by promoting best practices, increasing provider training, providing technical assistance to facilities, and fielding a customer satisfaction survey of nursing home residents.<sup>56</sup> Some observers are concerned, however, that funding for these initiatives will come out of the money for regulatory oversight, thereby weakening that function.

### *Home- and Community-Based Services*

Texas finances a substantial amount of home- and community-based services, almost entirely through the Medicaid program. Texas Medicaid covers personal care, has eight home- and community-based services waivers, and is one of the very few states to participate in the "frail elderly" option. A majority of Medicaid long-term care beneficiaries receive home- and community-based services rather than institutional care.<sup>57</sup> However, home- and community-based services expenditures accounted for only about a quarter of

Medicaid long-term care expenses in 1998, despite the fact that they are growing much faster than nursing home spending.<sup>58</sup> Demand for Medicaid home- and community-based services waiver services far exceeds the number of funded places, and there is a waiting list of nearly 45,000 people.<sup>59</sup> In an interesting initiative, persons deinstitutionalized to the community are able to take their institutional funding with them. The state covers assisted living as part of its Medicaid home- and community-based services waiver for older people, but service use is low. The state is experimenting with consumer-directed home care, where clients hire, direct, and fire their workers, but use is limited primarily to younger people with disabilities.

The state is actively involved in planning new home- and community-based services and in consolidating existing programs, partly in response to the U.S. Supreme Court's *Olmstead* decision in 1999. This decision found that unnecessary institutionalization of people with disabilities was a violation of the Americans with Disabilities Act and, within limits, there was a right to home- and community-based services. Among other things, the long waiting list for home- and community-based services makes the state potentially legally vulnerable, and disability groups already filed an Americans with Disabilities Act complaint in 1998 alleging lack of home care coverage. Starting in 1999, the state has engaged in an extensive planning effort for home- and community-based services, involving all of the stakeholders. This process resulted in the Texas Promoting Independence Plan, which calls for a variety of community education and data collection efforts as well as an expansion of services.<sup>60</sup> Given the state's fiscal condition, funding will remain a major problem. On the organizational side, the state is exploring consolidating its Medicaid waiver programs, and in FY 2004 will create a new Aging and Disability Agency to combine all of the programs that serve persons with physical disabilities into one agency.<sup>61</sup>

## Other Issues

Texas state policymakers also face a number of issues that are relatively unique to Texas, including undocumented immigrants and health care, areas of the state without basic infrastructure, and health insurance for public school teachers.

### *Undocumented Immigrants and Health Care*

Because of its shared border with Mexico, Texas has a large number of both legal and undocumented immigrants. A recent estimate is that as many as 700,000 undocumented immigrants live in Texas.<sup>62</sup> Public hospitals and clinics throughout the state have traditionally provided care to undocumented immigrants on the same basis as other uninsured residents. Typically, hospitals and clinics do not ask patients if they are citizens, although they often require proof that they live in the county.

In July 2001, Attorney General John Cornyn issued a highly controversial written opinion that federal law prohibited county hospitals from using public money to provide non-emergency services. According to Cornyn, the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits the use of public funds to provide non-emergency services to undocumented residents unless state law has newly granted authorization to do so. Because Cornyn contended recent Texas laws were not sufficiently explicit in reauthorizing such spending, he concluded that provision of care was illegal. Ironically, this opinion was issued in response to an inquiry from Harris County Hospital District administrators, a major provider of this type of care. The opinion is nonbinding, and does not carry the weight of law, but it opens public hospitals to legal challenges.

Consumer advocates and public hospitals have sharply criticized the opinion, contending that recent Texas legal changes and state constitutional amendments (e.g., HB 1398, 76th Texas Legislature) are sufficient to meet the requirements of the federal statute.<sup>63</sup> Moreover, some legal authorities contend that since no federal funds are involved, the federal provision is unconstitutional, a violation of the 10th amendment, which reserves powers to the states. They also argue that failure to provide care is ethically indefensible, bad medicine, and poor economics, in that failure to provide preventive care will result in

physical deterioration that will result in needed emergency care, which is required to be covered by Medicaid.

Despite the attorney general's opinion, it would appear that public hospitals are continuing to provide services to undocumented immigrants. Although highly controversial, there is support for the attorney general's opinion. The Houston district attorney began a criminal investigation to determine whether Harris County Hospital District officials had illegally provided services, and the Young Conservatives of Texas filed suit to halt the provision of these services. In addition, a *Dallas Morning News* poll found that 54 percent of those surveyed said hospitals should not provide free preventive care to undocumented immigrants; 39 percent said they should.<sup>64</sup>

### **Colonias**

Unlike other states where services are more developed, 500,000 Texans live in areas of the state near the Mexican border known as *colonias*, which have limited or no access to basic services, such as potable water, waste water disposal, and paved roads. In these areas, housing is usually substandard and access to health care is very limited. Other states on the United States–Mexico border also have *colonias*. To better meet the needs of people living in these areas, in three areas the state has begun a pilot test of an initiative emphasizing more interagency coordination, improved service quality, and direct community participation in the design of service delivery systems.<sup>65</sup>

### **Teachers' Health Insurance**

Many teachers in Texas lack health insurance because not all public school districts offer it. Legislation approved in 1981 would have mandated local districts to provide coverage, but it was vetoed by Governor Bill Clements with the rationale that "teachers were already covered by their spouses' policies."<sup>66</sup> A decade later, the legislature passed a law specifying minimum standards for health insurance that school districts must make available to school employees (but not necessarily pay for). Studies by the Teacher Retirement System in 1999 and 2000 found that nearly half of all school districts were not in compliance with the law, and in some cases, no health insurance policies at all were in place.

Largely as a result of strong and persistent lobbying by the Texas State Teachers Association, the legislature in 2001 enacted a bill that will provide health insurance for all teachers, partly subsidized by the state. The new system is aimed primarily at smaller school districts that currently do not offer coverage. While teachers are eager to obtain the insurance, there have been complaints that the new premiums are too high, and some districts that have the option are declining to participate.<sup>67</sup>

### **Conclusion**

The large number of uninsured, an aging population, and the importance of immigrants complicate policymaking in Texas. Public programs to meet health care needs are limited, in part because tax revenues are low and there is strong resistance to funding public programs. Nonetheless, over the past few years, the state has implemented a number of initiatives to expand health services. As Texas looks to the future, it faces four challenges.

First, as with many other states, Texas's fiscal condition has deteriorated over 2001, placing strong pressures on the state budget. Despite this pressure, the state enacted simplification of the Medicaid application for children, funded SCHIP (including programs for low-income state employees and legal immigrants), established a new prescription drug program for seniors and people with disabilities, created a new state role for the provision of health insurance for public school teachers, and helped to alleviate some of the fiscal difficulties of the nursing home industry. The governor, however, did veto a much more ambitious effort to expand coverage using local funds. The continuing decline in the economy, which has deepened as a result of the terrorist attacks of September 11, threatens these initiatives and others for the future to expand coverage. If the economy does not improve, the state may face having to raise taxes or cut programs in the future.

Second, although the 2001 legislature enacted some initiatives designed to encourage Medicaid and SCHIP enrollment of children, Medicaid savings are also required. The Health and Human Services Commission has wide latitude in how to accomplish these savings. What it chooses to implement could have major impacts on the future of the program. In addition, SCHIP spending may increase faster than its budget, triggering a search for ways to control costs.

Third, Texas has placed a great deal of emphasis on managed care as a way of increasing access, improving quality, and saving money, and the state is considering expanding enrollment. Providers, who have never been happy with either commercial or Medicaid managed care, are particularly dissatisfied with the administrative complexity of the program and are resistant to expansion of managed care and to additional cost savings. Overall, HMOs have had a difficult time in the state, perhaps creating instability in the future.

Finally, the state's long-term care system, especially nursing homes, is very much in flux. Nursing homes are in financial difficulty for a variety of reasons, and quality of care is a major concern. The state has invested a lot in planning home- and community-based services, in part to comply with the *Olmstead* decision, but waiting lists remain long. The extent to which the balance of care will change to noninstitutional services is a major question.

## Endnotes

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- m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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