HOUSE RESEARCH ORGANIZATION

focus report

Texas House of Representatives

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Health Care for Uninsured Texans

The number of individuals without health insurance in Texas is relatively high compared with other states. According to recent U.S. Census Bureau statistics, Texas is tied with Arizona for the highest percentage (24.5 percent) of uninsured residents among the 50 states. In 1997, about 3.4 million adults and 1.4 million children in Texas were covered by neither private health insurance nor Medicaid. The Texas Department of Health (TDH) estimates that about 86 percent of Texas' uninsured children are members of families with one or more working parents who cannot afford health insurance or whose employers do not offer health insurance.

Texas' relatively high level of poverty is one reason why the number of uninsured is so high. In 1997, according to Census data, 16.8 percent of Texas' population was impoverished, compared to 13.3 percent for the nation as a whole. Among other reasons cited for the high number of uninsured:

- Texas has many service-oriented, low-wage, and nonunion businesses that do not offer health benefits.

- The rising cost of health benefit coverage has caused some businesses and families to drop benefits.

- The Texas Insurance Purchasing Alliance has not been able to substantially improve access to affordable health care for employees of small businesses.

- State programs enacted in 1997 to increase access to coverage for the uninsured have not reached their full expected enrollment.

- Eligibility for the Texas Medicaid program is relatively restrictive, and many children who are eligible for Medicaid are not enrolled.

Texas' situation in part reflects national trends. The percentage of uninsured is rising nationwide, even though the economy is growing and unemployment is low, according to a recent study by the Employee Benefit Research Institute (EBRI), based in Washington, D.C. EBRI attributed this trend in part to the decline in publicly funded health benefits for people who lost coverage through military downsizing and welfare changes, the rising costs of health care, the shift of workers from manufacturing to the service sector, the increased use of part-time workers, and declining unionization.

People who lack health-benefit coverage or do not have sufficient coverage or money to pay for medical care are often called *medically indigent.* Most people cannot afford to pay for the treatment of serious medical conditions without health insurance, and many people cannot buy insurance because premium rates are unaffordable and their employer does not offer group health insurance.

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Texas' approach to issues surrounding medical indigency has been based on a culture of personal self-sufficiency, traditions upholding local government responsibility and authority, and the proddings of federal incentives and mandates. These factors have created a patchwork of programs and providers, including the state/federal Medicaid program, Texas' county and local health departments, and nonprofit hospitals.

State law requires all hospitals to provide emergency services regardless of a patient's ability to pay — the only instance in which private for-profit hospitals are required to provide charity care. In 1996, Texas hospitals provided $3.6 billion in uncompensated care (charity care plus bad debt charges). Of this amount, 49 percent was provided by hospital districts and other public hospitals, 34 percent by private nonprofit hospitals, and 17 percent by for-profit hospitals. Doctors, unlike hospitals or counties, are under no legal obligation to provide charity care, nor to report to the state their provision of such services.

Texas has three programs to promote health-benefit coverage through the private market: the Texas Health Insurance Risk Pool, the Texas Healthy Kids Corporation (THKC), and the Texas Insurance Purchasing Alliance (TIPA). Although programs for the medically indigent operate independently of each other, changes in one program may affect other programs or providers. For example, improving access to health insurance for working families through TIPA could reduce the number of children seeking health benefits or services through THKC, public hospitals, and local health departments.

The 1999 Legislature may examine ways to expand, coordinate, and improve health care services for the poor and uninsured. Among the possible initiatives:

• Three interim committees have adopted recommendations to implement the new federal Children's Health Insurance Program (CHIP), which could bring the state an average of $423 million per year in new federal funding.

• The House Public Health Committee and the House County Affairs Committee have developed recommendations to improve the County Indigent Health Care Program.

• Texas can expect to receive $17.3 billion over the next 25 years from the settlement of the state's lawsuit against major tobacco companies. Many people have proposed dedicating all or most of these funds to pay for health-care activities.

This report focuses on the more comprehensive and controversial programs enacted by the state to provide health care for poor and uninsured Texans. The state also delivers health-care services to low-income individuals and families through many other programs, providers, and funding sources that target more specific populations and services.

New Federal Initiative: Children's Health Insurance Program (CHIP)

The House Appropriations Committee, the House Public Health Committee, and the Senate Interim Committee on Children's Health Insurance have recommended establishing and funding a state-designed CHIP plan. CHIP is a federal initiative, enacted in the Balanced Budget Act of 1997, under which Texas is eligible to receive an average of about $423 million per year over the next 10 years if the state establishes a health insurance program that meets federal criteria and contributes matching funds of about $151 million per year. According to estimates by the Texas Health and Human Services Commission (HHSC), at least 471,000 children in Texas are likely to qualify for CHIP in 2001 because they live in families with incomes above the current Medicaid limit but below 200 percent of the federal poverty level (FPL).

States may provide CHIP coverage to infants in families with incomes up to 235 percent of the FPL and to children aged 1 to 18 in families with incomes up to 200 percent of the FPL. To participate in CHIP, states may either expand their Medicaid programs or use a benefits package that is the same as or actuarially equivalent to either the Federal Employee Health Benefit Plan, a state employee health benefit plan (in Texas, Health Select), or the state's largest commercial health management organization (HMO) plan (in Texas, NYLCare). The state also may use a combination of approaches, such as expanding Medicaid to include certain segments of the population while using a separate plan for other low-income Texans.

States were required to submit an implementation plan to the federal government by July 1, 1998, to draw down their CHIP allotment for federal fiscal year 1998. HHSC, under direction from the legislative leadership, submitted a Phase I implementation plan that expanded Medicaid coverage to include all children aged 15 to 18 who live in families with incomes at or below 100 percent of the FPL. These children already were scheduled to be phased into the Medicaid program by 2001 under previous federal Medicaid requirements.

A draft of Texas' plan to implement Phase II, which would further expand CHIP eligibility, became available in January 1999 on the Internet at the HHSC's web site, **www.hhsc.state.tx.us**.

During the interim, the House Appropriations Committee, the House Public Health Committee, and the Senate Interim Committee on Children's Health Insurance met jointly to receive testimony and advice from consumers, insurers, and providers. Rather than expand Medicaid eligibility, which would not allow Texas to cap state expenditures at a predetermined dollar amount, legislators directed HHSC and TDH to come up with other plans that met federal CHIP requirements and that also:

- covered as many children as possible;
- analyzed costs for eligibility levels ranging from 133 percent to 200 percent of poverty;
- considered additional benefit options; and
- included cost-sharing and outreach activities.

The agencies estimated costs and participation rates for three types of CHIP plans: a Medicaid expansion; a Medicaid "look-alike" plan in which the benefits and administrative structure would be similar to Medicaid but enrollment would be capped when state appropriations were spent; and a separate state-designed health-benefit plan that would have used a distinct administrative structure. In November 1998, the agencies recommended adopting a Medicaid look-alike plan that would use existing Medicaid administrative structures. The agencies predicted that state costs for the state-designed plan could range from $69 million to $166 million in the initial biennium and from $164 million to $375 million in fiscal 2002-2003, depending on further direction by the Legislature regarding program eligibility, benefits, and outreach activities.

Major issues:

- **Should Texas be involved in CHIP?** Opponents say Texas should not yield to the enticement of federal dollars and set up another public program. They say that the number of uninsured children has been exaggerated and that Texas should not expand government bureaucracy to pay for something that families should handle on their own. They also say that federal assistance is guaranteed for only 10 years, making it hard to dismantle a program once federal funds dried up.

Yearly Income and the Federal Poverty Level (FPL) by Family Size, 1998

Percent of FPL	Family Size = 2	Family Size = 4
25%	$ 2,712	$ 4,113
100%	10,850	16,450
133%	14,431	21,879
150%	16,275	24,675
185%	20,073	30,433
200%	21,700	32,900
235%	25,498	38,658

Sources: U.S. Department of Health and Human Services for 100% of poverty; HRO extrapolation to show income at levels above and below poverty.

Supporters counter that CHIP would reduce the costs that state and local governments and school districts bear for caring for uninsured children. They say CHIP also would help prevent economic losses and other costs associated with decreased worker productivity and poor childhood development. Supporters say a CHIP plan can be designed to support parental responsibility by requiring families to pay what they can and inducing families to obtain insurance in the private market as their incomes rise. Fears that the federal government would dismantle this program are unwarranted, since it had bipartisan support. Also, Texas has three years to spend each year's CHIP allotment, so it would have three years to modify or phase out the program should the federal government reduce assistance after the tenth year.

- **State funding proposals**. The interim House and Senate committees recommended spending $151 million annually on a CHIP program. HB 1, the filed version of the budget bill for fiscal 2000-01, would appropriate $179.6 million for the biennium for CHIP from funds the state is scheduled to receive from the settlement of its lawsuit against major tobacco companies. (See page 11.) Not specified in either proposal was whether the recommended amount would cover increased enrollment of children in the Medicaid program, an expected outgrowth of efforts to enroll CHIP kids. However, the January draft of Phase II anticipates covering the costs of both CHIP and the newly enrolled Medicaid children within the recommended $151 million annual budget for CHIP.

Supporters of the Phase II draft say that state expenditures could be budgeted with greater certainty,

since CHIP is a new program with no track record of costs, and Medicaid is an entitlement program that obligates the state to serve all people who are eligible.

Opponents of the draft of Phase II say CHIP outreach could add as many as 122,000 children to the Medicaid rolls. If these new Medicaid costs are absorbed by the CHIP budget, the CHIP program will fall far short of its potential. CHIP eligibility would have to be limited to between 100 percent and 150 percent of the FPL, and Texas would not be able to pull down its full federal block grant allocation, which could be reallocated to other states. The fact that Texas could have 598,000 children eligible for Medicaid but unenrolled by 2001 points to a major problem with the Medicaid program, not with CHIP, so CHIP funding should not be so limited. Newly enrolled Medicaid children should be funded through the Medicaid budget, they say, as would have happened if the state had made better efforts in the past to enroll all Medicaid-eligible children. With anticipated budget surpluses and new tobacco settlement money, the time could not be better for Texas to fund children's health adequately in both the Medicaid and CHIP budgets.

- **CHIP eligibility**. The January draft of CHIP Phase II proposes targeting uninsured children in families with incomes between 100 percent and 150 percent of poverty, or about 303,000 children aged 18 or younger. It also proposes cost sharing, such as payments of $1 to $2 per prescription and $5 for emergency room visits, up to an annual cap of $100 per family. Supporters of the draft provisions call the proposed eligibility standards a good first step in implementing a new and potentially costly program. Families in this income range are the least likely to afford or have access to private health-benefit coverage, and the risk of previously insured families dropping their coverage for publicly financed CHIP benefits would be minimized. Cost-sharing requirements would be minimal, yet they would help defray costs to the state, especially by minimizing excessive or unwarranted use of health benefits.

  Opponents say CHIP eligibility is set too low and does not cover enough children. They point to estimates that by 2001, Texas will have about 801,000 uninsured children in families between 100 percent and 200 percent of the FPL. Texas should make a greater effort to provide health care for these children, and without the assistance of federal matching dollars through CHIP, local governments or other state and private programs will wind up paying these costs. Opponents also say that families with incomes below 150 percent of the FPL would find it hard to come up with required copayments, no matter how minimal, which would prevent many families from seeking needed medical care for their children and would reduce the cost-effectiveness that health benefits provide through access to preventive and primary care.

- **CHIP benefits**. Under federal requirements, a state-designed CHIP plan must provide general health-care services that are actuarially equivalent to Texas' Health Select or NYLCare plans. However, some say additional benefits are necessary to ensure adequate health care for growing children, such as dental benefits and special services for severely and chronically ill and disabled children, often called "special needs" children. The January draft plan for CHIP Phase II would offer a more comprehensive package of benefits than a typical commercial plan provides, including limited dental coverage, but some question whether it would sufficiently cover all the services that severely and chronically ill and disabled children might need, such as durable medical equipment, skilled nursing, and mental health services. Also, Texas must decide how families can obtain these benefits — for example, whether through the state or through private insurers. One possibility being discussed is to use the THKC both to provide benefits and to allow families to assume an increasing share of premium costs as their incomes rise.

Publicly Funded Health Care

Medicaid

Medicaid, a health-benefits program for certain low-income individuals, was created by Congress in 1965 and established in Texas in 1967. Medicaid expenditures are split between the federal government and the states according to each state's per-capita income, which is adjusted annually. In fiscal 1999, Texas pays about 37.5 percent of all program costs and 50 percent of most administrative costs. The rest is paid by the federal government. In fiscal 2000, Texas' share will increase to about 38.6 percent of total program costs. For fiscal 1998-99, Texas budgeted $6.8 billion in general revenue to pay the state's portion of the Medicaid program, out of a total program budget of $18.2 billion.

Because Medicaid is an entitlement program, the federal government does not, and states cannot, cap the number of eligible individuals who may enroll in the

program or the amount of money that can be spent on providing program-authorized health services to eligible individuals. However, states can control spending by the design of their eligibility standards and the delivery of program services.

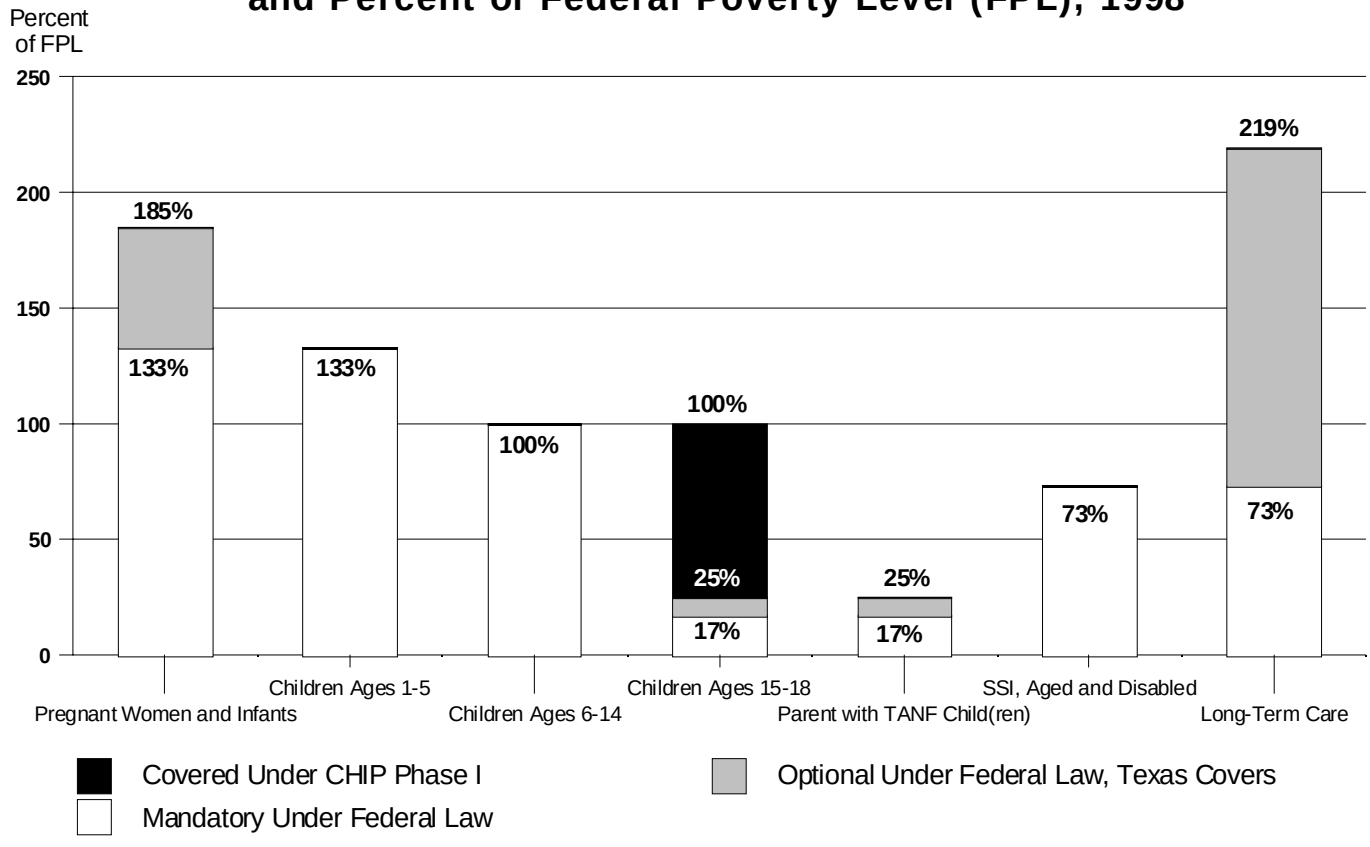
The chart below shows Medicaid eligibility in Texas by age of recipient and type of service. Texas uses the federal minimum income standards, except for pregnant women and individuals requiring long-term care. States may expand Medicaid eligibility beyond the federal minimum standards, such as by loosening maximum income and asset requirements. For example, some states, in calculating income eligibility, exclude a specified level of income, so that a family is allowed a baseline income that is not counted toward the federal poverty guidelines. Also, unlike most states, Texas takes into account family assets when determining Medicaid eligibility.

Federal law requires state Medicaid programs to provide a specified baseline of services to eligible individuals, but states also may receive matching funds for specified "optional" services. Texas provides the required baseline services and most optional services allowed under federal law. All Medicaid services must be available on a statewide basis, and most services must be available to all recipients in the same amount, duration, and scope.

About 1.7 million people—predominantly women and children—are enrolled in the Texas Medicaid program. Children represent 57 percent of Medicaid recipients but account for only 23 percent of total Medicaid expenditures. A child's eligibility depends on family income and the age of the child. For example, children below age 1 who live in families at 185 percent of poverty or less are eligible to receive Medicaid benefits, but children aged 6 to 18 must reside in poorer families whose income is equal to or less than 100 percent of poverty.

In 1998, for Phase I of the Texas CHIP plan, Texas extended Medicaid eligibility to teens aged 15 to 18 who live in households with incomes at 100 percent of the FPL or below. Enrollment for Phase I began July 1, 1998. As of November 1, about 33,000 additional teens had become Medicaid recipients. Before expansion, such

Medicaid Eligibility in Texas by Age, Type of Service, and Percent of Federal Poverty Level (FPL), 1998



teens could be eligible for Medicaid only if their family's income was below 25 percent of the FPL.

About 64 percent of Medicaid expenditures pay for mostly long-term care services for low-income aged and disabled people, who constitute 23 percent of Texas' Medicaid population. Medicaid funds also are used to pay monthly Medicare premiums for low-income elderly and disabled individuals who are also Medicare-eligible. Medicare, the federally funded health insurance program for aged and disabled people of all income levels, primarily pays for short-term "acute care" services.

In 1995, the Legislature directed that the Texas Medicaid program convert from a fee-for-service-based program to a managed care system, in which the state contracts with HMOs or individual doctors to form the state-administered Texas Health Network. Medicaid managed care programs, called STAR (State of Texas Access Reform) programs, are now established in six areas of the state and will be in place statewide by 2002. A special Medicaid pilot project in Harris County, called STAR+PLUS, provides both acute and long-term care services through managed care organizations.

Major issues:

- **High numbers of eligible but unenrolled children**. Recent state estimates show that almost 600,000 uninsured children are eligible for Medicaid coverage but are not enrolled. Reasons include the difficult application process, stigmatization associated with welfare, traditional habits of seeking health-care benefits only when sick, and the lack of effective state outreach — which some say has been based on state incentives to keep enrollment, and therefore costs, low.

- **Uneven eligibility requirements**. Income and age requirements can split family members into those who are covered by Medicaid and those who are not. For example, within the same family, Medicaid may cover a mother and a baby, but not a sick 9-year-old child. Families often cycle in and out of Medicaid coverage because of changes in income, age, and pregnancy status. Some people also argue that the procedures for reporting and verifying assets, put in place by the Legislature to prevent people who are income-poor but asset-rich from obtaining Medicaid benefits, are too bureaucratic and time-consuming and prevent eligible families from enrolling.

- **Maximizing state and local expenditures**. Some advocate expanding Texas Medicaid coverage to include children and adults now being served by public hospitals, hospital districts, and counties. This would relieve local entities from bearing the total cost of indigent care by matching their expenditures with federal Medicaid dollars. SB 10, enacted in 1995, directed state agencies to develop a coordinated approach that would match local expenditures with federal Medicaid funds and expand coverage to more uninsured individuals. However, the state has not yet designed a plan that both meets federal approval and satisfies local concerns about controlling the expenditure of local funds.

- **Managed care versus fee-for-service approach**. More evaluation is needed to determine whether the benefits of using managed care to reduce state Medicaid costs will outweigh difficulties in implementing managed care and instructing doctors and patients how to use the new system. Managed care provides recipients with a "medical home" where they may receive consistent oversight of their health. However, some fear that private managed care organizations could threaten the delivery of indigent health care by receiving Medicaid payments that formerly helped support public hospitals and other traditional charity care providers and by not providing adequate care to enrollees.

Disproportionate Share Hospital Program

This program, also called Dispro or DSH, makes special payments through Medicaid to hospitals that serve a large number of indigent patients. In fiscal 1997, about 170 Texas hospitals received $1.5 billion in DSH payments, of which $950 million was federal money. The federal government subsidizes DSH at the same matching rate as for health care services (62 percent federal, 38 percent state funds). Texas uses local public hospital and hospital district tax dollars and state-appropriated funds to state hospitals to pay for the state's Medicaid share of the Dispro program, thereby using dollars already being spent to obtain matching federal funds.

Major issue:

- **Funding losses**. Due to federal program changes in 1991 and 1993, DSH payments have been dramatically declining in Texas, eroding important financial support for health care for the uninsured. Texas is expected to lose an estimated $450 million in federal DSH payments over the next five years.

By 2001, federal funds will be capped at $765 million, almost $200 million less than what Texas received in fiscal 1997.

DSH funding losses could be offset by increasing health coverage of populations now served by public hospitals — for example, through CHIP, THKC, and county indigent care programs. Also, the recent agreement between tobacco companies and Texas counties, hospital districts, and public hospitals calls for the establishment of a permanent trust fund that will receive $1.8 billion over four years. (See page 11.) This fund could help alleviate some of the problems caused by reduced DSH funding.

County and Public Hospital Duties

The indigent health-care responsibilities of Texas counties and public hospitals are defined under the Indigent Health Care and Treatment Act (Health and Safety Code, ch. 61). The act requires counties to establish indigent health-care programs that conform to minimum standards for eligibility, covered services, and payment responsibilities. Counties are not responsible for the care of indigent residents of an area served by a public hospital or hospital district. To be reimbursed for care of indigent residents, health-care providers must notify counties according to specified procedures.

A county is eligible to receive state assistance once it has spent 10 percent of its general revenue tax levy (GRTL) on mandatory indigent health-care services for eligible individuals. Counties are not required to report expenditures to the state nor to spend more than 10 percent of their GRTL. For fiscal 1996-97, the Legislature appropriated $12 million for state assistance to counties, but the counties drew down only about $7.4 million. For fiscal 1998-99, lawmakers appropriated $11.4 million. To date, the counties have used only about $2.6 million.

The law requires public hospitals, such as county- or city-run hospitals, to provide at least the same level of inpatient and outpatient hospital services that counties are required to provide, along with any other services they provided to indigent residents before January 1, 1985. Public hospitals must establish eligibility standards that are no more restrictive than those required for county indigent programs, and they receive no state assistance in paying for indigent care. In 1997, 157 public hospitals in Texas reported providing $1.2 billion in charity care.

Hospital districts are responsible for providing medical services to their "needy inhabitants" under the Texas Constitution (art. 9, sec. 4) and may have additional, more specific responsibilities for indigent health care under the statute creating the hospital district. In 1997, Texas' 106 hospital districts reported spending $871 million on charity care. Eligibility standards and the range of services provided vary from district to district.

Major issues:

- **Eligibility criteria**. In 1985, lawmakers set county program eligibility standards to conform with state standards to receive cash assistance through the federal welfare program, now called Temporary Assistance to Needy Families (TANF). The income limit for a single adult has changed very little since 1985. Because Texas' TANF income eligibility standard has not kept pace with general cost-of-living increases, the standard now represents about 11 percent of the FPL, down from about 25 percent in 1985. Critics say eligibility for indigent care should no longer be linked to TANF eligibility standards, which have reduced the number of indigent individuals who may receive county coverage for needed health-care services and have increased the number of uninsured individuals whom health-care providers treat without compensation.

  Some say TANF-based eligibility determination procedures are too cumbersome and time-consuming. They maintain that eligibility should be streamlined by linking it to a specific percentage of the FPL and standardizing it for use by counties, hospital districts, and public hospitals across the state. This would create a consistent safety net for all poor and uninsured Texans. For example, hospital districts' standards for indigent care eligibility vary from 11 percent to 200 percent of the FPL. Opponents of standardizing eligibility say this would increase state and local expenditures unless across-the-board standards were set so low that no counties had to expand their programs.

- **Services offered or required**. Health-care services in county programs must be identified as "mandatory services" by law for a county to receive credit for state assistance in paying for indigent care. However, the current list of mandatory services does not include many services that can prevent more complicated and expensive medical problems from arising.

  Hospital district responsibilities are not as clearly specified under the Constitution as public hospital and county responsibilities are by law. As a result, some hospital districts reduce their indigent care load by

providing fewer services than do counties and public hospitals and by paying for fewer services for indigent residents, who must travel outside the district for further care.

- **Cross-government spending and accountability**. Counties, public hospitals, and hospital districts are responsible for paying for an eligible indigent's care regardless of where that care is provided. As a result, payment disputes often arise between those entities and are exacerbated by different eligibility criteria in indigent health-care programs across the state. No state entity is authorized to mediate payment disputes nor to hold counties, public hospitals, and hospital districts accountable for meeting statutory minimum requirements. Some say such authority is needed.

- **State and local spending**. As noted above, counties must spend at least 10 percent of their GRTL on indigent care to qualify for state assistance. This across-the-board threshold does not take into account a county's fiscal capacity, health-care resources, and population characteristics. Critics say this unfairly burdens counties that have large percentages of uninsured individuals. Many counties, believing that they will never cross the 10 percent threshold, do not bother to submit payment reports to the state for credit. Therefore, the state has no reliable means of measuring local indigent health-care expenditures and of assessing whether and to what degree the counties are meeting indigent health-care needs.

  Also, some counties are asking for specific authority to participate in cost-effective methods of financing indigent care, such as managed care or coverage through a private insurer, and to count such expenditures toward state assistance.

Nonprofit Hospital Charity Obligations

Nonprofit hospitals are required by the Health and Safety Code, ch. 311, and the Tax Code, ch. 11, to provide charitable care, government-sponsored health care, and other services that constitute community benefits, such as donations, education, research, and subsidized health services. Charity care offered by nonprofit hospitals must reach specified minimum levels that take into account community needs and the hospital's resources and tax benefits. Nonprofit hospitals must submit to TDH specified financial data indicating their ability to meet one of the following standards for charity care and government-sponsored indigent health care:

- community needs at a level determined by a community needs assessment;

- an amount equal to at least 100 percent of a hospital or hospital system's tax-exempt benefits, excluding income tax; or

- an amount equal to at least 4 percent of the hospital or hospital system's net patient revenue, with a requirement that combined charity care and community benefits equal at least 5 percent of net patient revenue.

Charity obligations for nonprofit hospitals were placed into statute in 1993 (SB 427 by Ellis), and reporting requirements were amended in 1995 (SB 1190 by Ellis) and 1997 (SB 788 by Ellis). In 1997, 146 nonprofit Texas hospitals reported spending $752 million on charity care.

Major issues:

- **Enforcement**. Critics say the state is not adequately overseeing and enforcing nonprofit hospitals' obligations under the law. Initial data submitted to TDH indicate that some hospitals are not meeting the standards, yet no hospitals have been sanctioned. TDH is required to forward hospitals' financial data to the attorney general and the comptroller, including a list of hospitals that did not meet their charity care obligations, but enforcement actions are unspecified. State officials say evaluation on the basis of the submitted data is difficult and requires additional information from the hospitals and an expert in hospital management to audit the submitted calculations. Others say strict enforcement is neither necessary nor desirable now because hospitals have a year to make up unmet charity care obligations. In addition, changing reporting requirements make it difficult to evaluate hospitals' charity care activities and trends.

- **State requirements**. Critics say the charitable care standard of at least 4 percent of net revenue is too low and fails to ensure that nonprofit hospitals direct toward the public all the benefits they accrue by nonprofit status. They say the percentage should at least reflect the tax breaks that nonprofits receive, such as 6.25 percent for the state sales tax or some higher percentage that also takes into account their exemption from ad valorem taxes. Some also say that the standard has "lowered the bar" for what constitutes adequate community benefit because some nonprofit hospitals are providing fewer services now than they did in the past. Hospital advocates say the

4 percent standard is sufficient because nonprofit hospitals also provide communities with hard-to-calculate or intangible benefits, such as increased employment opportunities, improved access to health care, and medical research. Assessing the actual value of tax exemptions is difficult and would require periodic appraisals and measurements.

- **Reporting and accounting practices**. According to critics, the law allows hospitals to credit toward their indigent care obligation some costs that are not directly related to indigent care (such as parking lots or doctors' offices), or to credit a whole system of hospitals with meeting an uncompensated care requirement that is actually fulfilled by only a few hospitals within that system. Hospitals say they should be able to count basic costs of doing business as part of their charity care mission. They also say that the new reporting provisions rightly allow them to include bad debts, a large portion of their uncompensated costs. Also, the state loses no benefit if only a few hospitals within a system provide much of the charity care, because other system hospitals, such as those located in relatively wealthy suburbs, may face low demand for charity care and other community benefits.

Public/Private Health-Benefit Coverage

Texas Healthy Kids Corporation

THKC is a nonprofit public/private enterprise established by HB 3 in 1997 to provide health-benefit coverage to uninsured children. The corporation is not an insurer but contracts with private companies to provide coverage at affordable rates. Enrollment began on August 15, 1998, in Nueces and Smith counties, and has since expanded to 56 additional counties. THKC plans to open enrollment to the rest of the state in February 1999.

The corporation has decided for now to offer coverage to children aged 2 through 17. Eligibility for THKC coverage is not based on family income. The child must be a Texas resident attending school and must have been uninsured for at least 90 days.

Parents of enrolled children are responsible for premium payments, copayments, coinsurance, and deductibles. Premium payments are expected to be the primary source of funding. Premium costs vary by insurer but typically range from $41 to $68 per child per month. Premium payment assistance, available through a THKC fund derived from private donations, allows families with incomes below 180 percent of the FPL to purchase health coverage for $10 to $20 per month per child. THKC also offers a loan program for families who need temporary assistance in meeting premium payments.

As of January 1, 1999, THKC had enrolled 770 children. First-year enrollment efforts focused on reaching families who would pay their premiums in full. These families, however, account for only 25 percent of the children enrolled so far. About 75 percent receive some level of premium assistance.

The state contributed about $3 million for start-up costs in fiscal 1998-99 and is expected to provide $3 million for operating costs in fiscal 2000-01. HB 1, the filed version of the budget bill, would appropriate this amount from funds the state has received from the tobacco lawsuit settlement. (See page 11.)

In addition to state appropriations and family payments, the corporation also accepts grants and gifts of money, property, and services. Under certain conditions it may use community benefit donations made by nonprofit hospitals.

Major issues:

- **Program success**. Because enrollment in THKC coverage began less than a year ago, it is too early to measure whether the corporation is achieving the goals of lowering the number of uninsured children in Texas and achieving related Medicaid savings.

  The Legislative Budget Board's fiscal note for HB 3 anticipated that by 2002, state financial support of the corporation would cease and the program would have realized a net general revenue savings of about $33 million in the Medicaid program. The LBB did not project savings from reduced charity care given by public and private hospitals and other health-care providers. Detractors maintain that the corporation is a new state bureaucracy implementing a new public benefit program that will continue to grow and sap tax dollars.

  Efforts to raise private funds to support premium assistance have proven difficult. Texas Blue Cross/ Blue Shield, however, has offered to donate $10 million over the next five to 10 years, as part of a larger agreement with the attorney general concerning

the company's proposed merger with Illinois Blue Cross/Blue Shield.

- **Should THKC be part of CHIP?** Some say THKC presents a ready-made solution to help families help themselves in obtaining health insurance for their children under CHIP. THKC health benefits, though they would have to be modified to conform to federal requirements, already are specially designed for children's care and available for purchase on a sliding scale by poorer families. Opponents of incorporating THKC into CHIP say that THKC was promoted in the last session as a potentially self-sustaining nonprofit entity and that subsidizing it with taxpayer dollars through CHIP would make it more like a government program.

Texas Health Insurance Risk Pool

The risk pool offers health coverage to Texans who lack access to health insurance because of health problems or lapses in employment or employer-sponsored coverage. The 1989 Legislature created the pool but left it unfunded. The 1997 Legislature revised and funded it (HB 710 by Averitt). The pool was revived to meet federal requirements under the federal Health Insurance Portability and Access Act, enacted by Congress in 1996 to guarantee health insurance for those who lose coverage.

Health coverage under the risk pool was made available to the public on January 1, 1998, and about 3,000 enrolled in the first year, as expected. Enrollment is expected to reach a maximum of about 12,000 to 13,000 after several years of operation. Premiums for risk pool coverage, which is offered under two managed care plans, may run 50 percent to 100 percent higher than market prices, but the plans cover medical conditions normally rejected by private companies. If plan premiums fall short of the cost of claims, private health insurance plans can be assessed to support the pool.

Plan I has a $500 deductible and a $2,500 limit on out-of-pocket expenses when using network health-care providers and a $4,500 limit when using out-of-network providers. Plan II has a $1,000 deductible and out-of-pocket limits of $4,000 when using network providers and $7,000 when using out-of-network providers. Premiums range from $67 to $808 per month, depending on the insured's age, sex, residence zip code, and whether or not the insured is a smoker. Premium rates may be reevaluated in early 1999.

Major issue:

- **Assessment formula**. As more and more people enroll in the high-risk pool, the amount of money needed to cover claims costs also will rise. Texas Department of Insurance officials say the statutory methodology used to calculate assessments on private health-benefit plans may have to change to meet growing need. The risk pool could be shut down if claims costs are not met. Under federal law, private health-benefit plans then would be required to issue insurance to all who apply and meet other federal requirements — an unpalatable alternative for many insurers.

Health Coverage for Small Businesses

The Texas Insurance Purchasing Alliance (TIPA) is a nonprofit corporation established by the 1993 Legislature to help businesses with two to 50 employees obtain health-care coverage (Texas Insurance Code, art. 26.11 *et seq*.). TIPA operates under a six-member board appointed by the governor and approved by the Senate. The Legislature provided $250,000 in fiscal 1994-95 for start-up costs, and TIPA has been funded by member dues since then. In Texas, as in the rest of the U.S., most uninsured people are employed, either full-time or part-time, and about half are likely to work for small businesses. In 1993, small businesses told the Legislature that they would like to offer insurance for their workers, but the plans are often cost-prohibitive due to administrative overhead and the small size of the risk group.

The law allows employers to form a cooperative to purchase coverage from a private insurer or to purchase directly through the TIPA umbrella cooperative. Amendments in 1995 (HB 369 by Averitt) required insurers selling to small businesses to provide a basic benefits plan and a catastrophic plan. Insurers are required to issue and renew plans for any small employer who satisfies premium payments.

Initially, TIPA offered multiple plans and carriers, allowing small-business employees to choose among these on the basis of premium affordability and doctor choice, as employees of larger businesses are able to do. The lack of participating carriers, however, has curtailed such freedom of choice. Only Blue Cross/Blue Shield serves TIPA employers statewide, and only in San Antonio is there an alternate carrier, Wellchoice HMO.

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Financial Windfall: Tobacco Settlement Funds

In March 1996, then-Attorney General Dan Morales filed a lawsuit on behalf of the state of Texas against major American tobacco companies. The lawsuit sought to recover billions of tax dollars the state had spent to treat Medicaid patients who suffered from tobacco-related illnesses. The suit alleged that the industry had violated both state and federal laws, including conspiracy, racketeering, wire fraud, mail fraud, consumer protection, and antitrust laws.

In July 1998, Texas finalized a settlement of the lawsuit that ultimately awarded the state a total of $17.3 billion over the next 25 years. Nearly $2.3 billion of this will be directed to certain counties and hospital districts. As of January 8, 1999, payments totaling $1.1 billion had been deposited to the state General Revenue Fund, and the state is expected to receive another $689 million during fiscal 2000-01. On average, the state can expect to receive about $1 billion per biennium until the full amount has been paid.

HB 1, the filed version of the fiscal 2000-01 budget bill, groups the tobacco settlement funds in Article 12. The distribution of funds resembles the spending plan outlined in a February 1998 memorandum of understanding among Sen. Bill Ratliff, Rep. Rob Junell, and Morales, although the budget bill would award funds to a larger number of programs. The bill proposes spending $1.768 billion in settlement funds, the full amount the state is scheduled to receive through fiscal 2000-01, as follows:

- $179.6 million to fund the Children's Health Insurance Program (CHIP);

- $200 million for a pilot project to fund smoking cessation and anti-tobacco education programs and enforcement for juvenile-related anti-smoking laws;

- $150 million to create a Permanent Fund for Children and Public Health, an endowed source of funding for children's health programs and public health services;

- $400 million to create a Permanent Health Fund for Higher Education, an endowment for medical research and other programs;

- $555 million for the University of Texas M.D. Anderson Cancer Center and various public medical schools;

- $100 million for an EMS/Trauma System Endowment and $35 million for hospitals and facilities for the Texas Department of Health; and

- $148.5 million for programs supporting rural hospitals, long-term health care for children, public employee health-benefit plans, and other initiatives, including $3 million for operating costs of the Texas Healthy Kids Corporation.

About $2.275 billion of the settlement will be deposited in a permanent trust account from which Texas counties and hospital districts will be reimbursed for costs associated with indigent health care. Hospital districts and counties had intervened in the settlement, claiming that it would have barred them from obtaining separate damages for all the tobacco-related indigent health care they have provided.

On January 4, 1999, the tobacco industry paid the state $300 million, which was distributed on a per-capita basis to counties and hospital districts. These entities will receive supplemental distributions of $100 million in January 2000 and $50 million in January 2001 while the corpus of the trust fund is growing. Future disbursements will be based on each entity's unreimbursed expenditures for indigent health care.

Spending the settlement funds will depend on direction by the Legislature, which may choose to change the budget proposals and ignore agreements made during the settlement negotiations. Many health-care providers and consumers will advocate dedicating settlement funds to financing health-care programs and education, since the lawsuit was based on the state's health-care costs caused by smoking. Other public benefit programs may request settlement funds to help compensate them for costs stemming from tobacco-related diseases. Legislators also may feel pressure to use settlement funds to finance other state programs, since these funds are not subject to the constitutional cap on spending nondedicated general revenue.

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TIPA now provides coverage to about 775 employers, down from 1,100 in January 1998, and to 8,200 individuals. The alliance estimates that 50 percent of the TIPA-enrolled employers did not previously offer coverage to their employees, whereas small carriers outside of TIPA capture only about 17 percent to 20 percent of the uninsured market. TIPA estimates that almost half of the 416,000 small businesses in Texas still do not offer health benefits to their employees. In response, TIPA is redesigning its benefit plans and taking other measures to stay competitive.

Major issue:

- **TIPA's ability to compete**. Small-employer health benefit carriers have been raising premium rates significantly over the past few years. In addition to these market pressures, TIPA's ability to compete is in question because it has become associated with higher-risk enrollees. Carriers are dropping out because they are not getting enough business and fear high-risk enrollees. Employer participation is dropping because some say TIPA no longer offers a choice of carriers. Agents are referring high-risk groups to TIPA, which is required by law to issue insurance to all who apply and agree to pay for premiums, while sending lower-risk small-employer business to carriers who do not participate in TIPA. Proponents say that unless TIPA can pool the risk of all small businesses, many insurers will continue to "cherry-pick" the low-risk groups for themselves. Insurers say they have no control over how independent agents refer clients and that any additional regulations would make small-business health coverage more expensive, thereby reducing its availability in the marketplace.

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