



Special Report

THE UNINSURED: A Hidden Burden on Texas Employers and Communities

April 2005

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Fellow Texans:

In 2004, Senator Elliot Shapleigh asked my office to develop information on the percentage of Texans without health insurance in the state's metropolitan areas. This report has been prepared in response to his request.

According to the U. S. Census Bureau, Texas has the highest share of uninsured persons of any state. Based on the most recent data available, about one in four Texans lacked health insurance at some point. The U.S. average for the same period was more than one in six Americans.

I was aware of that unfortunate pattern. Until this study was completed, however, I didn't know that every major metropolitan area in Texas exceeded the U.S. average.

The Laredo and El Paso metropolitan statistical areas had the state's highest shares of uninsured residents, at 36 percent and 33 percent, respectively—about one in three. Brownsville-Harlingen-San Benito had 32 percent uninsured; Corpus Christi, 28 percent; and McAllen-Edinburgh-Mission, 28 percent.

Among the largest metropolitan areas, Houston led with almost 28 percent of its residents lacking health insurance. In Dallas, the uninsured rate was 25 percent; in San Antonio, 24 percent; and in Fort Worth-Arlington, 24 percent. Austin had the lowest share among the largest cities, at 18 percent, but that still exceeded the national average.

The sheer number of uninsured Texans ultimately makes health care less affordable for Texas employers and individuals alike. Much of the costs involved in providing health care to the uninsured ultimately are shifted to those who have health insurance—and to Texas taxpayers.

I have previously suggested ways in which the federal and state governments could help more Texans afford health insurance. Some of these have been enacted, such as a program that allows small businesses to form cooperatives to purchase affordable employee health insurance. Yet more remains to be achieved by federal, state and local governments, working in cooperation with the private sector and community groups. I have outlined several ways to proceed.

I firmly believe that the first place to start is to fully restore the cuts made in 2003 to the Children's Health Insurance Program (CHIP). Nearly 179,000 Texas children have lost health insurance coverage since September 2003. That represents over 35 percent of the previous CHIP caseload. Similarly, the ending of the Medicaid Medically Needy program in Texas will cost the state's hospitals an estimated \$517.7 million in state and federal funds in fiscal 2006 and 2007. This program paid hospitals to care for individuals with excessive medical bills and should be restored to prevent further growth in the numbers of uninsured Texans.

Tackling the health insurance problem will require innovative ideas and actions. As always, my office stands ready to help in this effort.

Sincerely,

Carole Keeton Strayhorn
Texas Comptroller

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CAROLE KEETON STRAYHORN • Texas Comptroller of Public Accounts

THE UNINSURED: A Hidden Burden on Texas Employers and Communities

Texans living in urban areas are less likely than the average U.S. citizen to have health insurance. According to the U.S. Census Bureau, almost one in six Americans is uninsured; in Texas, the ratio is one in four. While there is substantial variation among Texas cities, every major city has an uninsured rate higher than the national average.

The U.S. Census March 2004 survey reports that an average of about 5.4 million Texans, or 24.6 percent of the state's population, were uninsured.¹ Based on a Comptroller analysis of Census data, Laredo, Brownsville and El Paso had the highest rates of uninsured—one in three residents of these cities lacked health insurance. Houston's uninsured rate was almost 28 percent.² Austin has the lowest ratio of uninsured for this period, at 18 percent.

Census data are used in this report because they constitute the most common measure of the uninsured and the only source that provides data based on actual local observations. These data are discussed in the appendix. The data on Texas MSAs is an average of the three most recent census surveys.

The sheer number of uninsured Texans makes healthcare less affordable for Texas employers and individuals. Much of the cost of providing health care for the uninsured ultimately is transferred to those who have health insurance through higher health insur-

ance premium costs—and to Texas taxpayers who pay for uncompensated care in public hospitals and other programs.

Uninsured in Texas and the U.S.

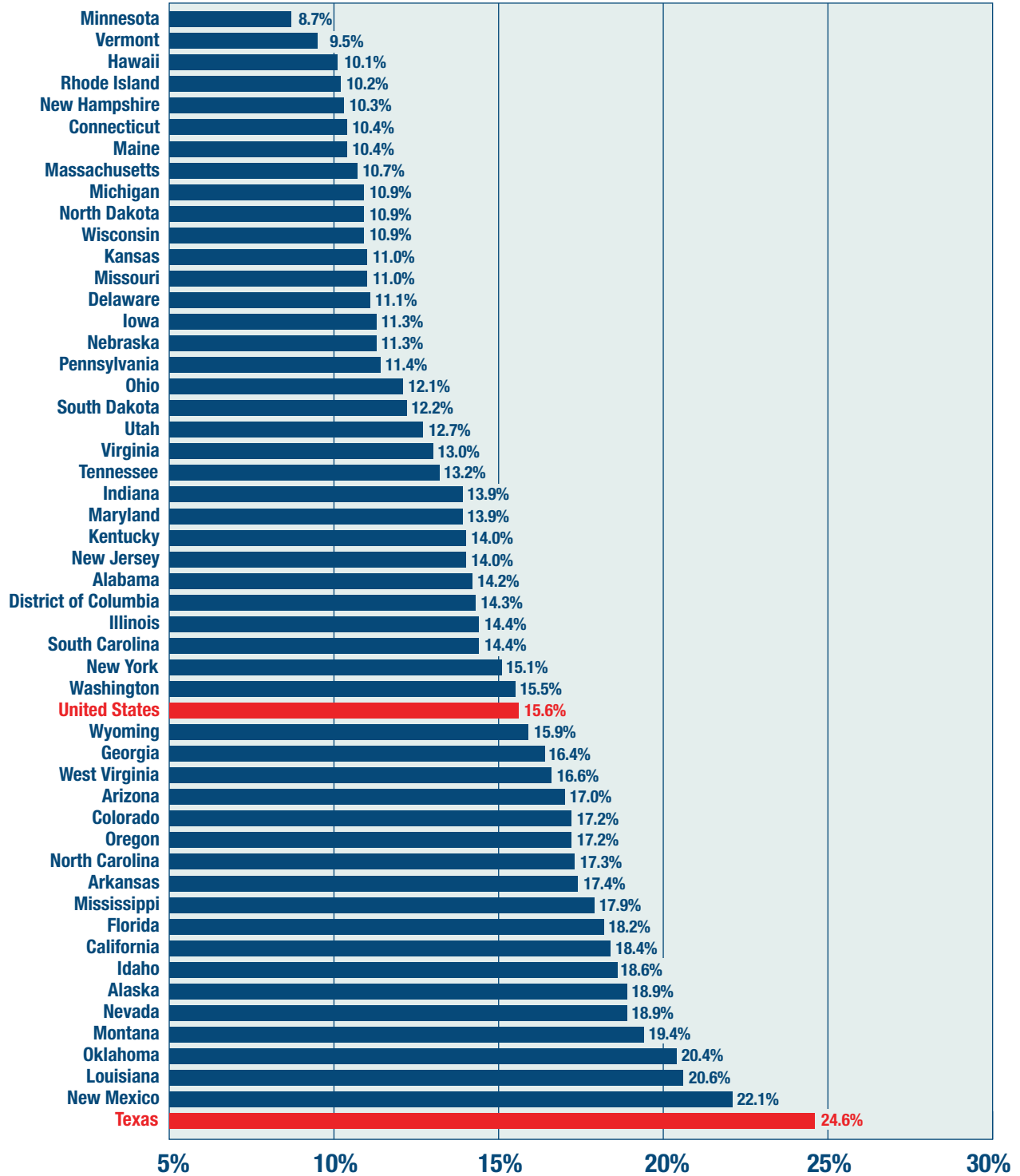
Data from the March 2004 survey shows that an estimated 15.6 percent of the U.S. population, or 44.9 million people, lacked health insurance at some point. In Texas during the same period, about 5.4 million people went without health insurance coverage making Texas the state with the largest share of uninsured in the U.S.³ Only California had more uninsured residents (6.5 million). California, however, ranked ninth in its share of uninsured (18.4 percent), trailing Texas (24.6 percent), New Mexico (22.1 percent), Louisiana (20.6 percent) and six other states. At the opposite end, Minnesota (8.7 percent) and Vermont (9.5 percent) had the nation's lowest uninsured rates (**EXHIBIT 1**).

Historical Trends

Since 1988, the U.S. uninsured rate has hovered around 16 percent, while Texas' has fluctuated between 20 and 25 percent. The uninsured rate in both the U.S. and Texas rose in the middle 1990s and dipped at the end of the decade, only to rise again over the last three years (**EXHIBIT 2**).

The U.S. Census March 2004 survey reports that an average of about 5.4 million Texans, or 24.6 percent of the state's population, were uninsured.

EXHIBIT 1
Percent Uninsured in Each State in 2003



Source: U.S. Census Bureau Annual Demographic Survey, March 2004.

Texas' share of uninsured children also is higher than the U.S. average. Between 2001 and 2003, 21 percent of Texas children were uninsured, compared to 11 percent nationally (EXHIBIT 2).

health care services provided to low-income, elderly and disabled persons. CHIP insures the children of working families who cannot afford private health insurance but earn too much to qualify for Medicaid.

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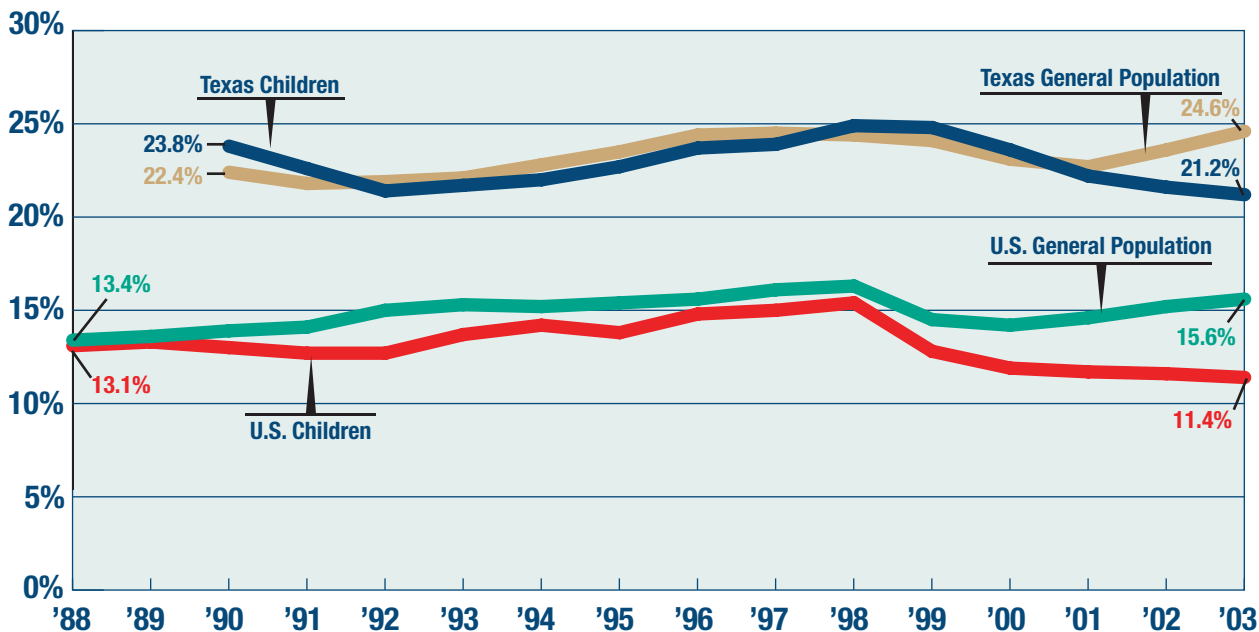
Who Are the Uninsured?

There is no such thing as a "typical" uninsured person. The uninsured are a diverse group that includes people who cannot afford private health insurance; who work in small businesses that do not offer insurance; who simply choose not to purchase health insurance, even though they can afford it; who are eligible—but not enrolled—in government-sponsored programs such as Medicaid or the Children's Health Insurance Plan (CHIP); and recent immigrants. Medicaid pays for

Moderate to Low-Income Texans

People making moderate and low-income wages are much less likely to have job-based health insurance coverage than those earning more.⁴ In Texas, an average of 59 percent of the uninsured population had incomes below 200 percent of the federal poverty line from 2001 to 2003, and 80 percent had incomes below 300 percent.⁵ In 2004, 200 percent of poverty was \$18,620 for one person and \$31,340 for a family of three; 300 percent was \$27,930 for one person and \$47,010 for a family of three.⁶

EXHIBIT 2
Percent Uninsured in Texas and U.S. 1988 to 2003
General Population and Children



Note: Because Texas data are a subset of the U.S. estimate, Texas figures are computed as a three year moving average. This evens out yearly variations which may not be representative, and reveals underlying trends.

Sources: U.S. Bureau of the Census, Texas Health and Human Services Commission and Texas State Comptroller's office.

Texans Who Do Not Receive Insurance Through Their Jobs

Most people with health insurance coverage receive it through their jobs. Employment-based health insurance covered almost 60.4 percent of the nation's population in 2003. Employment-based insurance usually is more affordable for employees than privately purchased insurance because employers obtain lower group rates from insurers and contribute toward their employees' coverage, for which they receive a federal government tax break.

Texas workers are less likely to have employment-based health insurance coverage than those in other states. In 2003, Texas ranked 48th in the nation, with only 52.4 percent of Texans having employment-based health insurance coverage.⁷

The Texas Department of Insurance (TDI) has identified trends that partly explain Texas' lower rate of employment-sponsored insurance. They note that Texans are more likely to work in retail trade and service industries that are less likely to offer health insurance through the workplace. Relatively fewer Texans work in the manufacturing sector, where employers are more likely to provide health benefits. In addition, TDI has found that most insurers and employers in the state have provisions that exclude part-time, contract and seasonal workers from health coverage.⁸

Texans Who Work in Small Businesses

Small businesses find it increasingly difficult to provide affordable health care insurance for their employees. Small businesses face higher health insurance premiums than larger businesses because they cannot self-insure, cannot create a large enough pool of employees to reduce the risk and have higher administrative costs. This is particularly true for businesses with fewer than 10 employees.

The U.S. average insurance premium for each employee in a business with fewer than 10 employees was almost \$3,565 in 2002, the last year for which data was available, but

only \$3,133 for companies with 50 or more employees, a difference of \$432 per year per employee. In Texas, the average insurance premium for each employee in a business with fewer than 10 employees was almost \$3,877 in 2002, but only \$3,195 for companies with 50 or more employees, a difference of \$682 per year per employee.⁹

In 2002, 63 percent of U.S. low-wage workers in private businesses with fewer than 10 employees did not receive health insurance coverage through their employer; in Texas, 73 percent did not.¹⁰

It can be costly for small businesses to provide health insurance, but when they do their employee participation rates are high. In 2002, 80.8 percent of all U.S. employees working for businesses with fewer than 10 employees were enrolled in a health insurance plan offered at work. The share in Texas was even higher, at 83 percent.¹¹

Texans Who Can Afford It, But Don't Want It

Texans with incomes above 300 percent of poverty usually are considered able to afford insurance.¹² In Texas, more than 20 percent of the uninsured had incomes above 300 percent of poverty from 2001 to 2003.¹³ A national study by Blue Cross and Blue Shield reported that more than 30 percent of the uninsured had income levels exceeding \$50,000, and that the fastest-growing population of uninsured people earned \$75,000 or more.¹⁴

Some higher-income workers forego health coverage because of high premiums. Others forego it simply because they are young and healthy and think they do not need it.

Texans Eligible for but not Enrolled in Government Programs

Many low-income Americans are eligible for existing government programs, such as Medicaid and CHIP, but may not know that they are eligible or may have chosen not to enroll. In the U.S., one-third of the uninsured are eligible for government-sponsored programs,

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but have not enrolled in them.¹⁵ Children in families with incomes below 200 percent of the federal poverty level are the most likely to enroll in public programs.¹⁶

Texas Children Cut From CHIP

In September 2003, the Texas Health and Human Services Commission (HHSC) implemented a number of budget cuts to the CHIP program. These cuts, the first reductions since the program was adopted in 1999, affected the program's benefits, eligibility and operation. The cuts eliminated income deductions that families could use to qualify for CHIP; imposed higher co-payments and monthly premiums; instituted a 90-day waiting period before children could be covered; and did away with mental health, dental and vision coverage. (Mental health coverage was later partially restored.)

In addition, for the 2004-2005 biennium, eligible families were required to reapply for CHIP every six months. An assets test was imposed for families with incomes of more than 150 percent of the federal poverty level. Families with more than \$5,000 in "countable" assets such as bank and savings accounts no longer qualify for CHIP.¹⁷

As of March 2005, nearly 179,000 children have been dropped from CHIP—a 35.3 percent drop since September 2003, when the cuts were implemented.¹⁸ HHSC reviewed children who had lost CHIP coverage for at least two months between January 2004 and March 2004. In their report issued December 2004, HHSC noted that only 47 percent obtained other insurance. About 66 percent of those who obtained other insurance enrolled in Medicaid. To qualify for Medicaid, their families would have had to have lower incomes, depleted assets or higher medical expenses for their children than when they were enrolled in CHIP.

A smaller number of families that lost CHIP coverage obtained employer-sponsored health insurance. In 2002, 38 percent of families leaving CHIP who enrolled in other insurance were enrolled in employer-sponsored health insurance; in 2004, the share was just 23 percent.¹⁹

Texans With Catastrophic Medical Bills

The Medicaid Medically Needy Program for adults was eliminated in 2003. This program had provided Medicaid coverage for adults who earned too much money to qualify for Medicaid, but faced catastrophic medical bills.²⁰ For example, an eligible participant could have been a young adult with severe trauma from an automobile accident or a disease requiring extensive hospitalization. Hospitals are required to treat trauma care patients under the provisions of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. Medical care cannot be delayed if the person cannot pay or has no insurance coverage.

Before the elimination of the program, Medicaid paid doctors and hospitals part of the cost of care for the medically needy; the state received federal funds at a federal matching rate of just over 60 percent. After the program was cut, hospitals lost not only Medicaid payments, but also Medicare payments for uncompensated care that were tied to this program. Restoring the program would pay local governments and hospitals \$517.7 million over two years.²¹ It would also generate additional uncompensated care payments from other programs to take care of medically needy adults.

As of March 2005, nearly 179,000 children have been dropped from CHIP—a 35.3 percent drop since September 2003, when the cuts were implemented.

Immigrants

A University of California at Los Angeles study found that 12 metropolitan statistical areas (MSAs) with higher-than-average uninsured rates are located in states with large concentrations of immigrants—Texas, California, Arizona, Florida, New Jersey and New York.²² The study also noted that in these MSAs, Hispanics account for a large percentage of the moderate and low-income residents who are less likely to be able to afford health insurance coverage.²³

In Texas, non-citizens are almost three times as likely to be uninsured as native U.S. citizens.²⁴ Immigrants, many of whom are Hispanics, often work in economic sectors less likely to offer health insurance than others, such as construction; may be younger and

less likely to feel the need for insurance; or may lack a family tradition of having insurance.

A study commissioned by border counties in Texas, California, Arizona, and New Mexico found that about 25 percent of the uncompensated costs incurred by Southwestern border-county hospitals in 2000 resulted from medical treatment provided to undocumented immigrants without health insurance. The study attributes higher reported levels of uncompensated hospital care in border versus non-border counties to undocumented immigrants seeking emergency medical care.²⁵ The study also reports that in 2000, emergency health care to undocumented immigrants cost border-area hospitals \$79 million in California; \$74 million in Texas; \$31 million in Arizona; and \$6 million in New Mexico.²⁶

The U.S. Congressional Budget Office (CBO) has noted that, in periods when health insurance premiums rise rapidly, employment-based coverage drops, such as from 1987 to 1993 and from 2000 to the present.

Factors Contributing to Health Care Costs

Perhaps the biggest factor keeping rates of uninsured high is the fact that health care costs consistently rise more quickly than

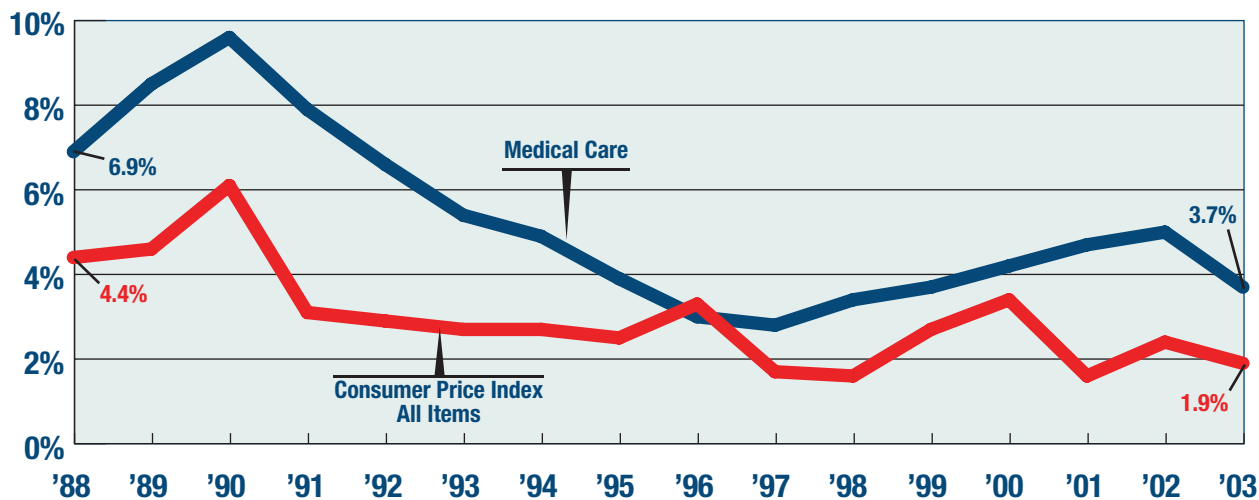
those of other goods and services. In 15 of the 16 years from 1988 to 2003, the medical care component of the consumer price index (the primary measure of inflation) rose at a higher rate than the index as a whole, an average of 5.3 percent for medical care versus 3 percent for the CPI (**EXHIBIT 3**).

Over the long term, rising health care costs contribute to higher insurance premiums and make fewer individuals and companies able to afford insurance. The U.S. Congressional Budget Office (CBO) has noted that, in periods when health insurance premiums rise rapidly, employment-based coverage drops, such as from 1987 to 1993 and from 2000 to the present. This indicates that rising premiums contributed to the decline in employer-based insurance coverage, which in turn led to higher uninsured rates. Conversely, when the growth in premiums slows, employment-based coverage stabilizes or improves.²⁷

Health Care Industry Inefficiency

Several reasons are usually given for the continuing rapid rise in health care costs. These include excessive use of tests and other procedures due to legal liability con-

EXHIBIT 3
Annual Change in the Consumer Price Index for All Items and for Medical Care 1988 to 2003



Source: U.S. Bureau of Labor Statistics.

cerns; a lack of consumer awareness due to insulation from health care costs paid for by others; and the general inefficiency of the health care sector, which has not been automated or geared for information-sharing to the same extent as other industries.

The Midwest Business Group on Health estimates that 30 percent of U.S. healthcare expenditures are misspent on inefficient or ineffective care, costing the typical employer between \$1,900 and \$2,250 per covered employee each year.²⁸ The study provides examples of overuse of procedures, tests, medications and treatments and underuse of proven treatments, medical errors and unnecessary administrative activities. The group recommends that public and private health care purchasers identify high-priority problems, measure performance, share performance information and reward or penalize providers based on the quality of care they provide.

Sharing electronic health care information among providers (hospitals and medical practices) and independent laboratories, radiology centers, pharmacies, payers, public health departments and other providers could save health care purchasers billions of dollars by eliminating redundancies and saving administrative time. One study estimated that the U.S. health care system could save \$77.8 billion a year with a fully operational health care information exchange. Examples of such savings include the computer-assisted reduction of redundant tests and reduced delays and costs associated with paper-based ordering and reporting of results.²⁹

State Regulation Increases Costs

Texas has a large number of health care mandates that can add considerably to the cost of health insurance. These mandates include required coverage for specific providers or settings; required coverage for specific diseases, medical conditions and services or specific groups; and various types of optional coverage for an additional premium.

Several studies have identified more than 60 Texas health insurance benefit mandates in state law.³⁰ These mandates increase the cost

of health insurance, particularly for small businesses and individuals who cannot self-insure and who must purchase policies subject to state regulation.

The 2003 Legislature's S.B. 451 allows insurers and health maintenance organizations to issue health insurance plans, called Texas Health Consumer Plans, that do not provide all the state-mandated health care benefits, to reduce their cost. The statute requires TDI to monitor the effect of the statute. Comments made during a review of TDI rules show that there is concern over the statute's ability to achieve savings, its effect on the uninsured and whether the legislation and its accompanying rules are clear and simple enough for health carriers to follow.³¹

More than a dozen states have evaluated the impact of health insurance mandates before they are enacted.³² Maryland, for example, hires a firm that specializes in actuarial estimates to study the financial, social and medical costs of a series of state mandates prior to legislative deliberations.³³

No Federal Tax Incentive for Individuals

Employer-based health care payments are not taxed. Employees who receive employer-paid health insurance also receive federal tax breaks, because employment-based health insurance payments are fully deductible from federal individual income taxes. These employees, in effect, can buy considerably more insurance with the same dollar than persons who must buy private insurance with taxable dollars.

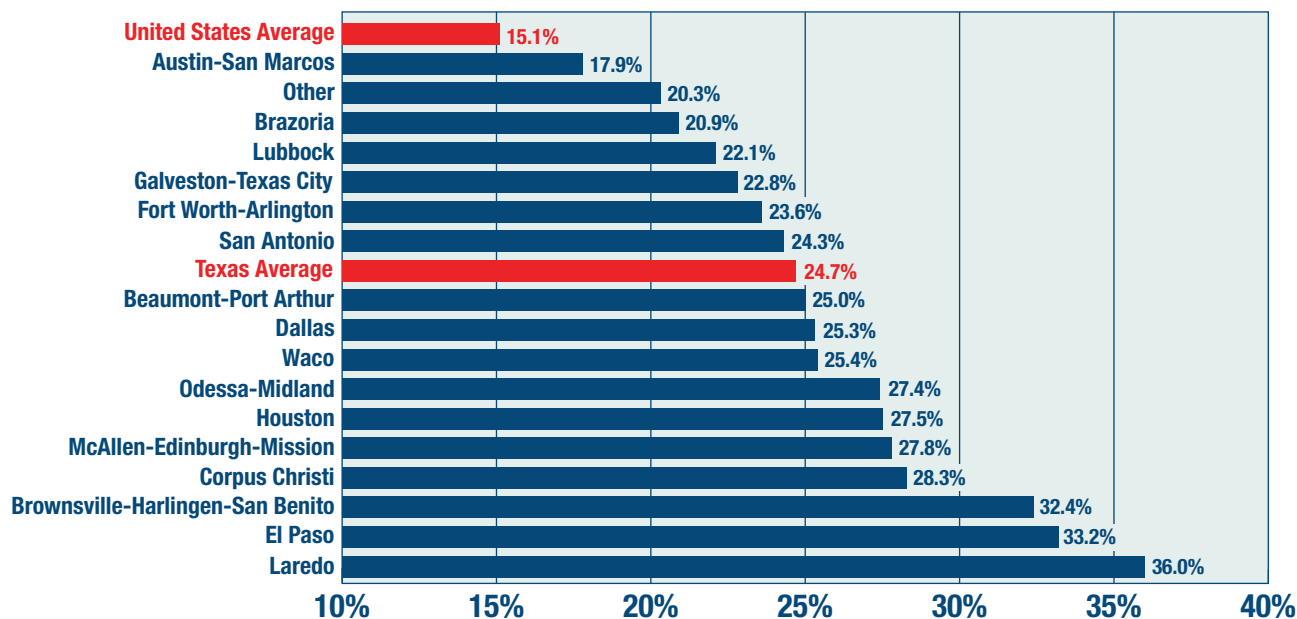
By contrast, individuals who purchase private health insurance receive no such tax breaks. A dollar in pretax wages may buy only 50 cents' worth of health insurance after federal, state and local taxes are taken out.³⁴

Variations in the Uninsured Rate

From 2001 to 2003, uninsured rates in Texas metropolitan areas ranged from a high of 36 percent in Laredo to a low of 17.9 percent in

From 2001 to 2003, uninsured rates in Texas metropolitan areas ranged from a high of 36 percent in Laredo to a low of 17.9 percent in the Austin area. All Texas MSAs, however, exceeded the U.S. three-year average of 15.1 percent.

EXHIBIT 4
Percent Uninsured in Texas and the United States
Three Year Average 2001 to 2003



Sources: U.S. Census Bureau, Texas State Comptroller's office.

the Austin area. All Texas MSAs, however, exceeded the U.S. three-year average of 15.1 percent (EXHIBIT 4).³⁵

Texas' largest MSAs had even more uninsured Texans than the Border area, because they have much larger populations. Almost 50 percent of Texas' uninsured—more than 2.6 million Texans—lived in Houston, Dallas, and Fort Worth-Arlington. Texas' border MSAs (El Paso, McAllen-Edinburg-Mission, Brownsville-Harlingen-San Benito and Laredo) had about 11 percent of all uninsured Texans, or more than 600,000 (TABLE 1).

Houston led Texas' largest metro areas in its share of uninsured residents, with a rate of 27.5 percent. Dallas was next with 25.3 percent, followed by San Antonio with 24.3 percent and Fort Worth-Arlington with 23.6 percent uninsured.

Three Texas MSAs along the Mexican border—Laredo, El Paso and Brownsville-Har-

lingen-San Benito—had the highest rates of uninsured, at 36, 33.2 and 32.4 percent respectively. The Corpus Christi and McAllen-Edinburg-Mission MSAs were not far behind, with uninsured rates of 28.3 and 27.8 percent respectively.

As noted earlier, the Austin-San Marcos MSA had the lowest uninsured rate in Texas, with only 17.9 percent of its population uninsured. Areas classified as "Other," including the smaller MSAs and rural areas of the state, had a combined uninsured rate of 20.3 percent. Brazoria MSA, which is adjacent to the Houston MSA, had an uninsured rate of 20.9 percent, only slightly higher than the "Other" category.

Poverty Effects

Texas MSAs with low average incomes and the highest rates of population in poverty also had the highest rates of uninsured. The

Three Texas MSAs along the Mexican border—Laredo, El Paso and Brownsville-Harlingen-San Benito—had the highest rates of uninsured, at 36, 33.2 and 32.4 percent respectively.

TABLE 1
Texas Demographic and Economic Factors by Texas MSA
Ranked by Percent Uninsured

MSA	Population (January 1, 2003)*	Percent Uninsured 3-year average**	Average Annual Wage 2003***	Unemployment Rate 2003****	Below 200 Percent of Poverty 3-year average*****
Laredo	212,405	36.0%	\$22,586	7.3%	63%
El Paso	705,459	33.2%	\$25,017	9.7%	59%
Brownsville-Harlingen- San Benito	363,029	32.4%	\$21,076	11.0%	47%
Corpus Christi	383,289	28.3%	\$30,025	6.7%	47%
McAllen-Edinburg-Mission	627,939	27.8%	\$21,573	13.6%	54%
Houston	4,467,286	27.5%	\$44,238	6.8%	35%
Odessa-Midland	241,898	27.4%	\$30,374	5.8%	48%
Waco	219,065	25.4%	\$29,026	5.1%	40%
Dallas	3,792,149	25.3%	\$45,050	7.1%	34%
Beaumont-Port Arthur	386,848	25.0%	\$33,466	9.5%	33%
San Antonio	1,674,806	24.3%	\$31,553	5.5%	37%
Fort Worth-Arlington	1,829,144	23.6%	\$38,061	6.4%	31%
Galveston-Texas City	264,847	22.8%	\$32,021	8.2%	32%
Lubbock	248,636	22.1%	\$26,674	3.6%	39%
Brazoria	259,801	20.9%	\$37,925	8.9%	27%
Other	N/A	20.3%	N/A	N/A	47%
Austin-San Marcos	1,345,551	17.9%	\$41,915	5.7%	24%
Texas	22,016,911	24.7%	\$37,411	6.7%	38%

Sources:

* Texas State Data Center Population Estimates January 2003

** Census Bureau March 2002, 2003 and 2004 Survey

*** Texas Workforce Commission ES-202 data set

**** U.S. Department of Labor, Bureau of Labor Statistics

***** Census Bureau March 2002, 2003 and 2004 Survey

five border MSAs had the highest percent of uninsured—and also the lowest wages in the state. Houston was an exception because, even though it ranked sixth in its percent of uninsured, the MSA has the state’s second-highest wages (TABLE 1).

In 2003, the Border MSAs had the highest shares of their populations with incomes below 200 percent of poverty. In Laredo, for example, 63 percent of the population was

living below the 200 percent threshold. Austin, by contrast, had the lowest uninsured rate; only 24 percent of the Austin population had incomes below 200 percent of poverty.

The “Other” category had the next-to-lowest rate of uninsured, but had a much higher rate of poverty, 47 percent. This is probably due to the fact that the “Other” category includes smaller cities and rural areas, that tend to have large elderly populations with relatively

low incomes but receive health insurance coverage through Medicare.

Houston's Experience

A 2004 study sponsored by Houston's business, government and community leaders documents the impact of a million uninsured residents in the Houston MSA. The report of the Houston Public Health Task Force found a fragmented and duplicative public health delivery system; inadequate access to outpatient care for low-income and uninsured residents; and an unacceptably high and growing number of uninsured residents who obtain their health care in emergency rooms.

The task force recommended the integration of five public agencies (the Harris County Hospital District, Harris County Mental Health Mental Retardation Authority, Harris County Psychiatric Center, Harris County Public Health and Environmental Services Department, and the City of Houston Health

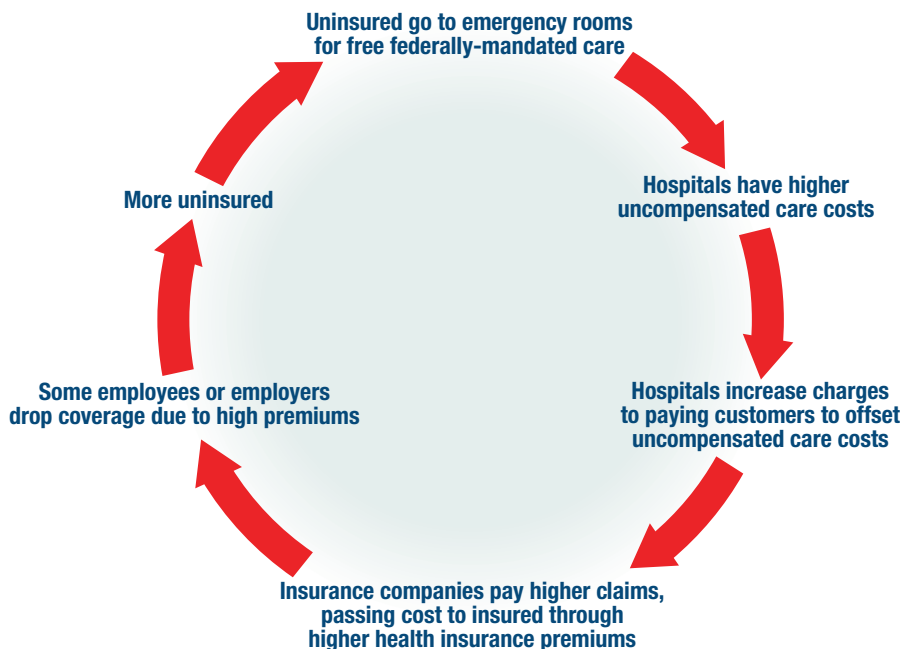
Department) into a comprehensive public health system and information network; added capacity at outpatient sites to provide an alternative to emergency room use; and a variety of programs to increase the number of insured.³⁶

The group's chair noted that Houston businesses are concerned about public health and access to care for a variety of reasons. The high health insurance premiums employers pay effectively subsidize the care received by the uninsured. And again, small businesses often cannot afford to offer health insurance because of the high cost of premiums. The number of uninsured grows because private insurance is not available or affordable.³⁷

Federal law requires emergency rooms to provide some level of care to all who need it, whether or not they have a true emergency, or the ability to pay for their care. All too often, the uninsured use the emergency room as their primary health care provider, at roughly three times the cost of compa-

Houston area hospitals lose an average of more than \$2,500 for every admitted trauma patient. Losses on some patients exceed \$200,000.

EXHIBIT 5 Links Between Business and the Uninsured



Source: Texas State Comptroller's office.

nable clinic care. A Houston study stated that about half the time, the uninsured use the emergency room for non-emergency conditions.³⁸

Hospitals must make up the loss of uncompensated care or go out of business; to cover these costs, they charge insured patients higher prices.³⁹ This prompts insurance companies to raise business health insurance premiums. Businesses, in turn, may transfer part of the higher cost to employees through higher co-pays, deductibles and premium payments. Public hospitals also may transfer the cost of uncompensated care to the taxpayer through higher property taxes levied to support hospital districts (**EXHIBIT 5**).

Hospitals facing losses due to the uninsured use of emergency rooms may choose not to become designated trauma facilities even if they have the capabilities, simply because they have no financial incentive to do so.⁴⁰ Houston area hospitals lose an average of more than \$2,500 for every admitted trauma patient. Losses on some patients exceed \$200,000.⁴¹

Some Houston emergency rooms, including those in its trauma centers, are “on diversion” more than 30 percent of the time; in other words, they are temporarily at capacity and will accept no additional patients, regardless of their medical condition or ability to pay.⁴² A survey of hospital emergency departments in Harris and surrounding counties found that emergency rooms were forced to divert ambulances 77 percent more often in 2001 than in the previous year. Furthermore, 59 percent of emergency departments reported that seriously injured patients were at risk due to delays in transfers to higher level-of-care hospitals.⁴³

Such diversions and transfers can have deadly consequences. A 2002 Harris County report documented the death of several individuals due to emergency room diversions.⁴⁴ The head of Save Our Emergency Rooms, a business and community coalition, has noted that in 2001, at least eight patients in the Harris County region died when they were turned away from a major trauma facility and sent instead to trauma centers that could

not provide full services.⁴⁵ As the head of the Houston Public Health Task Force said, “when a hospital is on diversion, it doesn’t matter if you own the hospital, because you are not getting in.”⁴⁶

For most businesses, health insurance premiums increased by 15 percent to 20 percent in 2004.⁴⁷ And, as employers cut back or eliminate health insurance coverage for their employees due to rising costs, the pool of uninsured increases. The problem is particularly worrisome in Houston, where more than a third of the community consists of small businesses that face ever higher health insurance premiums.⁴⁸

Possible Solutions

There is no single solution to the problem of the uninsured. Soaring health care costs and the rising costs of health insurance premiums are not simple problems to fix. Many Texas communities, however, have begun working on these problems in different ways. Some potential solutions follow.

Texas state government should make it easier for small businesses to obtain more affordable insurance by enforcing current law that allows small businesses to form cooperatives to purchase health insurance.

In response to a 2003 Comptroller recommendation, the Legislature passed H.B. 897, which allows small employers who band together in coalitions to purchase insurance to be treated as single employers under state law.⁴⁹ Permitting businesses with from two to 50 employees to join with other small businesses places employees in a large enough insurance pool to bring down the cost of the policies to a level more employers can afford.

Texas businesses have formed several of these coalitions, and the Texas Department of Insurance (TDI) recently issued a bulletin clarifying the uniform underwriting practices regarding small employer groups.⁵⁰ In a presentation to the House Insurance Committee on February 14, 2005, the TDI commissioner

...the Legislature passed H.B. 897, which allows small employers who band together in coalitions to purchase insurance to be treated as single employers under state law.

stated that the legislation has proven popular in Central Texas.

The TDI bulletin, however, noted that some carriers have threatened to terminate contracts with insurance agents who bring small employer health coalitions to them for coverage, and the TDI commissioner noted that this behavior is unacceptable.⁵¹ TDI should enforce the law by taking appropriate action to guarantee that small businesses are able to continue forming these coalitions.

Texas state government should reduce the impact of mandates and regulation on health insurance cost.

In 2000, the Comptroller's office recommended that the Legislature amend state law to require an analysis of the impact of proposed health insurance mandates before they become a part of legislation, and to give all such mandates a six-year sunset date for review. This would ensure that the mandates still make sense in light of current medical practice.⁵² The proposal, however, did not become law.

The Texas Legislature also should determine whether additional changes are needed for Texas Health Consumer Plans. These plans allow the exclusion of some mandates.

Texas state government should restore the Children's Health Insurance Program and increase the number of insured Texas children.

The Comptroller has recommended that the 2003 cuts to CHIP be fully restored. For four special sessions dating back to July 2003, the Comptroller has identified dollars available ranging from \$702.6 million during the first special session to \$1.2 billion identified before the fourth special session. For four consecutive special sessions, the Comptroller has advocated fully restoring the program. This would allow the state to capture federal funds now left on the table to help pay for children's insurance. For about \$98 a month (including prescription drug coverage) per child in fiscal 2005—or about \$1,175 a year—Texas can insure a child from a working family that isn't eligible for Med-

icaid but can't afford insurance. In comparison, one hospital stay for a child without health insurance costs an average of \$6,700. These children do not disappear. They turn up in local emergency rooms shifting the cost to local property taxpayers. The Health and Human Services Commission (HHSC) estimates it would cost about \$184 million in general revenue, based on current estimates, to restore CHIP coverage. The state dollars would draw down many more federal dollars. The match rate is 72 cents on the dollar from federal funds for every 28 cents of state funds in Fiscal 2006.

Texas state government should restore cuts to the Medicaid program that help pay for the uninsured.

Restoring the 2003 cuts in the Medicaid Medically Needy Program would help local hospitals and taxpayers and draw down federal dollars to support uncompensated care. HHSC added an exceptional item to its fiscal 2006-2007 legislative appropriations request that would partially restore the program at a cost of \$35 million in general revenue for the biennium.

Full restoration of the Medicaid Medically Needy Program would result in an additional \$517.7 million over fiscal 2006-2007 that would be potentially available to hospitals to offset the cost of caring for uninsured patients. About \$314.1 million of that total would come from federal funds and the remaining \$203.6 million from state general revenue.⁵³

The federal government should create financial incentives for individuals to purchase health insurance by providing federal tax credits.

The Comptroller's office has recommended that the federal government provide tax credits for individuals who buy their own insurance.⁵⁴ The federal tax code gives generous tax breaks to employees and employers who obtain employer-sponsored health insurance. A corresponding tax break should be given to individuals who buy their own private insurance. Such a tax credit would allow more persons to afford insurance. The

Full restoration of the Medicaid Medically Needy Program would result in an additional \$517.7 million over fiscal 2006-2007 that would be potentially available to hospitals to offset the cost of caring for uninsured patients.

federal government has not yet taken action on this matter.

Texas state and local governments should coordinate efforts to apply for federally funded programs to provide cost-efficient services to the uninsured.

In 2000, the Comptroller's office recommended that the federal government expand its program of federally funded clinics. These clinics are a lower-cost alternative to emergency rooms that can provide routine medical services for the uninsured.⁵⁵

The federal government did increase funding for the clinics, but Texas lags far behind other states in establishing them. As of 2003, Texas had 35 federally funded community health centers operating about 195 individual clinic sites. California, by contrast, had 83 centers with 599 clinic sites. Even Massachusetts, a relatively small state, has 33 centers operating 278 clinic sites. Other states with more clinic sites than Texas included New York (374 sites), Illinois (213), and Washington (207 sites).⁵⁶

Texas' local health departments should coordinate applications from local governments or private entities for these clinics. The Texas Department of State Health Services should help identify locations for them and provide potential applicants with information on organization and implementation.

Texas state government and the federal government should pursue a Medicaid waiver to make health insurance more affordable for some Texas communities.

Medicaid waivers are exceptions to the usual requirements of Medicaid granted to states by the federal government, generally for the purpose of testing innovative programs. A Medicaid waiver program could increase the number of people covered through Medicaid by authorizing the use of local tax dollars to draw down additional federal dollars at no cost to the state. The program also could waive state Medicaid requirements and allow communities to tailor programs to local needs.

The Greater Houston Partnership, a private, nonprofit organization with about 2,000 member businesses, has reported that such a program could use \$110 million in local tax dollars already being spent on health services in the Houston area to draw down \$160 million in additional federal funding. This could provide insurance to as many as 110,000 more people in Houston/Harris County, or about 10 percent of the current uninsured population there.⁵⁷ Along with Houston, San Antonio and El Paso Hospital Districts have expressed an interest in this waiver.

Texas communities should make the delivery of health care more cost-effective through coordination and the sharing of information among providers.

Texas businesses and communities are working to further automate medical records and develop safe electronic record transfer methods. Such efforts could reduce administrative costs and eliminate duplicative or unnecessary services and tests.

Central Texas has two such pilot projects under way, the Indigent Care Collaboration (ICC) program and the South Austin pilot program. The ICC program, which ultimately may involve the medical records of more than 100,000 uninsured residents in Austin and surrounding communities, could produce benefits including improved care, fewer duplicate medical tests, easier registration processes and a greater use of clinics as opposed to emergency room visits for non-emergency care. The South Austin project is an effort to share electronic medical records among about 200 local physicians and the St. David's South Austin Hospital with plans for expansion in the Austin area. Its intent is to reduce costs by eliminating duplicative tests and reducing administrative costs.

The federal government should increase the federal match for Medicaid to states bordering on Mexico.

These border states serve a disproportionately large number of illegal immigrants who are uninsured.

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Conclusion

Texas must make health insurance more affordable and health care for the uninsured more cost-effective. This will require the cooperation of Texas businesses, communities and local, state and federal officials.

Business, state and local governments, insurers, health care providers and even consumers must work together to find innovative ways to meet the health care needs of Texans.

Appendix:

Measuring the Uninsured

The Comptroller's office used data from the U.S. Census Bureau's Annual Demographic Survey (conducted each March) to generate estimates of the uninsured in Texas and 16 of its metropolitan statistical areas (MSAs). The 2004 survey included about 10,000 persons in Texas. On the advice of the Census Bureau, the Comptroller's office used a three-year average to give a more representative estimate of the percentage of the uninsured population in Texas and its MSAs.⁵⁸

The Annual Demographic Survey asks respondents what major types of health insurance coverage they had in the previous calendar year. If the respondent answers "no" to each of these questions, they are asked to

verify that they were not covered by any type of health insurance in the previous year.

The survey defines the uninsured as those who report not being covered by any private or government health insurance program including Medicaid, CHIP, Tricare (military insurance) or Medicare during the preceding year. Consequently, the March 2004 survey covers a person's health insurance status in 2003. The Census Bureau also notes that "compared with other national surveys, the survey's estimate of the number of people without health insurance more closely approximates the number of people who are uninsured at a specific point in time during the year than the number of people uninsured for the entire year."⁵⁹

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