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# Access to Health Care in Texas: A Patient-Centered Perspective

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# Access to Health Care in Texas: A Patient-Centered Perspective

**Abstract**

Access to health coverage in Texas is, and continues to be, an urgent policy issue. This article provides an overview and evaluation of the primary state- or local-based and private financial means through which Texans gain access to health care, and offers suggestions to the Texas Legislature to help improve coverage access.

**Keywords**

Health services accessibility--Texas, Medical care--Texas

**Disciplines**

Health Law and Policy

# ACCESS TO HEALTH CARE IN TEXAS: A PATIENT-CENTERED PERSPECTIVE\*

by Laura D. Hermer\*\* and William J. Winslade\*\*\*

I.	INTRODUCTION	33
II.	PATIENT-CENTERED CARE	36
III.	ACCESSING COMPREHENSIVE HEALTH CARE SERVICES IN TEXAS	40
	A. <i>Private Health Insurance</i>	41
	B. <i>Medicaid and SCHIP</i>	53
	1. <i>Medicaid</i>	53
	2. <i>SCHIP</i>	67
	C. <i>Indigent Health Care</i>	71
	D. <i>Other Pieces of the Safety Net</i>	85
	1. <i>Not-for-Profit Hospitals</i>	85
	2. <i>Individual Health Care Providers</i>	87
	3. <i>State and University Hospitals</i>	87
	4. <i>Federally Qualified Health Centers</i>	88
	5. <i>Rural Health Clinics</i>	88
	6. <i>Free Clinics</i>	89
	7. <i>Texas Department of Health and Local Health             Departments</i>	89
	8. <i>School-Based Health Clinics</i>	90
	9. <i>Emergency Medical Treatment and Active Labor Act</i>	90
IV.	CONCLUSION	93

## I. INTRODUCTION

This article describes and evaluates access to health care for Texas residents. Access to health care is a particularly important issue in Texas because 4.8 million out of 18.8 million non-elderly Texans have no health insurance and little or no access to health care.<sup>1</sup> With 25.7% of Texans under

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1. See Catherine Hoffman et al., *Health Insurance Coverage in America*, 2001 DATA UPDATE 33 (2003), available at <http://www.kff.org> (last visited Apr. 17, 2003).

the age of sixty-five without health insurance, Texas has a higher rate of non-elderly uninsured persons than any other state and has a 158% higher rate than the national average of 16.3%.<sup>2</sup> These statistics make it obvious that access to health care in Texas is an urgent public policy issue.

This article aims first to provide an overview of the primary ways in which Texans do gain access to health care—through private insurance and public programs at the state and local level. Such access to health care is evaluated by emphasizing the value of patient-centered care.<sup>3</sup> This means health care that makes serving the practical health care needs of patients (1) the focal point of the health care system, (2) the paramount responsibility of health professionals, and (3) the primary role of private and public financing health care.<sup>4</sup> It is care that meets the reasonable needs of patients when and where they have them.<sup>5</sup> It is care that is age and context appropriate.<sup>6</sup> It emphasizes reasonable continuity of care that is user-friendly and that is within the economic means of each patient.<sup>7</sup>

After a detailed survey of the access to health care that Texans have now, this article suggests nine options to help improve future access to health care in Texas.<sup>8</sup> These suggestions promote patient-centered health care in both the private and the public sectors.<sup>9</sup> This report is also designed to contribute to informed dialogue about a problem everyone—as current or prospective patients—must confront at various times.

This article discusses each of the major means, controlled and financed at the state, local, or private level, by which Texans access health care.<sup>10</sup> It first examines private health insurance, its history, and current issues it poses with respect to access.<sup>11</sup> The article then provides an overview of Medicaid and Texas's Children's Health Insurance Program (CHIP), addressing issues affecting the access to health care that impact eligible individuals and program recipients.<sup>12</sup> It then reviews indigent health care programs administered at the local level, examining the means of improving access for the low-income individuals served by them.<sup>13</sup> Finally, it provides an overview of the remaining nonfederal means by which certain Texans can access health care.<sup>14</sup>

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2. *See id.*

3. *See discussion infra* Part II.

4. *See discussion infra* Part II.

5. *See discussion infra* Part II.

6. *See discussion infra* Part II.

7. *See discussion infra* Part II.

8. *See discussion infra* Part IV.

9. *See discussion infra* Part II.

10. *See discussion infra* Part III.

11. *See discussion infra* Part III.A.

12. *See discussion infra* Part III.B.

13. *See discussion infra* Part III.C.

14. *See discussion infra* Part III.D.

After undertaking these evaluations, this article argues that the Texas Legislature has a number of options before it that should help make access to health care more patient-centered. First and foremost, patients need timely, appropriate, and good-quality health care from their providers.<sup>15</sup> The provision of such care is by no means merely a matter of ensuring the quality of health care providers' skill and performance.<sup>16</sup> Rather, a number of other access issues come into play.<sup>17</sup> First, health care consumers in the private market need the means to access health care when faced with a medical problem.<sup>18</sup> Given the current trend toward medical spending accounts, defined contribution plans, and stripped-down health insurance plans, the legislature should consider protecting patients from disastrously lean benefits plans.<sup>19</sup> The legislature can continue the strides it has made with Medicaid simplification by extending the process to adult Medicaid recipients and by de-linking the Medicaid application process from cash programs, such as Temporary Assistance to Needy Families.<sup>20</sup> Medicaid cost savings are likely better achieved by stepping up the prevention and prosecution of fraud and abuse by providers, rather than by cutting provider reimbursements.<sup>21</sup> The legislature may wish to increase outreach to individuals who may be eligible for Medicaid or Texas's CHIP.<sup>22</sup> It may also want to consider either requiring only the provision of primary and preventative care from local indigent health care programs and broadening eligibility for them or, instead, seeking a federal waiver to bring the care for eligible individuals under the auspices of Medicaid.<sup>23</sup> Finally, state and local governments and providers may consider collaborating to provide access to primary and preventative health care services for low-income individuals and families outside of normal working hours.<sup>24</sup> These steps, while modest in themselves, will help make access to health care in Texas more patient-centered.

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15. See, e.g., COMM. ON QUALITY OF HEALTH CARE IN AM., INSTIT. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY I (2001).

16. *Id.*

17. *Id.*

18. *Id.*

19. See discussion *infra* Part II.A.

20. See discussion *infra* Part III.B.1. But because of the current budget crisis, gains made regarding Medicaid simplification in the 77th regular session were rolled back in the 78th. See, e.g., Tex. H.B. 728, 78th Leg., R. S. (2003) (putting off 12 month continuous eligibility for children enrolled in Medicaid until September 2005).

21. See discussion *infra* Part III.B.1.

22. See discussion *infra* Part III.B.

23. See discussion *infra* Part III.B-C.

24. See discussion *infra* Part III.B-C.

## II. PATIENT-CENTERED CARE

In an ideal world, if a patient had a health issue or concern, he would go to an appropriate health care provider with whom he had a pre-existing and long-term relationship for care. He would obtain an appointment with relative promptness, and the provider would see him on time. The patient's health care provider would already have knowledge of the lifestyle and history of the patient from her prior experience with him, as well as knowledge of his baseline physiological and psychological functioning. She would use this knowledge to contextualize the new symptoms or concerns. She would also take the time to discuss what the new problem might be and how best to approach it, both in terms of a short-term solution or cure and, where relevant, a long-term approach to preventing the problem in the future or appropriately managing its effects. If the provider recommended further action, both she and the patient would include issues of cost and relative effectiveness in their considerations.

The health care provider would put the patient's needs—both medical and personal—first in this encounter. Not only would she spend as much or as little time as necessary interacting with the patient and discussing issues and concerns with him, but she would also avoid spending extra time and money chasing down unlikely causes of ailments because of malpractice fears or a desire to maximize revenues from the patient. The patient, for his part, would maintain a close and long-term treatment relationship with the physician. He would forthrightly communicate his symptoms, questions, disagreements, and concerns and openly discuss them. He would also, when in agreement with his health care provider's recommendations, do his best to heed his provider's advice about general and long-term health. Third party payors such as the federal and state government and private insurers would keep their interference in the physician and patient relationship to a minimum and would pay legitimate claims in a timely fashion. Legislation directly affecting the provider and patient relationship would be largely unnecessary, save those laws relating to licensure and screening out unscrupulous providers.

Obviously, that ideal world does not exist, and it is not possible to bring such a world into being and still provide health care to most of the population. Nevertheless, a scant few decades ago, people frequently had a more robust relationship with their principal health care providers than they generally do today.<sup>25</sup> This is not to claim that the physician and patient relationship was not then without problems (responses to some of which helped lead to the health care system we have today).<sup>26</sup> Nevertheless, in the fee-for-service era,

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25. See, e.g., PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 445 (1984).

26. See *infra* note 32 and accompanying text.

patient needs could assume greater primacy in terms of time and attention, because physicians could often receive greater revenues per patient than they do today.<sup>27</sup> Third party payors, both private and public, less assertively inserted themselves into the relationship, and less payor intrusion further allowed patient needs rather than cost constraints to retain a more central role.<sup>28</sup> Medical malpractice judgments, while never insignificant, were both less common and less costly than they often are today.<sup>29</sup> Additionally, it was far more common for individuals to work for only one company or business throughout their entire career.<sup>30</sup> When more people worked for the same company over their lifetime, it was arguably in the company's interest to be concerned about the employee's health over long periods and to offer health benefits that took account of the individual's needs over his or her life.<sup>31</sup>

This picture has changed rather dramatically since the heyday of fee-for-service medicine. While fee-for-service medicine may have been associated with a stronger provider and patient relationship, it was also associated with tremendous and unsupportable escalations in the price of health care.<sup>32</sup> Managed care systems, which were intended in part to prevent such excesses, now insure over 90% of those with private health insurance<sup>33</sup> and a sizeable fraction of those with public health insurance such as Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP).<sup>34</sup> Such systems, while not theoretically inimical to a patient-centered approach to health care, have shifted the focus away from caring for both individual patients and patient populations to preserving their bottom lines by cutting costs and

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27. See, e.g., Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400 (1996). They often did this by performing a large number of services per patient, for each of which they could bill and thus increase their revenues. *Id.*

28. See discussion *infra* Part III.A. It was not until the managed care era that prospective or concurrent review of treatment decisions took off. See discussion *infra* Part III.A. Such review is employed by some, but not all, types of managed care organizations. See discussion *infra* Part III.A.

29. See, e.g., Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 342 (2000); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1373 (1989). There was a significant increase in both the rate of medical malpractice cases and the verdict amounts through the 1970s and 1980s. See, e.g., Kinney, *supra*; Johnson, *supra*.

30. See, e.g., James H. Smalhout, *The Problem With "Sticky" Pensions*, L.A. TIMES, Oct. 31, 1999, at M2.

31. See, e.g., STARR, *supra* note 25, at 200-01.

32. See John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions the Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 16 (1997) (citing HEALTH INS. ASS'N OF AM. (HIAA), SOURCE BOOK OF HEALTH INSURANCE DATA 97 (1995) (based on data from the U.S. Department of Health and Human Services, HealthCare Financing Administration, U.S. Department of Commerce)).

33. See, e.g., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 69 (Sept. 2002).

34. See, e.g., KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND MANAGED CARE 1 (Dec. 2001), available at <http://www.kff.org> (noting that over half of all Medicaid recipients participate in some form of managed care).

service during a time when the price of health care is again starting to increase rapidly.<sup>35</sup>

Physicians themselves are also no longer as patient-centered as many of them once were in the care they deliver.<sup>36</sup> Their profit margins have been so squeezed by managed care organizations that, in the interest of generating revenue, they must often spend less time with each patient to see as many people as possible each day.<sup>37</sup> Frequently, they must word patient referrals and diagnoses with care in order to ensure appropriate insurance coverage, and neglect to do so at both their and their patient's peril.<sup>38</sup> In an effort by managed care organizations to shift risks to physicians and otherwise hold down costs, physicians may be on a capitated system or be subject to utilization review, precertification of claims, and temporary payment withholdings contingent on financial performance.<sup>39</sup> Malpractice concerns can require ordering certain tests and procedures even when they are likely useless or irrelevant in the particular circumstance at hand.<sup>40</sup> And even if both the physician and patient remain in the same location, their relationship may be severed, not because of choice, but because the physician leaves or is removed from an insurance company's provider group.<sup>41</sup>

Patients themselves have capitulated to health care that is no longer primarily centered on the most efficient and effective delivery of competent and appropriate health care to them.<sup>42</sup> They often treat illness more as an episodic affair rather than as part of their continuing health over the course of their lives.<sup>43</sup> In so doing, patients contribute to and reinforce the health care system's frequent focus on illness as a discrete event with a finite genesis and cure, rather than on viewing both the illness and approaches to diagnosing and

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35. See, e.g., *id.*; Drew E. Altman & Larry Levitt, *The Sad History of Health Care Cost Containment As Told in One Chart*, HEALTH AFFAIRS (2002), available at [http://www.healthaffairs.org/WebExclusives/Altman\\_Web\\_Excl\\_012302.htm](http://www.healthaffairs.org/WebExclusives/Altman_Web_Excl_012302.htm) (last visited July 22, 2003).

36. See Devin Friedman, *Dr. Levine's Dilemma*, N.Y. TIMES, May 5, 2002, § 6 (Magazine), at 64.

37. See, e.g., S. Trude, *So Much to Do, So Little Time: Physician Capacity Constraints, 1997-2001*, 8 TRACK REP. 1-4 (2003).

38. See *id.* Interestingly, a 2001 study found that in a large, multispecialty, capitated group practice, eliminating the need for referrals by primary care physicians had only minimal impact on patient usage of specialists. See Timothy G. Ferris et al., *Leaving Gatekeeping Behind—Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization*, 345 NEW ENG. J. MED. 1312, 1312-17 (2001).

39. See, e.g., Donald M. Berwick, *Part 5: Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1227-30 (1996).

40. See, e.g., K. DeVille, *Act First and Look Up the Law Afterward?: Medical Malpractice and the Ethics of Defensive Medicine*, 19 THEORETICAL MED. BIOETHICS 569-89 (1998).

41. See, e.g., Sorbero ME et al., *The Effect of Capitation on Switching Primary Care Physicians*, 38 HEALTH SERV. RES. 191-209 (2003).

42. See Kinney, *supra* note 29, at 341-44.

43. See, e.g., COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 15, at 27. This is despite the fact that health care has been shifting from care for episodic conditions to chronic conditions. See, e.g., *id.*



treating it within the context of the patient's lifetime health.<sup>44</sup> Patients may also seek a medical fix for problems that could have been avoided by different lifestyle choices.<sup>45</sup> The focus on medical cure once a problem has arisen, to the exclusion of prevention, ultimately contributes to the worsening of our health, not merely as individuals but also as a population.<sup>46</sup> Patients, furthermore, accept a system that runs largely at its own convenience, rather than at theirs.<sup>47</sup> Because of waiting times, patients must often take significant time off of work in order to obtain treatment.<sup>48</sup> Many others must forego care altogether because they cannot take the necessary time off, for fear of jeopardizing their jobs.<sup>49</sup>

These are merely some of many examples of how the health care system is drifting further and further from a patient-centered focus. As another example of this trend, improving access to health care is usually conceptualized as a financial matter. Numerous books and articles have been written about how to change this or that aspect of the health care system in order to improve financial access.<sup>50</sup> Indeed, finances are crucial to any discussion of access to care. But *conceptualizing* access to care from a financial perspective ensures that finances take primacy over what should instead be the focus of the discussion. Talking about health care from a financial perspective begins to sound as if the primary goal of the health care system is to perpetuate itself. But this is not what the health care system ought to be about. Rather, it should be about the elementary notion of providing appropriate and competently performed health care services to all people, both efficiently and effectively.<sup>51</sup> Thus, the discussion must be reoriented. While financial considerations are obviously important and must have a role in any

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44. See, e.g., *id.*

45. See, e.g., Dr. Claude Lenfant, *Physicians Need Practical Tools to Treat the Complex Problems of Overweight and Obesity*, 63 AM. FAM. PHYSICIAN 2139 (2001).

46. Cf. *Health Insurance Certificate Act: Hearings on H.R. 2698 Before the Subcomm. on Health of the Comm. on House Energy and Commerce*, 108th Cong., 1st Sess. (July 17, 2003) (Statement of Miss Dede Spitznagel, Executive Vice President, Healthcare Leadership Council) (discussing the effect of episodic care and the failure to seek preventative care by the uninsured on communities and the health care system).

47. See David Blumenthal, *Effects of Market Reforms on Doctors & Their Patients*, HEALTH AFFAIRS (1996), available at <http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/library/v15n2/s13.pdf> (last visited Aug. 30, 2003).

48. See *id.*

49. See *id.*

50. See, e.g., SHARON SILOW-CARROLL ET AL., *EXPANDING HEALTH INSURANCE COVERAGE: CREATIVE STATE SOLUTIONS FOR CHALLENGING TIMES* (2003), available at [http://www.cmf.org/programs/insurance/silow-carroll\\_creativestate\\_596.pdf](http://www.cmf.org/programs/insurance/silow-carroll_creativestate_596.pdf) (last visited July 22, 2003); JON R. GABEL ET AL., *ARE TAX CREDITS ALONE THE SOLUTION TO AFFORDABLE HEALTH INSURANCE? COMPARING INDIVIDUAL AND GROUP INSURANCE COSTS IN 17 U.S. MARKETS* (2002), available at [http://www.cmf.org/programs/insurance/gabel\\_taxcredits\\_527.pdf](http://www.cmf.org/programs/insurance/gabel_taxcredits_527.pdf) (last visited July 22, 2003).

51. See, e.g., COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 15, at 3.

consideration of access to health care, the focus must be changed from a financial-centered perspective to a patient-centered one.

A patient-centered discussion asks questions such as the following: What is it that patients need from their health care system? How should patients and their health care system be expected to interact? What responsibilities do patients have with respect to financial access matters? What responsibilities do they have with respect to their own health? How should they interact with their health care providers? What should patients be able to expect from health care financiers and health care providers? By moving to a patient-centered approach to health care access, patients are placed where they ought to be—in an active role, doing their part to help ensure both their own health and the health of the health care system. By moving to a patient-centered approach, both health care providers and financiers must be more responsive to and respectful of the needs of patients.

This is not, of course, to abandon financial considerations. Without consideration of financial issues and constraints, an analysis of how to make the health care system more patient-centered would have little to do with reality. In Texas, a large patchwork of means by which people financially access health care exists.<sup>52</sup> While most of these means, as will be discussed, have not been around for very long in the grand scheme of things, the primary means of accessing care—the private insurance system—is both strongly ingrained in society's collective belief system and strongly entrenched as a political interest, both in Texas and throughout the country.<sup>53</sup> In this regard, there presently exists little desire, political or otherwise, to overhaul the current system in a way that would eliminate the major private forms of access now in existence. This article therefore has no intention of making such a proposal. Rather, it will instead look at what can be done to make the health care system more patient-centered, using the structure that presently exists.

### III. ACCESSING COMPREHENSIVE HEALTH CARE SERVICES IN TEXAS

The health care system that we have in Texas—as in the rest of the United States—is a patchwork of different means of financial access. In 2001 63% of Texans were covered by private health insurance.<sup>54</sup> This is less than the national average of 70.9%.<sup>55</sup> The vast majority—88.7%—of Texans covered by private health insurance obtained their coverage through their

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52. See discussion *infra* Part III.

53. See discussion *infra* Part III.A.

54. See U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State: All People: 1987 to 2001 (2002), available at <http://www.census.gov/hhes/hlthins/historic/hihist4.html> (last visited Oct. 28, 2002).

55. See *id.*

employer or through the employer of a family member.<sup>56</sup> The remainder purchased coverage on their own through the individual market.<sup>57</sup> Medicare, a federal program for the elderly and disabled, covered 10.7% of Texans—presumably the vast majority of the elderly population and a sizeable proportion of the significantly disabled population.<sup>58</sup> Medicaid, a joint federal and state program for certain low income individuals and families, covered 10.3% of all Texans in 1999.<sup>59</sup> The military covered approximately 2.9% of all Texans.<sup>60</sup> Texas children receiving coverage through CHIP, a joint federal and state program for children under the age of nineteen whose families make less than 200% of the federal poverty level (FPL), totaled 1.7%.<sup>61</sup> Nearly one quarter—23.2%—of all Texans had no health insurance at all in 2000-2001.<sup>62</sup> This represents an increase from 1999 and 2000 levels.<sup>63</sup> According to another study, Latinos comprised 50% of the uninsured in Texas in 1999.<sup>64</sup> When other groups were added, minorities made up two-thirds of the uninsured in Texas in 1999.<sup>65</sup> Included among the uninsured are those few who were able to obtain some care through a county indigent health care program.<sup>66</sup> We will look, in turn, at each of these means of accessing health care in Texas.<sup>67</sup>

#### A. Private Health Insurance

In Texas, as in the rest of America, health care is primarily provided through one's place of employment. While this seems an inexorable fact of life today, employment-provided health insurance came widely into being only about fifty years ago. In fact, health insurance itself is a relative newcomer to

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56. *Id.*

57. *Id.*

58. *Id.*

59. See REPORT FROM TEX. BLUE RIBBON TASK FORCE ON THE UNINSURED, MAJORITY REPORT TO THE 77TH LEGISLATURE 22 (2001), available at [http://www.senate.state.tx.us/75r/senate/commit/archive/BR/Blue\\_Ribbon.pdf](http://www.senate.state.tx.us/75r/senate/commit/archive/BR/Blue_Ribbon.pdf) (last visited Aug. 30, 2003).

60. *Id.*

61. See, e.g., CTR. FOR MEDICARE & MEDICAID SERVS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM ANNUAL ENROLLMENT REPORT (2002), available at <http://cms.hhs.gov/schip/schip01.pdf> (last visited Oct. 28, 2002); KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE IN AMERICA 2001 UPDATE 24 (Jan. 2003), available at <http://www.kff.org> (last visited Sept. 3, 2003).

62. ROBERT J. MILLS, HEALTH INSURANCE COVERAGE: 2001 10 (2002), available at <http://www.census.gov/hhes/www/hlthin01.html> (last visited Oct. 28, 2002). The figures total more than 100%, likely because of dual enrollment of some individuals (e.g., those enrolled in both Medicare and private health insurance). See *id.*

63. See *id.*

64. See *id.* at 4.

65. *Id.*

66. *Id.*

67. That is with the exception of Medicare, Medicare is a federal program and is not administered at the state level.

the market. Less than one hundred years ago, health insurance generally did not exist.<sup>68</sup>

Although employment provides the vast majority of private health insurance, this state of affairs is largely a historical accident.<sup>69</sup> During World War II, the government enacted wage controls to prevent escalation during the tight labor market.<sup>70</sup> As a result, competing firms that could not offer higher wages to attract employees began providing benefit packages to entice workers.<sup>71</sup> The practice caught on and became widespread.<sup>72</sup> This unintended result of wartime wage controls eventually became codified in 1954 when the federal government changed the tax code to allow an employer's contributions to an employee's health insurance coverage to be excluded from the employee's taxable income.<sup>73</sup> Such contributions are also a tax-deductible business expense for the employer.<sup>74</sup> Not only do benefits enjoy favorable tax treatment, but they are also a proper subject of collective bargaining by labor unions (which were much stronger in the 1940s and 1950s than they are now).<sup>75</sup> Favorable tax treatment and union demand for benefits were instrumental in both the rise of health insurance and the provision of health insurance through employment.<sup>76</sup> While only approximately twelve million people were enrolled in group hospital insurance plans in 1940, that number had increased to 101 million in 1955.<sup>77</sup> This number remains relatively unchanged today.<sup>78</sup>

For the majority of the working population in the United States, employer-sponsored health insurance is a valuable benefit of employment.<sup>79</sup> Typically, employees pay only a small fraction of the cost of their own coverage, leaving the lion's share to the employer (dependents' premiums, on

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68. See, e.g., Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990's*, 21 J.L. MED. & ETHICS 141 (1993); STARR, *supra* note 25, at 84.

69. See Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 636 (1994).

70. *Id.*

71. *See id.*

72. *Id.*

73. See Day, *supra* note 32, at 15 n.50.

74. Bodenheimer & Grumbach, *supra* note 69.

75. *Inland Steel Co. v. NLRB*, 170 F.2d 247, 255 (7th Cir.), *cert. denied*, 336 U.S. 960 (1949).

76. Bodenheimer & Grumbach, *supra* note 69. The federal government's subsidization of this system is enormous, totaling an estimated \$75 billion in 1991. *Id.* It is also highly regressive, as the size of the benefit is directly proportionate to one's income. *See id.*

77. *Id.*

78. See, e.g., PAUL FRONSTIN & RUTH HELMAN, *EMPLOYERS AND HEALTH BENEFITS: FINDINGS FROM THE 2000 SMALL EMPLOYER HEALTH BENEFITS SURVEY 4* (2000). This figure included a significant number of working adults over the age of sixty-five; the percentage of non-elderly adults receiving health insurance through employment totaled 65%. *Id.*

79. *Id.* In 1998 employment-based health insurance covered 65% of the non-elderly adult population. *Id.* Public health insurance such as Medicaid and Tricare, in comparison, covered only 14% of the non-elderly population. *Id.* Tricare covers military retirees, as well as families of active duty, retired, and deceased service members. *Id.*

the other hand, tend to be more expensive for employees, as employers typically pay a smaller share of them).<sup>80</sup> Such a system may seem a triumph for those interested in minimizing government involvement in and payment for health care and other social goods. But this is far from true. Because employment-based health insurance is not taxed to the beneficiaries and yet employers may deduct 100% of their premium costs, the federal government provides an enormous subsidy to the private health insurance system.<sup>81</sup> In 1998 the cost of this subsidy to the federal government was estimated to be \$111.2 billion.<sup>82</sup> In comparison, in the same year the federal government spent a total of \$99.5 billion—over \$10 billion less—on its share of the Medicaid program in all fifty states and U.S. territories.<sup>83</sup>

Not all jobs are created equal. In 1997 only 57% of workers nationwide in firms with fewer than one hundred employees were offered health benefits, as compared to 85% of workers in firms with one hundred or more employees.<sup>84</sup> In 2001 35% of all employers did not offer health benefits to their employees.<sup>85</sup> This helps explain how 82% of the forty-four million Americans who lacked health insurance in 2000 can live in a family with at least one worker. Many of those workers are simply not offered the option of health insurance through their employer. Sixty percent of uninsured workers are employed by small firms or firms that employ between two and fifty workers.<sup>86</sup> The most significant reason cited by employers with fewer than two hundred employees for not offering health insurance benefits was cost.<sup>87</sup>

Nationally, employees who are not offered health benefits are more likely than those who are offered such benefits to be low-income, part-time, minority, female, or under the age of thirty.<sup>88</sup> Nearly 50% of employers who do not offer health insurance pay wages of less than \$15,000 per year—barely above the 2001 FPL for a family of three—to at least half of their employees.<sup>89</sup> In contrast, only 12% of employers who do offer such benefits pay wages of less than \$15,000 per year to at least half their employees.<sup>90</sup> Employers who do not offer health benefits are also significantly more likely to have fewer full-time employees and to have more workers who are female, minority, or

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80. *Id.*

81. John Sheils & Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998*, HEALTH AFFAIRS 176-78 (1999).

82. *Id.* at 178.

83. HEALTH CARE FINANCING ADMINISTRATION (HCFA), NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CALENDAR YEARS 1960-2000 (2001).

84. FRONSTIN & HELMAN, *supra* note 78, at 4.

85. See KAISER FAMILY FOUND., *supra* note 33, at 35.

86. FRONSTIN & HELMAN, *supra* note 78, at 5.

87. KAISER FAMILY FOUND., *supra* note 33, at 55.

88. FRONSTIN & HELMAN, *supra* note 78, at 11.

89. *Id.*

90. *Id.*

under the age of thirty than those employers who do offer such benefits.<sup>91</sup> Workers who are better-off—white, male, over the age of thirty, and work for a firm with more than fifty employees—are more likely than the rest of the working population to have access to employment-based health insurance.<sup>92</sup>

So how does Texas compare? While not quite comparable to the data presented above, a 2001 study of nonpoor (i.e., those with a family income exceeding 200% of the FPL), adult, uninsured Texans performed by Texas A&M University's Public Policy Research Institute revealed that 75% of the 598 respondents to the study's survey were presently employed.<sup>93</sup> Of the employed respondents, 64% were employed by someone else and 36% were self-employed.<sup>94</sup> A significant majority of them, 42%, had jobs in the professional sector.<sup>95</sup> Clerical and sales workers comprised the next largest groups at 12% and 13%, respectively.<sup>96</sup>

Unsurprisingly, the largest portion of the uninsured Texans in the study, 39%, worked for firms employing fewer than five people.<sup>97</sup> Another 20% worked for firms employing between five and nineteen people.<sup>98</sup> As demonstrated above, on a national scale small employers typically provide health insurance less frequently to their employees, largely due to problems with economies of scale.<sup>99</sup> More surprising was the finding that 22% of the uninsured Texas respondents worked for firms with one hundred or more employees, a percentage significantly higher than the national average in the study cited above.<sup>100</sup>

The Texas Department of Insurance's 2001 study of Texas employers with fifty or fewer employees revealed that nearly half of the 10,968 respondents did not offer health insurance to their employees.<sup>101</sup> Eighty-five percent of those who did not currently offer health insurance had also not offered health insurance to their employees any time in the past five years, and 75% said they either definitely or probably would not offer health insurance coverage to their employees in the next three years.<sup>102</sup> Yet 41% of the same firms reported that they had unsuccessfully attempted to purchase insurance for their employees in the last five years.<sup>103</sup> Premium cost—in keeping with

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91. *Id.*

92. *Id.*

93. ANN LESSEM ET AL., UNINSURED TEXANS: ATTITUDES TOWARD COVERAGE 42-47 (2002).

94. *Id.*

95. *Id.*

96. *Id.* at 48-49.

97. *Id.*

98. *Id.* at 50.

99. *Id.*

100. *Id.*

101. TEX. DEP'T OF INS., SMALL EMPLOYERS AND HEALTH INSURANCE: FINAL RESULTS OF THE TEXAS SMALL EMPLOYER SURVEY 2001, 2-3 (2002)

102. *Id.*

103. *Id.* Forty-six percent of the respondents did not offer health insurance. *Id.*

national data—was the most significant factor in their decision to forego offering coverage.<sup>104</sup>

Health insurance premiums are set to rise again throughout the private market and, in fact, appear to be rising more steeply in Texas than generally throughout the United States.<sup>105</sup> In 2002 premiums had already risen 25%, as compared to a 15% increase nationwide.<sup>106</sup> Many employers are changing to self-insured plans wherever possible, apparently on the assumption that the cost hikes either overstate the actual costs of providing health care or that the cost hikes stem in part from costs of providing care mandated by the state legislature, such as mammograms, to which self-insured employers are not subject.<sup>107</sup> Others are simply passing on added costs to their employees or dropping coverage altogether.<sup>108</sup>

Both of these approaches are problematic. Those employers changing to self-insured plans in hopes of staving off enormous health care cost increases are likely to find modest respite, at best. The actual costs of providing health care are indeed rising significantly, although some preliminary data does appear to indicate that insurers may in fact be increasing their premium costs more than necessary to cover their expenses.<sup>109</sup> Moreover, at least one independent study has preliminarily found that legislative health care mandates, such as a legal requirement that insurers cover at least one mammogram per year for all female subscribers over the age of forty, are cost-neutral when considered altogether.<sup>110</sup> While some mandates have a net effect of increasing health insurance costs, others lead to cost savings by facilitating earlier (and cheaper) diagnosis and treatment for certain conditions.<sup>111</sup> Together, these findings suggest that broader forces are at play in rising health care costs than can be managed by simply exiting the market for standard health insurance.

Those employers who remain nonself-insured and pass on increased costs to their employees may not themselves see significant problems as a result of their choice, presuming that they do not see a flight of their best employees as

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104. *Id.* at 3-4. Senate Bill 10 (S.B. 10), enacted in the 78th regular session and effective September 2003, allows for small employers to join health group cooperatives for pooling purposes in purchasing health insurance. Tex. S.B. 10, 78th Leg., R.S. (2003).

105. *See, e.g.*, Bill Hensel, Jr., *Texas Worker Health Costs Soar; 25% Premium Hike May Force Some Businesses to Drop Coverage*, HOUS. CHRON., Apr. 24, 2002, at A1, available at 2002 WL 3258741.

106. *Id.*

107. *See, e.g., id.*

108. *Id.*

109. Bill Brubaker, *CareFirst May Hike Premiums 20 Percent; Increased Medical, Drug Costs Blamed*, WASH. POST, Aug. 9, 2002, at E01, available at 2002 WL 24826753 (citing Paul Ginsburg of the Center for Studying Health Care System Change as noting that “earnings reports confirm premiums are rising faster than insurers’ medical and prescription-drug costs”); *see also* Bradley C. Strunk et al., *Tracking Health Care Costs*, HEALTH AFFAIRS (2001), available at <http://www.healthaffairs.org/2005/strunk.rp.pdf> (last visited Sept. 3, 2003).

110. *See* Hensel, *supra* note 105.

111. *See id.*

a result. Their employees, on the other hand, may be harmed, both individually and in terms of their more general choices in the private market for health insurance. Over the past decade, the vast majority of those with health insurance provided through employment participated in managed care plans.<sup>112</sup> The growth of managed care is often credited with the slowing of previously steep premium increases in the mid-1990s.<sup>113</sup> But consumer backlash against the narrowed choices offered by managed care led to a decline in the number of individuals enrolled in health maintenance organizations (HMOs) as compared to preferred provider organizations (PPOs) and other less stringently-restricted managed care plans.<sup>114</sup> It also led to legislation at the state and federal levels to help prevent some of what were perceived to be managed care's most egregious curbs on health care spending, such as refusals to pay for treatment that could have saved a patient's life or preserved bodily function.<sup>115</sup> Now, a number of commentators believe we are witnessing the end of the managed care era.<sup>116</sup> Assuming for a moment that this may be the case, the question is: What might replace it?

Much talk has occurred these days about switching to plans that place significant cost burdens on health care consumers based on the consumers' health care consumption and choices.<sup>117</sup> The theory is that managed care plans, with their limited cost-sharing requirements, ironically helped lead, in the post-backlash era, to excessive use of medical care.<sup>118</sup> Some argue that consumers need to learn restraint by being responsible for the economic effects of their health care choices.<sup>119</sup> Toward this end, a number of plans have been proposed or created.<sup>120</sup> "Defined contribution plans" are one such proposal.<sup>121</sup> Under such plans, employers would offer employees a certain

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112. See, e.g., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2002 ANNUAL SURVEY 54 (Sept. 2002).

113. See, e.g., HCFA (now CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)), OFFICE OF THE ACTUARY, NATIONAL HEALTH EXPENDITURES PROJECTIONS: 1998-2008 (1998).

114. See KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2001 ANNUAL SURVEY 16 (2001).

115. See, e.g., TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003 (Vernon 1999); see also S. 1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001). For an example of such a refusal, see, e.g., Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (finding that the plaintiff, whose HMO denied authorization for a transfer to a facility that was equipped to treat his neurological emergency, thereby delaying his treatment, became quadriplegic as a result of spinal compression).

116. See, e.g., James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFFAIRS (2002), available at [http://www.healthaffairs.org/web/exclusives/Robinson\\_web\\_exc\\_032002htm](http://www.healthaffairs.org/web/exclusives/Robinson_web_exc_032002htm) (last visited Sept. 3, 2003); Robert M. Crane & Laura A. Tollen, *Out of the Frying Pan and Into the Fire*, HEALTH AFFAIRS (2002), available at [http://www.healthaffairs.org/web/exclusives/crane\\_perspective\\_web\\_excl\\_032002.htm](http://www.healthaffairs.org/web/exclusives/crane_perspective_web_excl_032002.htm) (last visited Sept. 3, 2003); Strunk et al., *supra* note 109.

117. See, e.g., Robinson, *supra* note 116.

118. See *id.*

119. See *id.*

120. See *id.*

121. See, e.g., Sally Trude & Paul H. Ginsburg, *Are Defined Contributions a New Direction for Employer-Sponsored Coverage?*, CTR. FOR STUDYING HEALTH SYSTEM CHANGE 1 (2001), available at



sum of money per year.<sup>122</sup> The employee would have the option of using this money toward paying directly for health care, paying for a health insurance plan, or paying for some of both.<sup>123</sup> If the employee wants or needs options that cost more than the sum of money provided by the employer, the employee would be responsible for all of the additional cost.<sup>124</sup> This option relieves employers from the task of funding and administering health care benefit plans and arguably insulates them from having to absorb the full brunt of increases in health care costs.<sup>125</sup> Supporters of defined contribution plans also argue that it should be attractive to employees because it provides more opportunity for consumer choice between different health care plans and options.<sup>126</sup>

Estimates of the number of employers who are interested in switching to a defined contribution plan, and the number of employees similarly interested, vary significantly depending on the institution performing the research.<sup>127</sup> According to the Heritage Foundation, a conservative think tank, 46% of senior executives of Fortune 1000 companies interviewed nationwide were “receptive” to the idea of switching to a defined contribution plan.<sup>128</sup> The same foundation found 73% of employees interviewed to be “extremely,” “very,” or “somewhat” interested in replacing their current health benefit options with a defined contribution plan.<sup>129</sup> The more liberal Kaiser Family Foundation, on the other hand, found that in 2001 only 24% of employers with fewer than two hundred employees said they are “very” or “somewhat” likely to switch to a defined contribution plan in the next five years.<sup>130</sup> Larger firms were even less likely to show interest, with only 13% responding that they were “very” or “somewhat” likely to switch in the same time period.<sup>131</sup>

The 2001 Health Confidence Survey, performed by the moderate Employee Benefits Research Institute, obtained a mixed result when asking employees whether they would favor a defined contribution plan over their employers’ present provision of health insurance benefits.<sup>132</sup> Respondents strongly favored the defined contribution option where the employees choose the health insurance with the employer paying the insurer the amount now being paid and the employees paying the difference over continuing to have

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<http://www.hschange.org/CONTENT/273/273.pdf> (last visited Aug. 30, 2003).

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *See infra* notes 128-34 and accompanying text.

128. James Frogue & Grace-Marie Turner, *Improving Americans’ Health Care Coverage Through Defined Contributions*, HERITAGE FOUND. REPORTS, June 28, 2001, at 1a.

129. *Id.*

130. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2000 ANNUAL SURVEY 170 (2000).

131. *Id.*

132. EMPLOYEE BENEFIT RESEARCH INST., HEALTH CONFIDENCE SURVEY, HEALTH INSURANCE: EMPLOYER INVOLVEMENT AND DEFINED CONTRIBUTIONS (2001).

employers choose and pay for health insurance as they do now (64% versus 29%).<sup>133</sup> But respondents strongly *disfavored* the pure defined contribution option where the employer gives the employees the money currently being spent and the employees buy health insurance on their own when compared to continuing to have employers choose and pay for health insurance as they do now (31% versus 63%).<sup>134</sup> Based on this study, employees may favor greater choice and flexibility in health insurance plans than they currently enjoy but still strongly value employer involvement in the process.<sup>135</sup>

Another proposal would create plans that place a large cost-sharing burden on the consumer.<sup>136</sup> Some plans could be easily revamped from existing models.<sup>137</sup> For example, PPOs are “managed care lite” plans that generally function much like HMOs in terms of payment for in-network services but also provide a certain, often small, percentage reimbursement for out-of-network services, and PPOs often do not use primary health care providers as gatekeepers for obtaining access to more specialized care.<sup>138</sup> Such plans could be easily modified to require subscribers to pay a set percentage—for example, 20% of the office visit cost—in lieu of the current set dollar figure per in-network service—for example, \$20 per office visit.<sup>139</sup> As different providers charge different fees for the same service, this could attune consumers to cost discrepancies and make them more likely to take the discrepancies into account when making health care choices.<sup>140</sup> It would also place a significantly larger cost burden on the consumer.<sup>141</sup> At least one recent study suggests that this could translate into substantial cost-savings for employers.<sup>142</sup> In conjunction with such plans, employers offer employees Medical Spending Accounts (MSAs) into which they contribute pre-tax dollars that the employees can access for paying deductibles, copayments, or other noninsured health care costs.<sup>143</sup> Such plans have already come into existence and are starting to proliferate.<sup>144</sup> As such, they may eventually supplant the old managed care order with little debate or fanfare.<sup>145</sup>

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133. *Id.*

134. *Id.*

135. *See id.*

136. *See, e.g.,* Robinson, *supra* note 116.

137. *See, e.g., id.*

138. *See, e.g., id.*

139. *See, e.g., id.*

140. *See, e.g., id.*

141. *See, e.g., id.*

142. *See, e.g., id.* (discussing the effect on premiums); see Jason S. Lee & Laura Tollen, *How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing*, HEALTH AFFAIRS (2002), available at <http://healthaffairs.org/webexclusives/2104Lee.pdf> (last visited Aug. 30, 2003).

143. *See, e.g.,* Robinson, *supra* note 116.

144. *See, e.g., id.*

145. *See, e.g., id.*

In addition to altering the types of health insurance policies available, some believe individual tax credits can be used as a means of relieving employers of some of the burden of paying for health care and putting it onto consumers.<sup>146</sup> Both the Bush administration and Congress have proposed providing tax credits to individuals and families, assisting them in the purchase of health insurance policies.<sup>147</sup> The proposals to date would provide credits based on family size and income.<sup>148</sup> The average size of the tax credit proposed by the Bush administration would be \$1,155 per eligible family.<sup>149</sup> Another proposal, floated in the Senate in 2001, would provide an average credit of \$1,535 per eligible family.<sup>150</sup> One study by the moderate Center for Studying Health System Change found that the Bush proposal would subsidize, on average, about 43% of a family's premium cost, as compared to 54% for the Senate proposal.<sup>151</sup> The study concluded that while such a subsidy would "provide significant help to a substantial number of people" who are both young and in excellent health, it would not be useful for those who are older, who have lower incomes, or who are in poorer health because it would require them to spend far too high a percentage of their income on health insurance—here, over 16%.<sup>152</sup> The individual insurance policies that could be purchased using these tax credits would also have significantly higher deductibles and thinner benefits than those available through conventional group insurance.<sup>153</sup>

Managed care may indeed be meeting its end and health care costs may indeed be dramatically rising, but before embracing any or all of the proposed private market solutions to these issues, consideration must be given regarding what impact those solutions will likely have on people's access to health care. After all, health insurance is not an end in itself. It is, of course, only useful to the extent that it assists in meeting Texas residents' needs for health care. Thus, while resolutions, such as the one passed during the Texas Legislature's 77th regular session memorializing Congress to provide tax credits for those buying health insurance in the individual market, may ultimately yield results that are helpful to some Texans, those resolutions will likely do little to help

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146. See, e.g., Jack Hadley & James D. Reschovsky, *Tax Credits and the Affordability of Individual Health Insurance*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE ISSUE BRIEF No. 53 (2002), available at <http://www.hschange.com/CONTENT/458/458.pdf> (last visited Aug. 30, 2003).

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*; see Jon Gabel et al., *Individual Insurance: How Much Protection Does It Provide?*, HEALTH AFFAIRS (2002), available at <http://healthaffairs.org/webexclusives/2103Gabel.pdf> (last visited Aug. 30, 2003).

152. Hadley & Reschovsky, *supra* note 146.

153. *Id.*; see Gabel et al., *supra* note 151.

solve most of the thornier and more pervasive issues involving access to health care via private insurance.<sup>154</sup>

The private market solutions discussed above all share the feature of imposing a greater share of health care costs on most private market subscribers than they currently bear.<sup>155</sup> Proponents of these solutions may be correct that the different mechanisms employed by each are likely to make consumers more cost conscious.<sup>156</sup> But the same features are also likely to result in a significant number of people having to forebear coverage altogether or having to incur crushing medical debt, notwithstanding the existence of coverage, ultimately leading to an increase, rather than a decrease, in the number of the uninsured.<sup>157</sup> For many lower income individuals, most or all individual policies on the private market would be out of their reach because the amount available, with which to purchase them, through either a defined contribution plan or a tax credit is excessively small in relation to their income and necessary financial obligations.<sup>158</sup> For others in poor health, the cost-sharing requirements or thin benefit packages imposed by affordable policies would be insufficient to meet their high medical needs.<sup>159</sup> These people, most of whom could obtain coverage under our present managed care system, would then be forced to rely upon the ever-dwindling supply of charity care and government assistance or to go without coverage.<sup>160</sup>

Moreover, while it may appear that proposals, such as defined contribution plans and employer-funded MSAs, will lead to greater consumer choice, the opposite may very well occur.<sup>161</sup> In a market where a wide variety of coverage options are available, those with higher health care needs and those with a lesser appetite for risk will, if financially possible, choose more comprehensive coverage.<sup>162</sup> But those who perceive themselves to be healthier, as well as those with a greater appetite for risk, will tend to choose cheaper and less-comprehensive policies.<sup>163</sup> As this self-selection continues, comprehensive coverage policies will have an increasingly large proportion of sick subscribers because healthier subscribers will choose less expensive options.<sup>164</sup> With an increasingly sick subscription population, comprehensive coverage options will become more and more expensive until such coverage

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154. See, e.g., Tex. S. Com. Res. 37, 77th Leg., R.S. (2001)

155. See *supra* notes 121-36 and accompanying text.

156. See, e.g., Trude & Ginsburg, *supra* note 121.

157. See, e.g., *id.*

158. See *supra* notes 121-36 and accompanying text.

159. See Trude & Ginsburg, *supra* note 121.

160. See, e.g., *id.*

161. See Seth J. Chandler, *Visualizing Adverse Selection: An Economic Approach to the Law of Insurance Underwriting*, 8 CONN. INS. L.J. 435, 445 (2002).

162. See *id.*

163. *Id.*

164. *Id.* at 436.

eventually prices itself out of the market altogether.<sup>165</sup> Should this happen, the private market may eventually be unable to serve most people who are older or less healthy. A large number of such people are already seeking care through Medicare and Medicaid,<sup>166</sup> and Texas surely does not want to see its Medicaid rolls swelling with people who used to be covered by private health insurance who can no longer afford coverage or health care. To retain comprehensive options, both healthy and sick people need to subscribe to them.<sup>167</sup>

Moreover, society needs both healthy and sick people to have sufficiently comprehensive coverage to shield them in the event that their health takes a significant turn for the worse.<sup>168</sup> Some currently healthy people who choose to gamble with their health care will ultimately end up regretting such a decision when they become seriously ill.<sup>169</sup> Is society willing to tell such people, "Too bad; you made your health care coverage choice and you chose poorly, so now you need to bear the consequences of that choice, even though this may mean facing permanent injury or death because you can't afford treatment"? This is, indeed, what society would tell such people with respect to their choices of most consumer goods. But health care is different. This is, in part, why Medicaid programs are funded and why some counties have broader indigent health care programs than required under Texas law.<sup>170</sup>

Robert Crane and Laura Tollen of the Kaiser Permanente Institute for Health Policy make the following suggestions for legislation, which may help ward off some of these problems in the changing health insurance market:

(1) Set standards that specify both a set of benefits and a level of cost sharing below which carriers cannot go. A balance must be struck between under- and overregulation in this area: Too-rich benefits (that is, too many benefit mandates) and too little cost sharing can force people to drop coverage because it is unaffordable. Increased cost sharing does moderate premium increases, potentially keeping some persons insured who would otherwise become uninsured. However, an absence of regulation or limits on cost sharing may result in high rates of underinsurance (or "illusory" insurance), particularly for low-income persons with chronic conditions.

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165. *Id.*

166. See ANDY SCHNEIDER & RACHEL GARFIELD, MEDICAID BENEFITS (Aug. 2000), available at <http://www.kff.org> (last visited Sept. 1, 2003).

167. See, e.g., Crane & Tollen, *supra* note 116. Unfortunately, Texas just enacted a law allowing insurers to offer benefit plans that do not include state-mandated benefits, whether in part or in whole. See Tex. S.B. 10, 78th Leg., R.S. (2003). The only "floor" provided is a requirement that all such policies cover obstetrical and gynecological care. See *id.* It is up to the consumer to determine what otherwise state-mandated benefits are excluded by the policy. See *id.*

168. See Crane & Tollen, *supra* note 116.

169. See *id.*

170. See TIM BROWN, COUNTY INDIGENT HEALTH CARE PROGRAM THE COUNTY INFORMATION PROJECT (2000).

(2) Create risk-spreading mechanisms among carriers so that those offering comprehensive coverage do not experience premium “death spirals.” Such mechanisms may include high-cost condition pools, reinsurance, and risk adjustment. Many models of such mechanisms exist in the public and private sectors, and researchers continue to refine and improve them.

(3) Develop market rules that protect comprehensive plans against adverse selection in certain circumstances. For example, employees switching during open enrollment from catastrophic to comprehensive coverage would be required to undergo a preexisting condition waiting period.<sup>171</sup>

Texas already mandates that insurance carriers in the small-group market offer a “basic” and a “catastrophic” health insurance plan to employers and sets a minimum for allowable coverage under each plan.<sup>172</sup> Yet Texas does not mandate that those plans represent the minimum standard allowable for any basic or catastrophic health insurance plan offered to employers.<sup>173</sup> Rather, Texas merely requires that the insurance carrier market these plans in addition to any others it might offer.<sup>174</sup> Given the present push for health insurance plans that offer fewer benefits in exchange for increasing out-of-pocket costs, Texas ought to determine a reasonable minimum for health insurance, below which it makes little practical sense to spend money on ostensibly comprehensive coverage.<sup>175</sup> Health coverage in name only is a waste of resources and a trap for the unwary and poorly-educated. Yet that reasonable minimum must also be sufficiently trim to be affordable to those with few resources. While people should not be forced to face an utter calamity should they develop a serious health condition and find themselves underinsured due to their choice of a thinner benefit policy, they should also not be allowed to switch with relative ease to a comprehensive plan (perhaps having only to wait several months for an open enrollment period) should they fall seriously ill. This would make the choice between more and less comprehensive insurance plans almost wholly without risk, such that many people would need to give only little thought to their decision. Not only will risk-free choice work against the goal of making health care consumers more aware of the financial impact of their choices, but it will also contribute to making comprehensive health plans the dumping ground of the ill.<sup>176</sup> A balance must be found between promoting greater health care consumer responsibility and protecting the ability of consumers to obtain and afford the insurance and services they need.

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171. *See id.*

172. *See, e.g.*, TEX. INS. CODE § 26.44A (Vernon 2001).

173. *See id.*

174. *See id.* § 26.42.

175. *But see supra* note 167 and accompanying text (regarding state mandates and S.B. 10).

176. *See supra* note 167 and accompanying text.

### B. Medicaid and SCHIP

If one does not have access to health insurance through one's employer and is also not able to fund one's own health care costs, what does the health care safety net have to offer? For a certain number of uninsured adults and a larger number of uninsured children, the largest fallback options are Medicaid and SCHIP.<sup>177</sup> Both are publicly funded programs that provide comprehensive care, and both are jointly funded by Texas and the federal government.<sup>178</sup>

#### 1. Medicaid

Medicaid is currently the only joint federal and state public health care program that covers people in all age groups.<sup>179</sup> It offers comprehensive health services to those who meet its qualifications.<sup>180</sup> It is also an entitlement program.<sup>181</sup> This means that if one meets the eligibility criteria for Medicaid, one has a legal right to participate in the program.<sup>182</sup> The government has a corresponding duty to fund and maintain the program so that all eligible people can receive its services.<sup>183</sup> No one can take those rights and duties away, unless the laws change. While the federal government sets certain minimum eligibility criteria for those seeking Medicaid coverage, states may offer more expansive coverage if they choose.<sup>184</sup> Thus, Medicaid eligibility requirements differ from state to state.<sup>185</sup> In Texas, those groups of non-elderly Texas residents who are also U.S. citizens or permanent residents<sup>186</sup> and are generally eligible for Medicaid include the following:

- (1) Temporary Assistance for Needy Families (TANF) recipients (generally to qualify, recipients must be families with dependent children whose countable income is at or below 17% of the FPL);<sup>187</sup>

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177. See CANTON FENZ, *THE ACCESS PROJECT, PROVIDING HEALTH CARE TO THE UNINSURED IN TEXAS: A GUIDE FOR COUNTY OFFICIALS* 3 (2000).

178. See *id.*

179. See, e.g., KAISER FOUND. ON MEDICAID & THE UNINSURED, *MEDICAID: A PRIMER* 1 (Mar. 2001), available at <http://www.kff.org> (last visited July 23, 2003).

180. *Id.*

181. *Id.*

182. See *id.*

183. *Id.* at 16.

184. *Id.* at 4.

185. *Id.*

186. Other aliens, including illegal aliens, are eligible only for emergency services provided by Medicaid if they meet certain income and resource requirements. Andy Schneider et al., *Medicaid Eligibility*, in KAISER FAMILY FOUND., *THE MEDICAID RESOURCE BOOK* 7 (Jan. 2003), available at <http://www.kff.org> (last visited Apr. 17, 2003); see CTRES. FOR MEDICARE AND MEDICAID SERVS., *STATE MEDICAID MANUAL* 3211.1 (2002), available at [http://cms.hhs.gov/manuals/45\\_smm/sm\\_03\\_3\\_3210\\_to\\_3256.asp#\\_toc490729258](http://cms.hhs.gov/manuals/45_smm/sm_03_3_3210_to_3256.asp#_toc490729258) (last visited Apr. 17, 2003).

187. See KATHLEEN MALOY ET AL., *CAN MEDICAID WORK FOR LOW-INCOME WORKING FAMILIES?*

- (2) Pregnant women and infants under 12 months of age earning less than 185% of the FPL;<sup>188</sup>
- (3) Children between the ages of 12 months and 5 years earning less than 133% of the FPL;
- (4) Children between the ages of 6 and 19 years earning less than 100% of the FPL;
- (5) Certain medically needy recipients who meet TANF resource limits and other criteria, and whose income does not exceed 133.33% of the TANF limits (e.g., \$275 per month for a family of three in 2001);
- (6) Children aging out of foster care plans who earn less than 400% of the FPL;
- (7) Individuals who are receiving supplemental security income (SSI) cash benefits under Title XVI of the Social Security Act; and
- (8) Elderly individuals meeting certain income requirements who receive Medicare.<sup>189</sup>

Note whom this list does not include. Non-elderly, nonpregnant, childless adults (other than certain young adults transitioning from foster care to independence) are not eligible for Medicaid in Texas, regardless of their degree of impoverishment or medical need.<sup>190</sup> Because of TANF's minuscule pre-enrollment income caps, adults with children who earn virtually any income are also not eligible.<sup>191</sup> Thus, the vast majority of adults, particularly working adults, are ineligible for the broadest health care safety net program available to all age groups in Texas.

Those who qualify for Medicaid, though, are entitled to a rich menu of benefits. Texas Medicaid beneficiaries receive the following through federal mandate: (1) inpatient hospital services; (2) outpatient hospital services, rural health clinic services, and federally qualified health center services; (3) laboratory and X-ray services; (4) services furnished by a nurse-midwife, certified pediatric nurse practitioner, or certified family nurse practitioner; (5) certain nursing facility services for individuals twenty-one years of age or

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104 (Apr. 2002), available at <http://www.kff.org> (last visited Sept. 1, 2003). In Texas, after the income disregard, recipients can generally only earn up to 34% of the FPL per month after their first four months of enrollment. *Id.* This means that in 2002 a family of three can earn no more than \$395 per month in order to qualify for Medicaid using this method. *Id.*

188. The budget enacted in the 78th regular session effectively reduced this percentage to 158% of the FPL for the next biennium. See Center for Public Policy Priorities, *Comments on Medicaid-Related Proposed Rules* (2003), available at <http://www.cppp.org/products/policyanalysis/briefingpapers/com-711-03.html> (last visited July 23, 2003).

189. See, e.g., ANNE DUNKELBERG, *MEDICAID AND STATE BUDGETS: A CASE STUDY OF TEXAS 15-16* (2002), available at <http://www.kff.org> (last visited Sept. 1, 2003). The foregoing groups must also meet resource requirements particular to each group. *Id.*

190. See *id.*

191. See *id.*



older; (6) home health care services (for those entitled to nursing facility services); (7) early and periodic screening, diagnostic, and treatment services for individuals who are eligible under the plan and are under the age of twenty-one; (8) family planning services and supplies furnished to individuals of child-bearing age who are eligible under the State plan and who desire such services and supplies; and (9) physicians' services furnished by a physician in the office, the patient's home, a hospital, a nursing facility, or elsewhere.<sup>192</sup> They also receive the following benefits which Texas chooses, at its own option, to provide to them through Medicaid: (1) ambulatory surgery; (2) limited birthing center access; (3) case management for certain people; (4) limited chiropractic services; (5) access to Christian Science sanitarium; (6) day activities and health services; (7) emergency medical services; (8) access to licensed professional counselors and masters of social work; (9) hearing aids and related audiologists' services; (10) home and community-based care; (11) hospice care; (12) intermediate care for the mentally retarded and developmentally disabled; (13) home respiratory care; (14) limited nurse-anesthetist services; (15) school health services; (16) limited maternity care; (17) medically necessary oral surgery and dentistry; (18) optometry and eyeglasses; (19) home personal care services; (20) physical therapy; (21) podiatry; (22) limited prescription drugs; (23) limited psychologists' services; (24) rehabilitation services; (25) telemedicine; (26) and limited home tube feeding.<sup>193</sup>

Nationally, children constitute the majority of Medicaid enrollees.<sup>194</sup> In 2000 the Kaiser Commission on Medicaid estimated nationally that children comprised 51.2% of all Medicaid enrollees, followed by non-elderly and nondisabled adults (21.4%), the blind and disabled (17.3%), and the elderly (10.1%).<sup>195</sup> In Texas, the numbers are relatively similar.<sup>196</sup> The Department of Health and Human Services reported that in August 2003, 71.8% of all Texas Medicaid recipients were nondisabled children or non-elderly, nondisabled adults, 14.1% were blind or disabled, and 13.8% were elderly.<sup>197</sup> Yet when looking at what the different groups of enrollees consumed, children consumed very few resources in comparison to the disabled and elderly.<sup>198</sup> Nationally, the blind and disabled were estimated to have led all groups in consumption of resources in 1998—the most recent year for which final

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192. See 42 U.S.C. § 1396d(a) (2000); SCHNEIDER & GARFIELD, *supra* note 166, at 8-9.

193. See DUNKELBERG, *supra* note 189, at 17-18.

194. See KAISER FOUND. ON MEDICAID & THE UNINSURED, *supra* note 179, at 2.

195. *Id.*

196. See TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID ENROLLMENT BY PROGRAM CATEGORIES FOR AUGUST 2002 (2002), available at <http://www.hhsc.state.tx.us/research/dssi/LatestEnrollmentbyCategory.html> (last visited Aug. 13, 2002).

197. *Id.*

198. TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID IN PERSPECTIVE 5-15 (2002).

national figures are available—comprising 39.4% of all expenditures.<sup>199</sup> The elderly followed at 27.1% of expenditures, then children at 14.9%, and non-elderly and nondisabled adults at 9.7%.<sup>200</sup> In Texas, the picture is relatively similar. The blind or disabled accounted for 36% of expenditures in fiscal year (FY) 2000.<sup>201</sup> This was followed by the elderly, who accounted for 29% of all Medicaid expenditures.<sup>202</sup> The nondisabled, non-elderly adults accounted for 12% of expenditures, and children accounted for 22% of expenditures.<sup>203</sup>

Most Texas Medicaid beneficiaries get all these benefits at no personal cost to them.<sup>204</sup> Under federal law, only a few classes of beneficiaries may be required to pay a premium for their benefits.<sup>205</sup> Most notably, this class includes elderly individuals and disabled working individuals whose family income exceeds 150% of the federal poverty guidelines.<sup>206</sup> As observed above, these groups (albeit at all income levels, not just those earning more than 150% of the FPL) are responsible for the greatest Medicaid expenditures.<sup>207</sup> An elderly person's premium may not exceed 10% of the amount by which her family's income exceeds 150% of the federal poverty guidelines.<sup>208</sup> A disabled worker's premium, on the other hand, may run on a sliding scale as the individual's income increases from 150% to 200% of the federal poverty guidelines.<sup>209</sup>

Federal law provides that states generally may *not* require cost-sharing (or payment of a share of the cost of medical services provided) from covered children, pregnant women, individuals receiving long-term care who are required to spend all but a nominal portion of their income on such care, people receiving emergency medical services or family planning services, and people receiving hospice care.<sup>210</sup> Such individuals comprise the vast majority of Medicaid enrollees. Cost-sharing may be imposed on other groups.<sup>211</sup> But any permitted cost-sharing must be "nominal" in amount.<sup>212</sup>

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199. See VERNON SMITH ET AL., MEDICAID SPENDING GROWTH: RESULTS FROM A 2002 SURVEY 2 (2002), available at [www.kff.org](http://www.kff.org) (last visited Aug. 30, 2003).

200. *Id.*

201. TEXAS HEALTH & HUMAN SERVS. COMM'N, *supra* note 198, at 5-15.

202. *Id.*

203. *Id.*

204. 42 U.S.C. § 1396o(a) (2000).

205. *Id.* § 1396o(a)(1).

206. See *id.* § 1396o(c)-(d).

207. See SMITH ET AL., *supra* note 199.

208. 42 U.S.C. § 1396o(c)(2). Child care expenses are deducted from the family's income in making this calculation. *Id.*

209. *Id.* § 1396o(d).

210. *Id.* § 1396o(a)(2).

211. *Id.* § 1396o(a)(3).

212. *Id.* The Secretary of Health and Human Services is charged with determining what "nominal" means. *Id.*

In the 2001 legislative session, the Texas Legislature directed the Texas Health and Human Services Commission (the "Commission") to implement cost-sharing for Medicaid recipients and anticipated \$3 million in savings as a result.<sup>213</sup> In April 2002 a Commission workgroup, in response to the legislation, recommended that the Texas Medicaid program implement an enrollment fee for recipients earning 101% or more of the FPL and an emergency services fee for all recipients.<sup>214</sup> Both would be voluntary.<sup>215</sup> The suggested enrollment fee would be between \$5 and \$10 for individuals and \$10 and \$20 for families.<sup>216</sup> The suggested emergency services fee would be \$3.<sup>217</sup> The workgroup also recommended a fee of \$1 to \$3 for all brand-name drugs prescribed for non-emergent therapy resulting from an emergency room visit.<sup>218</sup> With respect to co-payments for other services, the workgroup made the following observations, among others:

Copays can serve as a barrier to services, even if they are voluntary, and can induce enrollees to skip medically needed care, not just unnecessary care. Copays place an additional administrative burden and administrative costs on providers.

Copays may discourage utilization of medically necessary care.

The additional administrative burden of copays will decrease provider participation in the program.

Copays are not proven to influence more appropriate utilization.<sup>219</sup>

As a result, it expressly did not suggest the implementation of co-payments for physician office visits or other medical care.<sup>220</sup>

Effective December 15, 2002, the state adopted regulations implementing the above recommendations.<sup>221</sup> The regulations provide for cost-sharing of up to \$3 per unit for nonemergency services provided in an emergency department and for prescription drugs for all nonpregnant Medicaid beneficiaries over the age of nineteen who are not receiving long-term care, emergency care, family planning, or hospice services.<sup>222</sup>

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213. See TEX. HEALTH & HUMAN SERVS. COMM'N, COST SHARING WORKGROUP SUMMARY (2002), available at [http://www.hhsc.state.tx.us/medicaid/reports/Cost\\_Sharing\\_Sum\\_042102.html](http://www.hhsc.state.tx.us/medicaid/reports/Cost_Sharing_Sum_042102.html) (last visited Sept. 3, 2002).

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. See 1 TEX. ADMIN. CODE ANN. § 354.3200 (2003).

222. See *id.*

Medicaid serves an essential role in covering Texans who would otherwise have few, if any, options for obtaining health coverage.<sup>223</sup> As noted above, a majority of Texans are covered by private health insurance, and private health insurance in Texas is generally provided through employment.<sup>224</sup> As such, the unemployed are far more likely, in general, to be uninsured than the employed.<sup>225</sup> While just about anyone in any socio-economic group may find himself unemployed at some time in his life, certain classes of individuals are more likely than others to find themselves in that predicament.<sup>226</sup> The significantly disabled comprise one such group.<sup>227</sup> Children are another.<sup>228</sup> Those with minimal job skills and earning capacity who are also taking care of small children are also more likely to be unemployed.<sup>229</sup> Impoverished elderly individuals comprise yet another such group.<sup>230</sup> In addition, low-income pregnant women, while perhaps not more likely to be unemployed than others (provided they do not also have small children at home), are, as low-income workers, far more likely than others not to have health insurance provided through their employment.<sup>231</sup> Yet all these groups have particular health care needs. In fact, with the arguable exception of families with minor children, they are far more likely than the general population to require health care. Moreover, the health care that these groups require is likely to be far more expensive, on average, than that which the general public usually receives.

Because the individuals in these groups are likely to fall outside of the group health insurance market, they would need to turn to the individual market if they were to obtain their health insurance on their own. But even for healthy individuals, policies purchased in the private individual insurance market tend to be far more costly than those purchased in the group market. Because nearly all people who can obtain access to health care through Medicaid have low incomes, individual market policies are well outside the means of most of them.<sup>232</sup> More importantly, even if they could afford it, individual private market health insurance would be unavailable to many

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223. See TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID PROGRAM (2003), available at <http://www.hhsc.tx.us/medicaid/index.html> (last visited Aug. 30, 2003).

224. See U.S. Census Bureau, *supra* note 54.

225. See *id.*

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. Medicaid covers a substantial fraction of all births in Texas. In 1998 women receiving Medicaid accounted for over an astonishing 40% of the births in Texas. See KAISER FAMILY FOUND., BIRTHS FINANCED BY MEDICAID AS A PERCENTAGE OF TOTAL BIRTHS, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+CHIP&subcategory=Births+Financed+by+Medicaid&topic=As+Percent+of+State+Births> (last visited Sept. 17, 2002).

232. See Hensel, *supra* note 105.

classes of Medicaid beneficiaries, precisely because of their health problems and needs.<sup>233</sup> Most health insurers would refuse to underwrite a policy for a pregnant, permanently disabled, or chronically ill individual unless forced by law to do so, given the medical bills such an individual will likely incur.

If we return to the list of services that Texas Medicaid provides, it becomes evident that Medicaid is specifically designed to meet the health needs of these particular groups.<sup>234</sup> For example, a number of Medicaid's services are not traditionally provided by most conventional health insurance plans. Case management and tuberculosis-related services, respiratory care services, home and community care for functionally-disabled elderly individuals, community supported living arrangement services, and personal care services, among other Medicaid services, tend to be required over a long period of time by the chronically-ill, disabled, or elderly. Conventional health insurance, on the other hand, tends to provide only relatively short-term treatment and care for illness and injury.<sup>235</sup> Moreover, unlike Medicaid, conventional policies have lifetime benefit limits that generally preclude long-term care for expensive, chronic ailments. This is because conventional policies are generally geared toward workers.<sup>236</sup> As such, they usually provide benefits intended to restore an ill or injured employee to a sufficient degree of health to resume working rather than long-term benefits for chronic illnesses or conditions.<sup>237</sup> Medicaid, on the other hand, is intended in part to provide for those people—the “deserving” poor—who do not have reliable access to the job market or who have long-term health needs.<sup>238</sup> Moreover, as an entitlement program, all members of the classes who are mandated to receive benefits *must* be given those benefits for which they are eligible, provided the members apply for them.<sup>239</sup> Thus, Medicaid generally does not have such limits, though Texas does control utilization of services through managed care, medical necessity determinations, establishment of reasonable maximum service levels, and other means.<sup>240</sup>

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233. Sarah Rosebaum & Kathleen Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families*, 60 OHIO ST. L.J. 1443, 1449 (1999). Rosenbaum and Malloy note that, “Medicaid’s extraordinary complexity arises from the fact that, rather than covering all low income persons, the program covers more than fifty distinct categories of low income and medically impoverished individuals and families. *Id.* Each separate category can best be understood as a response to some form of ‘market failure’ (the failure or unwillingness of the insurance industry to offer an affordable health care product).” *Id.*

234. See 42 U.S.C. § 1396d(a) (2000); SCHNEIDER, *supra* note 166; DUNKELBERG, *supra* note 189.

235. See generally STARR, *supra* note 25, at 236.

236. *Id.*

237. *Id.*

238. See, e.g., Sara Rosenbaum & David Rousseau, *Medicaid at 35*, 45 ST. LOUIS U. L.J. 7, 12-13 (2001).

239. See 42 C.F.R. § 440.240(b) (2001).

240. See *id.* § 440.230(b) for the federal rules permitting these actions. In this regard, some states are considering implementing certain cost-containment measures in light of recent budget shortfalls. THE KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID UPDATE: WHAT MEASURES ARE STATES

The most significant differences are generally geared toward disabled and elderly Medicaid recipients, for precisely the reasons discussed above.<sup>241</sup> Benefits that these individuals tend to consume, such as nursing home care, physical therapy, community supported living arrangements, and respiratory care services tend to be expensive because they are frequently required over lengthy periods of time. Thus, the disabled and elderly, although comprising only a minority of Medicaid users, use far and away the most Medicaid resources.<sup>242</sup> Again, these are resources that the private market is not presently equipped to provide—at least not at a reasonably affordable premium.

Medicaid is, therefore, an essential piece of the health care safety net. Without Medicaid, many people who are in need of health care yet are least able to pay for it, would have few, if any, means of accessing health care. Because most Texans do not want to see people dying in their own streets, Medicaid is important to everyone for support in at least some fashion, no matter what political beliefs we may hold. Yet Medicaid in its present form is unwieldy and costly. Its regulations are difficult to decipher at best, even for experienced health care policy analysts and advocates. Enrollment is difficult for potential beneficiaries, and the program is poorly publicized. Not only is paperwork for provider reimbursement onerous, but continuing eligibility for the program must be checked every six months at the time and expense of both beneficiaries and case workers.<sup>243</sup> Simply put, Medicaid is not patient-centered. It is not even provider-centered or government-centered. While the program provides desirable benefits to all three parties, it does so at great expense to everyone's time, money, and energy.

Medicaid can be improved. While the suggestions proffered do not purport to solve all of Medicaid's problems, most should be relatively easy to implement at the state level. To start, the complicated eligibility tests should be simplified. Texas ostensibly wants everyone who is eligible for Medicaid to enroll in it although in the present budget crisis, this is apparently no longer true.<sup>244</sup> Yet Texas *should* want everyone who is eligible to receive Medicaid to do so. Reasonable access to health care helps low income people keep their jobs and helps the economy in the process. Therefore, Medicaid is now directed not only toward those who are unlikely to be in the job market—low-

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CONSIDERING IN THE FACE OF FISCAL PRESSURES? (June 2002).

241. See *supra* text accompanying notes 235-44.

242. See HCFA, MEDICAID: A BRIEF SUMMARY (2002). Thus, for example, in 1998 elderly Medicaid recipients nationwide, representing 11% of all Medicaid beneficiaries, consumed an average of \$9,800 per person in benefits. *Id.* In the same year, approximately \$8,600 was spent per disabled person, who comprised 18% of all Medicaid beneficiaries nationally. *Id.* Conversely, in 1998 children, who comprised 51% of all Medicaid recipients, consumed only an average of \$1,150 per child nationwide. *Id.* Non-elderly and nondisabled adults, who comprised 21% of all beneficiaries, consumed an average of \$1,775 per person nationwide. *Id.*

243. See *id.*

244. See, e.g., Tex. H.B. 728, 78th Leg., R.S. (1999) (providing for a reduction of children's continuous eligibility for Medicaid to six months).

income elderly and severely disabled individuals—but also toward certain classes of low income workers. But even though Medicaid has been decoupled from cash welfare programs and redirected as a health care program for the working poor, the Byzantine eligibility requirements still appear to be aimed at making enrollment as difficult as possible for potential beneficiaries; this is inexcusable. Medicaid should be easy to obtain for those who need it and to whom the program is directed. While some elements of this problem can only be solved at the federal level, Texas can take steps to fix other elements.

First, the complicated and onerous enrollment process, which each state devises for itself, should be simplified. The Kaiser Family Foundation, a leading organization in the research and development of Medicaid policy, suggests that enrollment can be simplified in the following ways: (1) eliminate the face-to-face interview requirement; (2) accept mail-in applications; (3) reduce the complexity of the application form; and (4) simplify verification requirements.<sup>245</sup> Texas has already taken a good first step in this direction by simplifying the application process for low-income children seeking health insurance, but the other suggestions should be considered as well.<sup>246</sup> Allowing potential beneficiaries to self-declare income would also help ease the burden of continuing enrollment on beneficiaries.<sup>247</sup> It is very difficult for low income, ill, or disabled individuals and families, particularly those who work, to spend half the day at the local welfare office to ensure that their income has not risen above the cut-off point or to prove that their child still lives with them. Applying for Medicaid should be as easy as possible while still allowing the government to reasonably ensure that only eligible individuals and families are obtaining benefits.

Eliminating the asset test for Medicaid applicants would also make the application process more efficient. The asset test looks at what an applicant owns, including real property, household possessions, and automobiles, to ensure that the total value of the applicant's possessions is below a certain amount.<sup>248</sup> In Texas, a Medicaid applicant must demonstrate that she owns no more than \$2,000 worth of property and personal possessions.<sup>249</sup> Also, if she owns a car, it must be worth no more than \$4,650.<sup>250</sup> A study by the Kaiser Family Foundation of the states that have eliminated the asset test for families

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245. MALOY ET AL., *supra* note 187, at 9.

246. One report indicates that Texas officials were planning to consider eliminating the face-to-face interview requirement, as well as the asset test. *See id.* at 105. However, the state budget crisis faced in the 78th regular session scuttled any such plans and in fact rolled back certain aspects of Medicaid simplification passed by the 77th Legislature. *See, e.g.,* Tex. H.B. 728, 78th Leg., R.S. (1999).

247. MALOY ET AL., *supra* note 187, at 14.

248. VERNON K. SMITH ET AL., ELIMINATING THE MEDICAID ASSET TEST FOR FAMILIES: A REVIEW OF STATE EXPERIENCES 2 (2001), available at <http://www.kff.org> (last visited Aug. 30, 2003).

249. *Id.* at 20.

250. *Id.*

shows that the test's elimination not only made it easier for potential beneficiaries to apply for Medicaid, but it also cut down on the administrative cost of processing applications and increased the productivity of case workers.<sup>251</sup> Moreover, the study found that application of the asset test had very little impact on eligibility determinations.<sup>252</sup> Thus, its elimination likely would not result in a significant increase in beneficiaries who otherwise would not be eligible. At the same time, it streamlined the application process, allowing more eligible families to be enrolled at less administrative cost.<sup>253</sup>

Another problem is the connection Texas still makes between application for cash benefits and application for Medicaid benefits. As noted above, Medicaid eligibility used to be tied to eligibility for AFDC, formerly an entitlement program providing cash benefits to impoverished families.<sup>254</sup> With the 1996 change in the welfare laws, AFDC was repealed.<sup>255</sup> In its place, a nonentitlement program—Temporary Aid to Needy Families (TANF)—was enacted, and the tie between TANF cash assistance and Medicaid medical assistance was severed at the federal level.<sup>256</sup> Yet because of the previous tie between cash and medical assistance programs, most states had joint applications for the two, including Texas.<sup>257</sup> When TANF became the law of the land, Texas—along with many other states—lagged in changing its application forms. Thus, a person who wants to apply for Medicaid has to fill out a joint form for Medicaid and TANF (and food stamps as well) even if he does not want or need cash or food assistance.<sup>258</sup> The joint form is relatively lengthy and can be confusing. Moreover, as case workers increasingly tried to discourage people from applying for cash assistance, they also tended to discourage them from applying for Medicaid, even though the federal government (at least) wanted eligible people to take advantage of the Medicaid program.<sup>259</sup> Thus, a significant decline in the number of Medicaid enrollees in Texas started in 1996.<sup>260</sup> Only in 2002 did the caseload return to pre-TANF levels.<sup>261</sup>

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251. *Id.* at 10-11, 13.

252. *Id.* at 8, 14.

253. *Id.* at 11.

254. *See* MALOY ET AL., *supra* note 187, at 9.

255. *Id.*

256. *Id.*

257. *See, e.g.*, Claudia Schlosberg & Joel D. Ferber, *Access to Medicaid Since the Personal Responsibility and Work Opportunity Reconciliation Act 31, No. 9-10*, CLEARINGHOUSE REV. 528 (1998).

258. *See, e.g., id.*; Associated Press, *Federal Audit Finds Poor Families Being Improperly Denied Medicaid Benefits*, POCONO RECORD (1999), available at <http://www.pocorecord.com/1999/topstory/bhk08963.htm> (last visited Sept. 1, 2003).

259. *See, e.g.*, Schlosberg & Ferber, *supra* note 257; Associated Press, *supra* note 258.

260. *See* TEX. DEP'T OF HUMAN SERVS., TEXAS MEDICAID ENROLLMENT STATISTICS FOR SELECTED TIME PERIODS (2002), available at <http://www.hhsc.state.tx.us/research/dssi/McaidMnthlyUpdate.html> (last visited Aug. 13, 2002).

261. *Id.*



To remedy these issues, it appears that the TANF and Medicaid application processes should be entirely decoupled, but this may be easier said than done. In order to calculate eligibility for various aid programs, Texas relies on computerized programs that analyze data concerning each applicant and produce an eligibility determination.<sup>262</sup> Presently, the data used in TANF calculations and Medicaid calculations are shared.<sup>263</sup> This helps prevent having to enter data multiple times in order to calculate one person's eligibility for multiple programs.<sup>264</sup> Decoupling the systems entirely would therefore likely lead to increased administrative staff time.<sup>265</sup>

Nevertheless, failure to decouple the systems not only further confuses the Medicaid application process, but it also increases the stigmatization of Medicaid recipients as "welfare" clients. In some areas of the country, it has also resulted in faulty Medicaid eligibility determinations given that the rules for TANF eligibility and Medicaid eligibility can differ, yet sometimes state systems have erroneously applied the eligibility standards of the one to the other.<sup>266</sup> The significant nature of the problems with retaining vestigial links between the TANF and Medicaid determination systems calls for either decoupling the two systems or ensuring that the Medicaid determination systems are updated in a timely fashion to help avoid incorrect determinations based on irrelevant TANF considerations.<sup>267</sup> To date, Texas has decoupled only children's applications for Medicaid benefits from TANF and food stamp applications.<sup>268</sup> Now, children need fill out only one application for public health insurance, which will allow Texas to determine whether they qualify for Medicaid or Texas's CHIP.<sup>269</sup> But applications for adult Medicaid still remain consolidated with the application for TANF and food stamps.<sup>270</sup>

After simplifying the enrollment process and making it less inconvenient for individuals and families to apply for aid, the focus should shift to publicizing Medicaid's benefits and requirements for enrollment to likely populations and making enrollment forms easier to obtain. While many, if not most, low-income individuals and families are aware that the Medicaid program exists, they may not know how to go about applying for it or where to obtain the forms.<sup>271</sup> They may also not be aware that Medicaid has been

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262. MALOY ET AL., *supra* note 187, at 105.

263. *Id.*

264. *See id.*

265. *See* Schlosberg & Ferber, *supra* note 257.

266. *See id.*

267. *See id.*

268. *See, e.g.*, TEX. HEALTH & HUMAN SERVS. COMM'N, CHILDREN'S MEDICAID SIMPLIFICATION—SENATE BILL 43 PROPOSED IMPLEMENTATION OUTLINE, available at [http://www.hhsc.state.tx.us/chip/SB43/SB43\\_Simplification\\_Intro.html](http://www.hhsc.state.tx.us/chip/SB43/SB43_Simplification_Intro.html) (last visited Aug. 29, 2002).

269. *See, e.g., id.*

270. *See, e.g., id.*

271. For example, one study found that, among the elderly, many lack basic information about the program and about who qualifies. *See* MICHAEL J. PERRY ET AL., BARRIERS TO MEDICAID ENROLLMENT

decoupled from cash welfare or may mistakenly think, if they are immigrants, that applying for Medicaid will jeopardize their immigration status.<sup>272</sup> Even if they are aware that they may qualify for aid and know where to apply, they may refrain from doing so, given the complexity of the process and the need to travel to a welfare office for an interview.<sup>273</sup> Toward the latter end, Kaiser suggests widely disseminating news that the application process has been simplified.<sup>274</sup> News that Medicaid eligibility is not necessarily contingent on eligibility for TANF and that applying for Medicaid will not endanger a person's immigration status should also be publicized. Yet disseminating this news is not enough; obtaining application forms must also be made more convenient. States should publicize Medicaid's benefits and an overview of eligibility requirements in each locality's commonly spoken languages, and states should also make multilingual enrollment forms available near the entrances of all grocery stores and on the notice boards of all parks and community centers.

Of course, potential beneficiaries also need to take responsibility. Those who believe they or their family members might be eligible for Medicaid should apply for Medicaid promptly, before they need it, rather than waiting until they or their family members become ill or injured. Retaining eligibility, once it has been established, is not as difficult as the initial application process. Medicaid beneficiaries also—just like everyone else—have a responsibility to use their benefits judiciously. The program costs more money the more that benefits are used. Yet the state Medicaid budget is not limitless. In the present economic climate, it is more important than ever for enrollees to act responsibly in their use of benefits. Enrollees should be educated concerning this matter. Judicious use of scarce resources will conserve more for everyone.

It is also important for the legislature to carefully consider what steps it wishes to take to keep both Medicaid and the state budget solvent. While the legislature may be tempted to make cuts in provider reimbursement, this would not be a good choice.<sup>275</sup> Cuts in provider revenues will almost certainly have an adverse effect on services. Doctors and other health care providers are already reimbursed at very low levels for providing health care to

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FOR LOW-INCOME SENIORS 2 (2002), available at <http://www.kff.org> (last visited Sept. 1, 2003).

272. See, e.g., Schlosberg & Ferber, *supra* note 257.

273. One study found this to be the case among senior citizens. See *id.*; Marilyn Ellwood, *Medical Eligibility Maze, The Coverage Expands, but Enrollment Problems Persist* (1999), available at [http://www.urban.org/url.\(fm?10=309273\)](http://www.urban.org/url.(fm?10=309273)) (last visited Sept. 2, 2003).

274. SMITH ET AL., *supra* note 248, at 11.

275. Federal funds will limit cuts in provider reimbursement rates enacted in the 78th regular session to 2.5% from a previous level of 5%. See Gary Susswein, *Decision Frees Up Health Money*, AUSTIN-AM. STATESMAN (2003), available at <http://www.statesman.com/legislature/content/coxnet/texas/legislature/0803/0806perry.html> (last visited Aug. 6, 2003).

Medicaid beneficiaries, and sometimes they even lose money in the process.<sup>276</sup> As one nursing home official commented in connection with his state's proposed 5% reimbursement cut, "I think we're at a desperation point."<sup>277</sup> His company decided to close one of its four nursing homes because of fiscal losses from providing care to Medicaid patients.<sup>278</sup> Health care providers cannot indefinitely provide health care to Medicaid beneficiaries at a loss, and many providers may go out of business or stop providing care to Medicaid patients if they cannot recoup funds in other ways.<sup>279</sup>

If Medicaid is to remain viable, providers must be reimbursed sufficiently well to make at least a modest profit. Texas should thus attempt to achieve cost savings by other means, such as by stepping up Medicaid fraud detection.<sup>280</sup> House Bill (H.B.) 1743, enacted in the 78th Regular Session, should assist in the latter regard by expanding Medicaid fraud and abuse detection mechanisms and enforcement authority, as well as by expressly providing that an offense may be a state felony meriting a jail sentence.<sup>281</sup>

Steps such as one taken in the 77th session may have adverse effects on the Medicaid program.<sup>282</sup> H.B. 3038, which was passed and signed into law, provides for payment of group health insurance premiums and cost-sharing requirements for individuals who are eligible for both state medical assistance (through Medicaid or CHIP) and enrollment in a group health plan.<sup>283</sup> When such individuals are eligible for group health coverage only if another non-Medicaid eligible individual is enrolled in the group health plan, the act authorizes the Texas Department of Health to pay for the noneligible individual's premium (but not any cost-sharing requirements) as well.<sup>284</sup>

Putting aside the issue of likely needing to obtain a federal waiver to receive matching funds for the schema implemented by H.B. 3038, a number of issues inhere with this approach.<sup>285</sup> On one hand, H.B. 3038 signals a

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276. See, e.g., M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 109-10 (2001) (noting that, while the Boren Amendment once required states to reimburse providers at "reasonable" levels, low reimbursement rates to providers in the Medicaid program have become "entrenched" since its repeal).

277. Andrew Caffrey, *Regional Report: States Seek to Curb Medicaid Costs*, WALL ST. J., Feb. 7, 2001, at B13, available at 2001 WL WSJ2853539.

278. *Id.*

279. See *id.*

280. See *id.*; Tex. H.B. 1743, 78th Leg., R.S. (2003).

281. See Tex. H.B. 1743, 78th Leg., R.S. (2003).

282. See Tex. H.B. 3038, 77th Leg., R.S. (2001).

283. See *id.* S.B. 240 amended H.B. 3038, as enacted, by making enrollment in the program optional, rather than mandatory, for eligible beneficiaries. See Tex. S.B. 240, 78th Leg., R.S. (2003).

284. See Tex. H.B. 3038, 78th Leg., R.S. (2001). Note that S.B. 240, enacted in the 78th regular session, made the program optional for those in CHIP and changed "premium reimbursement" into "premium assistance." See Tex. S.B. 240, 78th Leg., R.S. (2003).

285. See, e.g., TEX. CHIP COALITION, CHIP BACKGROUND, available at <http://www.main.org/txchip/page2.html> (last visited Sept. 2, 2003).

strong commitment to a private system of health insurance.<sup>286</sup> It is also expected to lead to savings in both the Medicaid and CHIP programs.<sup>287</sup> It furthermore may allow some people who may not be eligible for Medicaid and who cannot afford other health insurance coverage to obtain coverage “on the back” of a Medicaid-eligible family member.<sup>288</sup> But on the other hand it may require some Medicaid-eligible individuals who may be inappropriate for private health insurance to be shunted into the system.<sup>289</sup>

With respect to the ability of enrollees to receive benefits, H.B. 3038 may not be problematic.<sup>290</sup> If the private health plan in which a beneficiary is enrolled does not offer certain services that are otherwise available under Medicaid, then Medicaid will cover those services separately for the beneficiary.<sup>291</sup> But children with special needs, disabled or elderly adults, and pregnant women will likely add significant costs to employers’ health insurance. This is particularly troubling in light of the current precipitous rise in health insurance premiums.<sup>292</sup> It is not reasonable for the state, in an attempt to lower its own health care costs, to significantly add to the costs of employers or to threaten access to health insurance for *all* employees of the affected employers. As discussed above, many employers who face rising health insurance premiums are considering dropping all health insurance coverage for their employees.<sup>293</sup> It would be terrible if employers were forced to drop coverage for all their employees because people who cannot reasonably be cared for in the private health insurance market are nevertheless forced into it by legislative act.

Medicaid is an essential program for those with significant health and financial needs. It provides access to health care for those who are least able to otherwise obtain it otherwise. Without Medicaid, society’s most impoverished, elderly residents would not be able to afford nursing home care.<sup>294</sup> One-third of the nation’s children would be uninsured.<sup>295</sup> This program must be preserved and maintained. Yet the program must be made easier to use for everyone. This does not mean eligibility expansion. Rather, arcane requirements, which do little to weed out the ineligible while making the program needlessly complex for both applicants and case workers, must be eliminated. Federal and state governments should simplify eligibility

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286. See Tex. H.B. 3038, 77th Leg., R.S. (2001).

287. See, e.g., JOHN KEEL, FISCAL NOTE, Tex. H.B. 3038, 77th Leg., R.S. (2001), available at <http://www.capitol.state.tx.us> (last visited Sept. 2, 2003).

288. *Id.*

289. *Id.* The program, on the other hand, is optional for those in Texas’s CHIP. See *supra* note 284 and accompanying text.

290. See Tex. H.B. 3038, 77th Leg., R.S. (2001).

291. See *id.*

292. See discussion *supra* Part III.A.

293. See discussion *supra* Part III.A.

294. See *supra* note 242 and accompanying text.

295. See *supra* note 242 and accompanying text.

requirements and enrollment procedures for the Medicaid program. Beneficiaries can help by signing up for benefits when they are healthy, rather than waiting until they need services. They can further help by communally thinking in their use of benefits. By making judicious rather than wasteful use of benefits, beneficiaries can help preserve the program not only for themselves but also for everyone who is eligible to participate.

## 2. SCHIP

SCHIP helps fill some of the gaps in Medicaid coverage, but only for children.<sup>296</sup> SCHIP is a joint federal and state program that generally covers children up to age nineteen in families who have income that is less than 200% of the FPL (e.g., \$36,800 for a family of four in 2003) and who lack private coverage.<sup>297</sup> But the 78th Texas Legislature effectively lowered the program's income limits in Texas to 150% of the FPL (e.g., \$27,600 for a family of four in 2003), effective September 1, 2003.<sup>298</sup>

SCHIP began in 1997 as a politically-palatable means of providing health coverage through a joint federal and state program to more children than were then covered under Medicaid.<sup>299</sup> While enough federal legislators could agree that children should have health care coverage, even if their parents fail to take full financial responsibility for providing it, they wished to provide coverage in a way that would not indefinitely obligate them to provide for all comers.<sup>300</sup> Thus, in contrast to the Medicaid program, the 1997 legislation enacting SCHIP created no entitlement.<sup>301</sup> This means that, for example, Texas may, if it wishes, choose to delay or even cap new enrollment for children rather than providing for all eligible applicants.<sup>302</sup> As discussed below, this flexibility will likely yield unfortunate consequences for many children who were enrolled or who wished to enroll in Texas's CHIP in the coming biennium.

Texas's CHIP provides comprehensive medical services to children in exchange for a small annual fee and cost-sharing requirements, set on a sliding scale based on income.<sup>303</sup> While it allows for variations among each state's

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296. See, e.g., TEX. CHIP COALITION, *supra* note 285.

297. *Id.*

298. See Tex. H.B. 2292, 78th Leg., R.S. (2003). For the federal poverty guidelines, see U.S. DEP'T OF HEALTH & HUMAN SERVS., THE 2003 HHS POVERTY GUIDELINES, available at <http://aspe.hhs.gov/poverty/03poverty.htm> (last visited Sept. 3, 2003).

299. See, e.g., Robert Tannenwald, *Implications of the Balanced Budget Act of 1997 for the "Devolution Revolution,"* PUBLIUS (1998), available at 1998 WL 25350906.

300. *Id.*

301. See, e.g., Sara Rosenbaum et al., *Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals an Impact on Low-Income Children*, 1 HOUS. J. HEALTH L. & POL'Y 33, 34 (2001).

302. *Id.*

303. See TEX. CHIP COALITION, *supra* note 285.

benefit packages, federal law requires that benefits include at least “inpatient and outpatient hospital services; physicians’ surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations.”<sup>304</sup> Additional services include “prescription drug coverage, mental health services, and vision and hearing services.”<sup>305</sup> Texas provides coverage in all these categories.<sup>306</sup> It also covers items such as durable medical equipment; disposable medical supplies; certain home- and community-based health care services; nursing care services; dental care services; substance abuse treatment services; case management and care coordination services; physical, occupational, and speech therapy; children’s hospice services; emergency medical services; an annual routine eye examination; and smoking cessation services.<sup>307</sup> The value of the benefits provided must meet certain requirements under federal law.<sup>308</sup> In accordance with these requirements, Texas required the benefit package—at least when first implemented—to be “actuarially equivalent . . . to the basic plan for active state employees offered through health maintenance organizations under the Texas Employees Uniform Group Insurance Benefits Act.”<sup>309</sup>

Texas, as all other participating states, determines the amount it wishes to spend on its CHIP.<sup>310</sup> The federal government will match these funds at a rate of more than \$3 for every \$1 that Texas spends, up to a certain maximum level.<sup>311</sup> If the number of eligible people attempting to access the program exceeds the funds available to pay for them, Texas must either come up with the extra money to fund services for them or start limiting or denying access.<sup>312</sup> Also, because those eligible for the program have no federal entitlement to SCHIP, the federal government can choose how much or how little it wishes to fund the program, thus ultimately leading to limits on the amount of matching money it provides to each participating state.<sup>313</sup> Presently, the federal government has appropriated \$40 billion for the program to be spent across all participating states over ten years.<sup>314</sup>

The Texas CHIP program faces problems in the present economic downturn. Because it is not an entitlement program, Texas can stop providing

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304. See 42 U.S.C. § 1397cc(c) (2000).

305. *Id.*

306. See, e.g., *TEXCARE P'SHIP, CHILDREN'S HEALTH INSURANCE PROGRAM*, available at <http://www.texcarepartnership.com/CHIP-CHIP-Page.htm> (last visited Sept. 3, 2003).

307. See STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOC. SEC. ACT, STATE CHILDREN'S HEALTH INSURANCE PROGRAM 23-26 (1999), available at <http://www.hhsc.state.tx.us/chip/cleg/phase2.html> (last visited Sept. 3, 2003).

308. See 42 U.S.C. § 1397cc(a)-(b).

309. TEX. HEALTH & SAFETY CODE ANN. § 62.151 (Vernon 2001).

310. TEX. CHIP COALITION, *supra* note 285.

311. See, e.g., *id.*

312. *Id.*

313. TEX. HEALTH & SAFETY CODE ANN. § 62.003(a) (Vernon 2001).

314. TEX. CHIP COALITION, *supra* note 285.

coverage or enrolling new children as the money dries up.<sup>315</sup> The federal government, to the extent it is able, has taken few steps to address this issue. Under current law, states that do not use all the federal funds allocated to them for SCHIP for the prior three years must return the money.<sup>316</sup> In February 2002, President Bush proposed lifting this requirement.<sup>317</sup> The White House calculated that, across all states, this plan would allow \$3.2 billion in federal SCHIP funding to remain in states' coffers for use in their children's health insurance programs.<sup>318</sup> But the catch is that states must put up their own funds in order to receive the federal matching funds.<sup>319</sup>

Notably, Bush's proposal was not implemented, and Texas accordingly lost \$285 million in federal funds appropriated for SCHIP.<sup>320</sup> Even if Bush's proposal had indeed been implemented it likely would not have mattered to Texas. In the present economic downturn, Texas has contracted, rather than expanded, its CHIP budget.<sup>321</sup> For a short time, the 78th Texas Legislature considered dropping Texas's CHIP altogether.<sup>322</sup> Instead, it directed the Texas Health and Human Services Commission to restrict enrollment to those earning only up to 200% of the FPL.<sup>323</sup> The legislature also reduced the period of continuous eligibility from twelve months to six months and imposed a three month waiting period for coverage to become effective.<sup>324</sup> It is estimated that these measures will reduce Texas's CHIP caseload by 170,000 children, from 516,000 (2003 enrollment) to 346,000 (projected 2005 enrollment).<sup>325</sup>

This is an unfortunate state of affairs, as Texas's CHIP was already significantly under-enrolled. In FY 2000, 130,519 children were enrolled in Texas's CHIP program.<sup>326</sup> Over one million Texas children through age

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315. TEX. HEALTH & SAFETY CODE ANN. § 62.003(a).

316. See, e.g., White House, *Innovative Health Care Options in Medicaid and the State Children's Health Insurance Program*, available at <http://www.whitehouse.gov/infocus/medicare/health-care/health-medicaid.html> (last visited Feb. 12, 2002).

317. *Id.*

318. *Id.*

319. See 42 U.S.C. §§ 1397aa(a), 1397ee (2000).

320. See Karen Masterson, *Texas Loses Millions in Health Care Funds/Other States to Receive Unused Money*, HOUS. CHRON., Oct. 16, 2002, at 1, available at 2002 WL 23230536.

321. Gary Susswein, *House Budget Cutters Rethink Slashing of Services; Some Fiscal Conservatives Raise Concerns About How Cuts Would Affect Neediest*, AUSTIN-AM. STATESMAN, Mar. 21, 2003, at A1, available at 2003 WL 3011278.

322. *Id.*

323. See Tex. H.B. 2292, 78th Leg., R.S. (2003).

324. *Id.*

325. See CTR. FOR PUB. POL'Y PRIORITIES, MEDICAID AND CHIP CUTS WOULD REDUCE TEXAS '04 AND '05 SPENDING BY AT LEAST \$10 MILLION (2003), available at <http://www.cppp.org/products/policy/pages/171-190/171-190html/PP186.html> (last visited Sept. 21, 2003).

326. CTR. FOR MEDICARE & MEDICAID SERVS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM ANNUAL ENROLLMENT REPORT (2002), available at <http://cms.hhs.gov/schip/schip01.pdf> (last visited Sept. 21, 2003). The number has since increased significantly. See DEP'T OF HUMAN SERVS. REP., CHIP ENROLLMENT AND REFERRALS (2002) (reporting an enrollment of 529,143 children).

eighteen were enrolled in Medicaid in 2000.<sup>327</sup> According to the U.S. Census Bureau, an average of 2,768,000 Texas children lived in families earning 200% of the FPL or less in 1998, 1999, and 2000.<sup>328</sup> Thus, during those years, well over one million children in Texas were eligible for either CHIP or Medicaid (provided they did not already have access to private health insurance through their parents or caretakers) but were not enrolled in either program.<sup>329</sup> In fact, it appears that despite their financial eligibility, few of these children were actually insured: the U.S. Census Bureau estimates that the vast majority of these children—973,000, on average—had no health insurance coverage in 1998, 1999, and 2000.<sup>330</sup> While Texas has successfully and dramatically increased its CHIP enrollment in the past two years, an enormous number of children still remain uninsured.<sup>331</sup>

With the notable exceptions of its present focus on contracting eligibility and need to focus greater efforts on outreach to enroll new children and retain children in the program at the end of each enrollment period, Texas has otherwise been doing a relatively good job with CHIP over the past few years. A recent quality of care survey found most parents believed the enrollment application was easy to understand and convenient.<sup>332</sup> Most children were enrolled within two months of the first application.<sup>333</sup> More families reported using doctors' offices and other non-acute sites, rather than emergency rooms, as their primary sites of care after enrolling in CHIP, although room for improvement still exists, particularly among Hispanic children.<sup>334</sup> The quality of health care provided to most enrollment groups was good overall, and children's disenrollment levels are relatively low (though by no means negligible), with less than 2% of families reporting any program dissatisfaction as a reason for disenrolling.<sup>335</sup>

No matter how difficult it may be in tough economic times, Texas needs to make its CHIP program a priority. Hundreds of thousands of children in Texas are eligible for CHIP yet are still not enrolled.<sup>336</sup> Children who are

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327. U.S. Census Bureau, Table HI05. Health Insurance Coverage Status and Type of Coverage by State for All People: 2000, available at [http://ferret.bls.census.gov/macro/032001/health/h05\\_000.htm](http://ferret.bls.census.gov/macro/032001/health/h05_000.htm) (last visited Sept. 21, 2003). Presently, 1,395,579 children ages eighteen and under are enrolled in Medicaid. See TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID ENROLLMENT (ALL AGES AND AGES 0-18) (2002), available at [http://www.hhsc.state.tx.us/research/dssi/db\\_search/regionsearch.asp](http://www.hhsc.state.tx.us/research/dssi/db_search/regionsearch.asp) (last visited Sept. 21, 2003).

328. U.S. Census Bureau, Low-Income Uninsured Children by State, 1998, 1999 and 2000, available at <http://www.census.gov/hhes/hlthins/liuc00.html> (last visited Sept. 21, 2003).

329. See *id.*

330. *Id.*

331. *Id.*

332. ELIZABETH SHENKMAN ET AL., QUALITY OF CARE IN THE CHILDREN'S HEALTH INSURANCE PROGRAM IN TEXAS, Vol. 1, 4 (2002).

333. *Id.*

334. *Id.* at 4-5, 8-9.

335. *Id.* at 10-14.

336. See, e.g., TEXCARE P'SHIP, TEXCARE PARTNERSHIP OUTREACH: A VISION FOR NEXT STEPS



uninsured risk health problems through delayed or skipped care and are also more likely to miss school than children with insurance.<sup>337</sup> They are more likely to use the emergency room, at greatly increased cost to Texas residents, than insured children.<sup>338</sup> A recent report also details the economic consequences of cuts in both Medicaid and Texas's CHIP, finding that for every dollar cut state tax revenues will drop by \$0.46, local taxes will rise by \$0.51, health insurance premiums will increase by \$1.34, and the Texas health care system will lose \$2.81 in federal funds, among other consequences.<sup>339</sup>

Texas needs to continue to ensure that as many of Texas's children as possible have access to health insurance through the CHIP program, notwithstanding budget crises.<sup>340</sup> Texas also needs to emphasize the importance of retaining coverage once children are enrolled.<sup>341</sup> The legislature needs to resist shrinking funding and roll back cuts and restrictions imposed in the 78th regular session.<sup>342</sup> Texas should also devote further efforts to outreach, particularly in the Hispanic community.<sup>343</sup> Outreach should entail not merely education about Texas's CHIP but should also entail education on the importance of having a consistent primary care giver and on the importance of retaining coverage once it is attained.<sup>344</sup>

### C. Indigent Health Care

This section concerns those who lack health insurance altogether. Lacking health insurance does not necessarily mean that one has no access to health services. Theoretically, those persons exist who could pay for any medical care they please and get the service and attention they want.<sup>345</sup> But it is unknown how many Texans provide for their health care in this manner. Concierge services are one variant of this: while those who enroll in such services usually have health insurance, they pay an added fee—\$4,000 per

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(2001).

337. See, e.g., *id.*

338. See *id.*; ELIZABETH SHENKMAN, AN ANALYSIS OF DISENROLLMENT PATTERNS IN THE CHILDREN'S HEALTH INSURANCE PROGRAM IN TEXAS 4-5 (2002), available at <http://www.ichp.edu/ResearchPDF/DisenrolleeReport-4-02.pdf> (last visited Sept. 21, 2003).

339. THE PERRYMAN GROUP, MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP): AN ASSESSMENT OF THEIR IMPACTS ON BUSINESS ACTIVITY AND THE CONSEQUENCES OF POTENTIAL FUNDING REDUCTIONS (2003), available at <http://www.thaonline.org/downloads/PerrymanReport.pdf> (last visited Sept. 21, 2003).

340. See Susswein, *supra* note 321, at A1 (discussing proposed budget cuts which are being considered and which cuts would eliminate CHIP).

341. See, e.g., SHENKMAN, *supra* note 338, at 5.

342. See Susswein, *supra* note 321.

343. See SHENKMAN, *supra* note 338, at 29.

344. See, e.g., *id.* at 5.

345. See *id.*

year for an individual and \$7,500 for a family—for extra services and attention from their physician, which health insurance will not cover.<sup>346</sup>

Others who pay cash for their medical services are not rich; in fact, they are far from it. Rather, they may, by choice or necessity, lack health insurance coverage. People who are employed in positions that either lack health insurance or that require a large employee contribution often fall into this category.<sup>347</sup> They may be young and healthy and gamble on not needing a physician's ministrations. Or they may be older and less healthy but still make the same gamble, perhaps choosing between having health insurance coverage or housing and food. Others may have lost their job, through which they had health insurance, and cannot afford to continue their coverage through COBRA, a federal law that allows most former employees to continue their employer-sponsored health insurance after they leave their job, as long as they timely pay the premium that was paid by their former employer, plus administrative costs.<sup>348</sup>

The problem for such individuals is that the so-called "safety net" for health care needs contains gaping holes, allowing many people to fall through.<sup>349</sup> What happens to the adults and children in Texas who lack health insurance? The lucky ones, of course, manage to get by without medical attention. If they need certain limited health care services, such as vaccinations or family planning assistance, they may be able to receive it through their local public health department.<sup>350</sup> They may also be able to obtain some services through a federally funded community health clinic, if one exists near them.<sup>351</sup> Such clinics offer certain health care services to the uninsured on a sliding scale basis.<sup>352</sup> But if they need comprehensive medical care, only one publicly-funded option potentially remains to them: Indigent Health Care Programs (IHCPs) operated at the county level.<sup>353</sup> These programs cover only the poorest of the poor—usually only those making less than 21% of the FPL,<sup>354</sup> with assets totaling less than \$2,000.<sup>355</sup> Moreover,

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346. Friedman, *supra* note 36.

347. See KAISER FAMILY FOUND. ON MEDICAID AND THE UNINSURED: THE UNINSURED AND THEIR ACCESS TO HEALTH CARE I (Jan. 2003), available at <http://www.kff.org> (last visited July 24, 2003) (noting that 82% of the uninsured are in working families, with 70% in a family with at least one full time worker and 12% in a family with at least one part time worker).

348. U.S. DEP'T OF LABOR, HEALTH PLANS AND BENEFITS: CONTINUATION OF HEALTH COVERAGE—COBRA, at <http://www.dol.gov/dol/topic/health-plans/cobra.htm> (last visited Sept. 1, 2003).

349. See KAISER FAMILY FOUND., *supra* note 347, at 2.

350. See Tex. Dep't of Health, *Texas Department of Health: Public Health Region 1 Programs and Services*, at <http://www.r01.tdh.state.tx.us/proginfo.htm> (last visited Sept. 21, 2003).

351. See *infra* note 450 and accompanying text.

352. See Jeannie Kever, *Assurance for the Uninsured: Safety net exists, but people still fall through cracks*, Hous. Chron., May 5, 2002, at D1, available at 2002 WL 3260872.

353. See CATON FENZ, PROVIDING HEALTH CARE TO THE UNINSURED IN TEXAS: A GUIDE FOR COUNTY OFFICIALS (2000) (discussing, in detail, Texas's Indigent Health Care Programs).

354. TEX. HEALTH & SAFETY CODE ANN. § 61.006 (Vernon Supp. 2003).

355. 25 TEX. ADMIN. CODE § 14.105(b)(2) (Vernon 2003).

they only cover those individuals who have no other source of payment for health care.<sup>356</sup> If a person seeking assistance through an IHCP is found likely to qualify for Medicaid, SCHIP, or another program and has not already been denied access by that other program, the person will be directed to seek assistance through those programs rather than through the IHCP.<sup>357</sup>

A county may operate its IHCP through one or more hospital districts or public hospitals.<sup>358</sup> In the absence of either of the above, it can simply have a County Indigent Health Care Program (CIHCP).<sup>359</sup> By state law, a CIHCP must provide, at a minimum, the following “basic” services:

- (1) primary and preventative services designed to meet the needs of the community, including:
  - (a) immunizations;
  - (b) medical screening services; and
  - (c) annual physical examinations;
- (2) inpatient and outpatient hospital services;
- (3) rural health clinics;
- (4) laboratory and X-ray services;
- (5) family planning services;
- (6) physician services;
- (7) payment for three prescription drugs a month; and
- (8) skilled nursing facility services, regardless of the patient's age.<sup>360</sup>

A public hospital or hospital district must only “endeavor” to provide the services listed above.<sup>361</sup> CIHCPs are required by state law to cover a maximum of \$30,000 per year in medical expenses per eligible indigent county resident.<sup>362</sup> Public hospitals and hospital districts are not subject to the same mandate, except when they cannot provide the services that an indigent resident requires and when the indigent resident obtains the services from a different provider.<sup>363</sup>

A county may provide more services than those listed above.<sup>364</sup> But for those with a CIHCP (rather than a hospital district or public hospital), their incentive to do so is limited.<sup>365</sup> Counties with a CIHCP receive matching funds from the state government for all basic qualified service expenditures

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356. TEX. HEALTH & SAFETY CODE ANN. § 61.023(a)(3).

357. 25 TEX. ADMIN. CODE § 14.101(m) (2003).

358. See TEX. HEALTH & SAFETY CODE ANN. §§ 61.029(a), (b).

359. *Id.* §§ 61.021, 61.022.

360. *Id.* § 61.028.

361. *Id.* §§ 61.054, 61.055.

362. 25 TEX. ADMIN. CODE § 14.204(c).

363. TEX. HEALTH & SAFETY CODE ANN. § 61.061.

364. See *id.* § 61.0285 (Vernon Supp. 2003).

365. See *id.* §§ 61.036, 61.0285(b), (c).

exceeding 8% of their annual general revenue tax levy.<sup>366</sup> After a county reaches this threshold, the state will provide \$0.90 for each qualified dollar the county spends in excess of the threshold.<sup>367</sup> While a county may receive matching funds from the state for expenditures made on basic qualified services for qualified county residents, the state will not count funds spent on any additional services or expended on residents whose income or assets exceed the maximum eligibility requirements established by state law.<sup>368</sup> Presently, only expenditures for those county residents earning less than 50% of the FPL, after deductions, and whose countable resources total no more than \$2,000 (\$3,000 for families with an elderly or disabled member), count toward the 8% figure needed to receive state matching funds.<sup>369</sup> CIHCP counties, such as Travis, which provide services to county residents whose income exceeds 50% of the FPL cannot, pursuant to present state law, receive state assistance in their care for these additional residents.<sup>370</sup> Counties operating a hospital district or public hospital, on the other hand, have greater diversity in their funding sources.<sup>371</sup> Such sources include local tax revenues, state payment through the Tertiary Care Fund, patient payments, public and private health insurance, and certain forms of federal funding.<sup>372</sup>

As noted above, few counties in Texas provide more than the mandatory minimum of care for the indigent population.<sup>373</sup> But those providing more contain a substantial percentage of the Texas population.<sup>374</sup> Preliminary projections from an ongoing study of eligibility criteria for each Texas county's IHCP indicate that approximately half the population of Texas lives in a county whose CIHCP provides care for those earning up to 50% of the FPL, and more often double that.<sup>375</sup> Some of those counties, including the largest, such as Harris and Dallas, provide free or subsidized care to those earning up to 250% of the FPL.<sup>376</sup>

On the other hand, Texas has counties that provide only the minimum level of services to the minimum spectrum of indigent residents, such as Atascosa, Medina, and Hidalgo, which were so strapped for funds in 2001 that

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366. See *id.* § 61.036.

367. See FENZ, *supra* note 353, at 20.

368. See TEX. HEALTH & SAFETY CODE ANN. §§ 61.036, 61.0285(b), (c) (Vernon Supp. 2003).

369. 25 TEX. ADMIN. CODE § 14.1 (Vernon 2001).

370. See TEX. HEALTH & SAFETY CODE ANN. § 61.023(b).

371. FENZ, *supra* note 353, at 15, 18.

372. *Id.*

373. See letter from Rene Murdock, IHCP Coordinator, Wood County Central Hospital District Indigent, to Laura Hermer (Feb. 13, 2002) (on file with the authors) (showing that Wood County provides less than the minimum amount of care mandated by state law and has stricter income and asset guidelines than those set forth by state law).

374. See Laura D. Hermer, *County Population Worksheet* (on file with Texas Tech Law Review).

375. See *id.*

376. *Id.*

they had to shut down their CIHCPs midway through the year.<sup>377</sup> If some Texas counties can provide health care to a far broader spectrum of residents than the minimum mandated under Texas law, and do so without going broke, why cannot all Texas counties do so?

While at first it would seem that counties with more inclusive indigent care programs must spend a correspondingly greater amount on their programs, an analysis of the data suggests this is not the case. Rather, counties such as Travis that, in conjunction with the City of Austin, provide free care for qualifying residents earning up to 100% of the FPL and care on a sliding scale for those earning up to 200% of the FPL, appear to spend only 6% to 10% of their general fund on their CIHCP.<sup>378</sup>

Travis County and the City of Austin (as the program is jointly run by both entities), with a 2000 population of 812,280,<sup>379</sup> budgeted over \$59 million between them to fund their Medical Assistance Program (MAP) and other charity care in FY 2002.<sup>380</sup> The City of Austin's MAP provides not only the general services mandated by Texas law to be included in all county indigent health programs, but also occupational, physical, and speech therapy; specialty physician services; home health services; certain durable medical equipment and supplies; expanded pharmacy services; dental services; and transportation services.<sup>381</sup> The City of Austin and Travis County also run Community Health Centers (CHCs) that provide primary care, as well as dental, social, pharmaceutical, and family planning services.<sup>382</sup> The City of Austin's Department of Health and Human Services estimates that the CHCs handle 100,000 to 120,000 visits per year.<sup>383</sup>

The City of Austin's portion of the indigent health care budget will total over \$45 million in FY 2002—a substantial sum.<sup>384</sup> Nevertheless, it comprises only 9.7% of the city's general funds, which were \$466.4 million in FY

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377. David Eggert, *Indigent Care Program Goes Broke in Atascosa*, SAN ANTONIO EXPRESS NEWS, June 1, 2001, at 01B, available at 2001 WL 17176885.

378. See TOBY HAMMETT FUTRELL, CITY MANAGER'S PROPOSED BUDGET, FY 2002-2003 (2002), available at [http://www.cityofaustin.org/budget/02-03/downloads/ab0203\\_policy.pdf](http://www.cityofaustin.org/budget/02-03/downloads/ab0203_policy.pdf) (last visited July 24, 2003); CHRISTIAN R. SMITH & LEROY NELLIS, FY 2003 ADOPTED BUDGET (2002) available at [http://www.co.travis.tx.us/planning\\_budget/2003budget/volume1/03adopted\\_exesummary.pdf](http://www.co.travis.tx.us/planning_budget/2003budget/volume1/03adopted_exesummary.pdf) (last visited July 24, 2003).

379. See U.S. CENSUS BUREAU: QUICK TABLES: TRAVIS COUNTY, TEXAS, available at [http://factfinder.census.gov/servlet/BasicFactsTable?\\_lang=en&\\_vt\\_name=DEC\\_2000\\_PL\\_U\\_GCTPL\\_ST2&\\_geo\\_id=05000US48453.html](http://factfinder.census.gov/servlet/BasicFactsTable?_lang=en&_vt_name=DEC_2000_PL_U_GCTPL_ST2&_geo_id=05000US48453.html) (last visited Mar. 8, 2002).

380. AUSTIN/TRAVIS COUNTY HEALTH & HUMAN SERVS. DEP'T, CITY OF AUSTIN & TRAVIS COUNTY FY 2002 AMENDED BUDGET FOR INDIGENT HEALTH CARE SERVICES (Mar. 7, 2002).

381. AUSTIN/TRAVIS COUNTY HEALTH & HUMAN SERVS. DEP'T, MEDICAL ASSISTANCE PROGRAM HANDBOOK, 8-9 (Dec. 2001).

382. See Community Health Centers, *Primary Care Division*, available at <http://www.ci.austin.tx.us/primarycare/chc.htm> (last visited Mar. 7, 2002).

383. See Community Health Centers, *Key Questions and Answers*, available at [http://www.ci.austin.tx.us/primary\\_care/questions.htm](http://www.ci.austin.tx.us/primary_care/questions.htm) (last visited Mar. 7, 2002).

384. AUSTIN / TRAVIS COUNTY HEALTH & HUMAN SERV. DEP'T, *supra* note 380.

2002.<sup>385</sup> Moreover, the city's property tax rate, at \$0.4597 per \$100 in 2002, is among the lowest of Texas's major metropolitan areas.<sup>386</sup> Additionally, the City of Austin and Travis County's CIHCPs do not receive any state matching funds otherwise available to counties with CIHCPs; rather, funding for the programs substantially comes from city and county revenues.<sup>387</sup> But they do receive several substantial grants from the Texas Department of Health, which help defray certain costs.<sup>388</sup>

The programs' take-up rates may have something to do with the City of Austin and Travis County's ability to have such an expansive program with a minimum of economic pain. For example, the City of Austin's Department of Health and Human Services estimates that the CHCs serve only approximately 35% of Austin's medically underserved population.<sup>389</sup> Actual take-up rates for specific programs are quite low, at least on their face.<sup>390</sup> The City of Austin's 2002 budget estimates that only 1.97% of all indigent residents (i.e., those earning less than 200% of the FPL) received access to hospital, specialty, and home health services through charity care funded by the city in 2000.<sup>391</sup> The budget also estimates that only 5% of all indigent residents received primary care through community medical services and 14.7% through the MAP in 2000.<sup>392</sup>

How many people in Travis County are eligible for the MAP or CHC program? Other than the information that the CHC program serves approximately 35% of the county's medically underserved population, data does not exist to answer this question.<sup>393</sup> Yet the data indicates that 21,425 people were enrolled in either the City of Austin or Travis County's MAP in FY 1999 to 2000.<sup>394</sup> This number comprises only 3.3% of the county's population.<sup>395</sup> While the data does not give the figures for Travis County in particular, 23.3% of all Texans lacked health insurance in 1999.<sup>396</sup> Assuming the percentage lacking health insurance has not changed appreciably in the

385. See Jesus Garza, Austin City Manager, City Manager's Proposed Budget, Fiscal Year 2001-2002 General Fund—2000-01 (2001).

386. *Id.* at T-15.

387. *Id.* at Health & Human Services—Total Budget \$81.5 million.

388. See TEX. DEP'T OF HEALTH, TEXAS DEPARTMENT OF HEALTH CONTRACTS GREATER THAN \$100,000 AS OF APR. 2, 2001.

389. See Garza, *supra* note 385, at Health & Human Services—2001-02.

390. See *id.* at Health & Human Services—2001-02, Program: Indigent Health Care.

391. See *id.* at Health & Human Services—2001-02.

392. See *id.* at Health & Human Services—2001-02, Medical Assistance Program / Primary Care Services.

393. See *id.* at Health & Human Services—2001-02.

394. See AUSTIN / TRAVIS COUNTY MEDICAL ASSISTANCE PROGRAM CITY & COUNTY ENROLLED DEMOGRAPHICS BY MAP PLAN UNDUPLICATED FY 99-00 (Jan. 2001).

395. See, e.g., CITY OF AUSTIN, DEMOGRAPHICS—WITH CENSUS 2000 DATA, MAPS, AND ANALYSIS (2003), at <http://www.ci.austin.tx.us/census/> (last visited July 24, 2003).

396. See U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 1999, at <http://www.census.gov/hhes/hlthins/hlthins99/hi99te.html> (last visited July 24, 2003).

ensuing three years and assuming Travis County has a similar rate of uninsured individuals, this would mean that a significant number of uninsured individuals in Travis County have not enrolled in either MAP or the CHC program.<sup>397</sup> What this reflects is uncertain. While it may mean that many of the uninsured who are otherwise eligible to participate in MAP or the CHC program had no health care needs, it may also reflect the fact that other programs operate in Travis county to care for the indigent that may include those who would otherwise qualify for MAP or the CHC program.

While one may argue that Travis, a more populous county with a correspondingly larger tax base, benefits from economies of scale that are unavailable to smaller counties, one rural county, Fisher, also provides free care to a broader spectrum of its population than most other Texas counties.<sup>398</sup> With only 4,344 people in 2000, Fisher County is rural and would seem no more able to provide for its indigent residents than any other similar county with a hospital district.<sup>399</sup> Yet it has opened its indigent health care program, free of charge, to anyone earning less than 133% of the FPL.<sup>400</sup> Those earning more than 133% of the FPL, but less than 200% of the FPL, can participate in the program on a sliding scale basis.<sup>401</sup> Additionally, the county has a primary health care clinic that provides free services to those earning less than 150% of the FPL and a family planning clinic, free to those earning less than 185% of the FPL.<sup>402</sup> According to Cathy Spencer, the county's grant coordinator, the indigent health care and primary health care programs together serve approximately 400 to 450 people per year—nearly 10% of the county's population.<sup>403</sup>

Two major components contribute to Fisher County's accomplishment of this feat. First, the county employs individuals who are dedicated to finding, writing, and obtaining state and federal grants to fund county health care.<sup>404</sup> Fisher County—like a number of other Texas counties, including Travis—currently receives state grant funding to help offset costs for certain health care programs (like its primary health care program) and is also presently seeking federal funding to help start a multi-county health clinic.<sup>405</sup> Second, it has no physician specialists and cannot provide many major

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397. See Garza, *supra* note 385, at Health & Human Services—2001-02.

398. See FISHER COUNTY HOSP. BD., FISHER COUNTY HOSPITAL DISTRICT INDIGENT HEALTH CARE ASSISTANCE POLICY (2001); FISHER COUNTY HOSP. BD., FISHER COUNTY HOSPITAL DISTRICT CHARITY CARE POLICY (2001).

399. See TEX. STATE LIBRARY AND ARCHIVES COMM'N, 2000 CENSUS: POPULATION OF TEXAS COUNTIES ARRANGED IN ALPHABETICAL ORDER, at <http://castor.tsl.state.tx.us/ref/abouttx/popcnty12000.html> (last visited July 24, 2003).

400. See FISHER COUNTY HOSP. BD., *supra* note 398.

401. See *id.*

402. Telephone Interview with Cathy Spencer, Fisher County Grant Coordinator (Mar. 7, 2002).

403. *Id.*

404. *Id.*

405. *Id.*

hospital and surgical services.<sup>406</sup> Thus, its expenditures per participant are relatively low—unlikely to exceed a few hundred dollars for any given individual.<sup>407</sup>

Compare these figures with Hidalgo County. Nearly 2,900 people were enrolled in the program that year.<sup>408</sup> In 2000 563,801 people lived in Hidalgo County.<sup>409</sup> Of those residents, 34.6% of them—194,701 individuals—earned less than 100% of the FPL.<sup>410</sup> Given those figures, it is not surprising that Hidalgo traditionally leads the state in county indigent health care program expenditures.<sup>411</sup> Hidalgo used over 8% of its general funds on its CIHCP in 2001, enough to receive state matching funds.<sup>412</sup> Yet, because of a change enacted in 1999, the state now caps the amount of matching funds it will provide.<sup>413</sup> Once the state matching funds ran out, Hidalgo attempted to continue its program using more of its own general funds.<sup>414</sup> In an effort to perpetuate its funds, Hidalgo reduced the number of prescriptions it would pay for each month, dropped optional services such as dental care, and lowered the cap on expenditures per person to \$10,000 from \$30,000.<sup>415</sup> As a result, the 108 residents who had already incurred more than \$10,000 in medical expenses through the program by the time the cap was lowered were immediately cut from the program.<sup>416</sup> Despite these measures, the county eventually had to shut the program down for the remainder of the budget year.<sup>417</sup>

Hidalgo County receives grants from the Texas Department of Health to assist it in funding certain public health programs that target lower income residents.<sup>418</sup> While these public health programs do not substitute for Hidalgo's CIHCP, some of the functions overlap. Thus, the public health programs can help relieve some strain on the CIHCP, at least to a small degree.<sup>419</sup> But the CIHCP does not presently receive any primary care

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406. *See id.*

407. *See id.*

408. Associated Press, *Hidalgo County Votes to Cut Indigent Health Care*, SAN ANTONIO EXPRESS-NEWS, Apr. 19, 2001, at 05B.

409. U.S. CENSUS, SUPPLEMENTAL SURVEY PROFILE: HIDALGO COUNTY, PROFILE OF SELECTED POPULATION CHARACTERISTICS (2000).

410. *Id.*

411. *See* Associated Press, *supra* note 408. But in 1999 Hidalgo only spent 5.84% of its general funds on indigent health care. *See* BROWN, *supra* note 170, at 5.

412. *Hidalgo Indigent Care in Trouble*, SAN ANTONIO EXPRESS-NEWS, Dec. 3, 2001, at 02B.

413. Telephone interview with Rudy de la Peña, Executive Director, Hidalgo County Indigent Health Care Program, (Mar. 12, 2002).

414. Associated Press, *supra* note 408.

415. *Id.*

416. *Id.*

417. *Id.*

418. Telephone interview with Rudy de la Peña, *supra* note 413.

419. *Id.*



grants.<sup>420</sup> It also, as noted above, receives state matching funds when it has expended the target percentage of general fund revenues.<sup>421</sup> In addition, the CIHCP only serves those county residents with an income of less than 21% of the FPL.<sup>422</sup> Yet Hidalgo's CIHCP had to shut down last year for several months.<sup>423</sup> How could this happen?

Several major factors contributed to this outcome. First, Hidalgo County has one of the highest percentages of impoverished individuals in the state.<sup>424</sup> A higher number of impoverished individuals generally entails a higher number of people who qualify for a county's indigent health care program.<sup>425</sup> Second, Hidalgo is one of the largest CIHCP counties in the state.<sup>426</sup> As noted above, a CIHCP county, unlike a hospital district, has no ability to levy tax that is specially earmarked for its CIHCP, and generally does not qualify for certain forms of federal funding that may be available to hospital districts and public hospitals.<sup>427</sup> Third, Hidalgo is on the border of Mexico and has a correspondingly increased number of undocumented residents.<sup>428</sup> Although many of the undocumented residents would otherwise qualify for Medicaid, they cannot access that program because they are illegally in the country.<sup>429</sup> Thus, when they need medical care, their fallback is the indigent health care program.<sup>430</sup> Fourth, as one of the only border counties with high-level hospital and other medical services, Hidalgo is a magnet for those seeking medical care.<sup>431</sup> Fifth, and perhaps as a consequence of the foregoing, its health care providers have a high rate of bad debt from patients who did not or could not pay their bills.<sup>432</sup>

Yet another factor contributes to Hidalgo's present problems with funding indigent health care. Texas altered its rules in 1999 for providing indigent health care at the county level.<sup>433</sup> In addition to mandating the provision of primary and preventative health care services and requiring all

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420. *Id.*

421. *Id.*

422. *Id.*

423. *Id.*

424. *Id.*

425. *Id.*

426. *Id.*

427. *Id.*

428. *Id.*

429. *Id.*

430. The Young Conservatives of Texas sued the Harris, El Paso, Dallas, and Bexar County Hospital Districts to make them stop providing non-emergent care to illegal immigrants. Michael Taylor, *Texas Conservative Group Seeks Limits on Health Services for Illegal Immigrants*, U-WIRE, Aug. 7, 2001. They based their suit on a 2001 advisory opinion by Attorney General John Cornyn stating that, as a result of the 1996 federal Personal Responsibility and Work Opportunity Reconciliation Act, no legal authority presently exists to provide such care. *Id.*

431. Telephone interview with Rudy de la Pena, *supra* note 413.

432. *Id.*

433. *Id.*

counties to open their programs to those who met the state minimum income and asset guidelines, Texas also lowered the threshold for receiving state matching funds.<sup>434</sup> Previously, a CIHCP county had to expend at least 10% of its general funds in order to receive state matching funds.<sup>435</sup> Now, it only has to expend 8% of its general funds.<sup>436</sup> Furthermore, if the state wishes to do so, it may assist a county even before the county has reached the 8% threshold.<sup>437</sup> Yet by expanding both indigent health care services and the number of counties that qualify for state matching funds, it also put a cap on the state resources which a county may access in order to fund its CIHCP.<sup>438</sup> Hidalgo County previously received a lion's share of state assistance funding.<sup>439</sup> Now, it can only capture a certain percentage of available state funds.<sup>440</sup> After it has received its maximum, Hidalgo is cut off from further state funding for the remainder of the fiscal period.<sup>441</sup> Thus, the change in the law had the effect of spreading funding more broadly around the state at the expense of a few counties, such as Hidalgo, which previously received more state assistance with its CIHCP.<sup>442</sup>

Hidalgo County may represent a special case. The pressures it faces as a border county with a well-developed medical infrastructure and a high poverty rate, among other issues, are perhaps more pronounced than those faced in many other Texas counties.<sup>443</sup> Still it is instructive regarding the pressures that may prevent some counties from being able to serve a broader spectrum of their residents. First, counties must care for their indigent residents irrespective of their numbers or needs.<sup>444</sup> Thus, for example, Hidalgo not only has a high percentage of impoverished residents relative to other Texas counties, but it also has a high number of undocumented aliens who are ineligible for Medicaid or other federally-funded programs.<sup>445</sup> Furthermore, Hidalgo County, with its medical infrastructure and specialists, can provide more costly care to its residents than other counties, such as rural Fisher.<sup>446</sup> While state law mandates that both Fisher and Hidalgo provide

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434. See TEX. HEALTH & SAFETY CODE ANN. § 61.028 (Vernon 2001 & Supp. 2002).

435. THE COUNTY INFO. PROJECT, COUNTY INDIGENT HEALTH CARE PROGRAM (2000).

436. See TEX. HEALTH & SAFETY CODE ANN. § 61.037(e)(1).

437. See 25 TEX. ADMIN. CODE § 14.1(e)(2)(C) (Vernon 2003).

438. See *id.* § 14.1(e)(4)(A), (F) ("The department distributes funds to eligible counties based on a maximum annual allocation, subject to funding. The maximum annual allocations will be based on such factors as spending history, population, and the number of residents living below the Federal Poverty Income Limit. . . . No county can be approved for more than 40% of available state assistance funds within a state fiscal year.").

439. Telephone interview with Rudy de la Pena, *supra* note 413.

440. 25 TEX. ADMIN. CODE § 14.1(e)(4)(c).

441. *Id.*

442. Telephone interview with Rudy de la Pena, *supra* note 413.

443. *Id.*

444. TEX. HEALTH & SAFETY CODE ANN. § 61.022 (Vernon 2001).

445. Telephone interview with Rudy de la Pena, *supra* note 413.

446. *Id.*

inpatient and outpatient care,<sup>447</sup> Hidalgo can provide care for the indigent resident who needs coronary bypass surgery while Fisher cannot.<sup>448</sup> Thus, Hidalgo County ends up paying for more expensive treatment because it has the ability to provide it, while residents of other counties must do without.

The state presently attempts to even out such disparities by providing matching funds to qualifying CIHCP counties, as discussed above.<sup>449</sup> But as evidenced by the plight of CIHCP counties such as Hidalgo, further action is necessary. All counties can at least provide for the primary and preventative health care needs of their residents. Fewer, however, can provide for more complicated and potentially life-threatening needs.

Two reasonable options subsist, given this state of affairs. First, the state could reduce its requirements on indigent health care programs.<sup>450</sup> Rather than requiring a county to provide a full panoply of services, it could instead require only primary and preventative health care services, such as those offered by Federally Qualified Health Centers (FQHCs).<sup>451</sup> FQHCs are private, nonprofit organizations that operate in medically-underserved areas—frequently rural or inner city areas that may also have a substantial migrant population.<sup>452</sup> They provide primary and preventative health and diagnostic services, as well as emergency care, transportation services, some dental and pharmaceutical services, patient referrals, and case management services.<sup>453</sup> While they have a fee schedule for each of the services they provide, FQHCs bill their clients (or their public or private insurance providers) on a sliding scale based on the patient's ability to pay.<sup>454</sup> Patients who earn less than 100% of the FPL generally receive their care for free, while those who earn at least 200% of the FPL generally receive no discount.<sup>455</sup> If this plan were implemented, counties would need to provide only basic care by family practitioners; generalists; internists; pediatricians; obstetrician-gynecologists; physician assistants; nurse practitioners and midwives; basic diagnostic and radiological tests; family planning services; well-child visits; dental, ophthalmological, and audiological services for children; prenatal and

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447. TEX. HEALTH & SAFETY CODE ANN. § 61.028(a)(2).

448. Telephone interview with Rudy de la Pena, *supra* note 413.

449. TEXAS HEALTH & SAFETY CODE § 61.038(b). Counties with hospital districts and public hospitals must seek assistance from other sources, such as their tax base and disproportionate share funds. 25 TEX. ADMIN. CODE § 14.1(e)(4)(c) (Vernon 2003).

450. See BUREAU OF PRIMARY HEALTH CARE, DEP'T OF HEALTH & HUMAN SERVS., GUIDELINES AND APPLICATION PACKAGE FOR FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE ENTITIES 24 (1999).

451. *Id.*

452. BUREAU OF PRIMARY HEALTH CARE, DEP'T OF HEALTH & HUMAN SERVS., HEALTH CENTER PROGRAM EXPECTATIONS 8-9 (1998).

453. *Id.* at 14-15.

454. See, e.g., BUREAU OF PRIMARY HEALTH CARE, *supra* note 450, at 24.

455. See, e.g., *id.*

perinatal services; certain pharmaceutical services; and transport and referrals to other physicians when appropriate.<sup>456</sup>

On the other hand, if the state wishes to continue to mandate that counties provide mandatory comprehensive services, then the state should provide extra assistance to those counties with the facilities and specialists to provide for costlier procedures and care that, pursuant to state mandate, they must provide, if available, to their indigent residents. Such assistance at the state level would not only help keep those counties' programs solvent, but ideally could also free up funds to provide more basic services to a broader spectrum of indigent residents, such as routine physician visits and care for minor illnesses and injuries, which, if left untreated, could develop into more serious conditions. On the other hand, if Texas truly wishes to maintain comprehensive health services for the indigent at the county level, it may instead make sense to seek a federal Health Insurance Flexibility and Accountability (HIFA) waiver to expand Texas's Medicaid program to uninsured, low-income, childless adults and other optional or expansion groups presently unserved by Texas's Medicaid program and use at least some of the local dollars that presently go to the county indigent health care programs to help fund the expansion.<sup>457</sup> This would, at least, bring in federal matching funds for the program, which are not available with respect to county indigent health care programs, except indirectly through disproportionate share program (DSH) payments.

This idea is not new. In the 77th regular session, the legislature enacted a bill that would have set up a demonstration project to accomplish just this purpose, but the bill was vetoed.<sup>458</sup> The legislature should again consider enacting a similar proposal. While programs implemented through a HIFA waiver must be budget neutral (meaning that they cannot require the federal government to provide more funds to the state than the state is already receiving in Medicaid matching funds and DSH payments), this should not be problematic. Texas's DSH payments have generally been dropping and are anticipated to continue to decline in coming years.<sup>459</sup> Expanding eligible

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456. Cf. BUREAU OF PRIMARY HEALTH CARE, *supra* note 450, at 14-15 (providing required services for FQHCs).

457. See generally HEALTH INS. FLEXIBILITY & ACCOUNTABILITY (HIFA) DEMONSTRATION INITIATIVE, at <http://cms.hhs.gov/hifa/default.asp> (last visited Sept. 2, 2003). HIFA waivers do not require states to extend all Medicaid benefits to expansion populations; rather, states may restrict benefits to "the benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State," for example. See *id.*, at <http://cms.hhs.gov/hifa/hifagde.asp> (last visited Sept. 2, 2003).

458. See, e.g., FISCAL NOTE, Tex. H.B. 2807, 77th Leg., R.S. (2001), available at <http://www.capitol.state.tx.us> (last visited Sept. 2, 2003). The bill would have created Medicaid demonstration projects aimed at providing health insurance for uninsured adults earning 200% of the FPL or less. *Id.* Local government would have provided the necessary matching funds. *Id.*

459. See, e.g., TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID IN PERSPECTIVE 5-11 (4th ed. 2002).

beneficiaries through a HIFA waiver and drawing federal funds for that purpose can help make up the revenue currently lost through the DSH.

Furthermore, assuming that illegal immigrants will always reside in Texas, the solution is not to deny them access to the IHCPs. Such a solution merely shunts responsibility for the cost of their care on the medical community because illegal immigrants are as likely as anyone else to need health care at some time and will get it, if it is unavailable elsewhere from expensive emergency rooms. Rather, the state should provide payment assistance for health care to border counties and other counties with proportionately higher numbers of illegal immigrants.

In the interest of providing health care as economically as possible to the broadest spectrum of people, Texas should also encourage counties to team up with FQHCs and other primary care service providers for low income individuals and families. Texas presently counts a CIHCP county's payment to FQHCs towards the 8% needed to trigger state matching funds, as long as the county timely registers its intent to meet its indigent health care obligation in part through services provided through an FQHC.<sup>460</sup> Yet only thirteen of Texas's numerous CIHCP counties declared their intention to fund indigent health care through an FQHC in 2003.<sup>461</sup> This may, in large part, be due to the relatively small number of federally qualified health centers in Texas. Counties, as well as the state, ought to promote the establishment of such centers as a means of further stretching limited health care dollars. It is true that FQHCs and other similar primary care centers serve not merely the desperately poor, as do most CIHCPs, but also serve those who earn comparatively more money and thus do not qualify for aid through most CIHCPs.<sup>462</sup> But Texas and its counties should be interested not merely in ensuring that the poorest of the poor receive at least basic medical care, but rather that all residents do. The business provided by funneling some of a county's indigent health care program clients through an FQHC or other center can provide the funding to help ensure the continued existence of the center. The promise of such business may also help encourage the creation of such a center where one does not already exist. In this way, a county can assist those who qualify for its indigent health care program to receive basic care and also, without the expenditure of any additional funds, help provide for the health care of other, non-eligible low income individuals and families by supporting the existence of health clinics that provide primary care for low income individuals on a sliding scale.

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460. See TEX. HEALTH & SAFETY CODE ANN. § 61.0285(a)(10) (Vernon 2002); Telephone Interview with Rosemary Linan, Indigent Health Care Program, Texas Department of Health (Aug. 29, 2002).

461. See Telephone interview with Rosemary Linan, *supra* note 460. The counties are Atascosa, Eastland, Fannin, Hardin, Hidalgo, Jasper, Kinney, McClennan, Medina, Orange, Tom Green, Uvalde, and Wichita. *Id.*

462. *Id.*

The state matching fund for indigent health care services should be left in place to assist those counties with greater numbers of indigent residents who qualify for their county's indigent health care program. Correspondingly, given either a reprieve from responsibility or further assistance with some of the more costly aspects of care, counties should be required to expand their primary care programs, including visits to generalists or internists and certain basic laboratory and radiological tests ordered by such clinicians, to impoverished residents with higher incomes than the present state minimum of 21% of the FPL. The experience of Fisher County shows that program expansion, at least at the level of primary care, need not break a county's coffers.

Each county should determine, based on census information, how many more residents would qualify for aid if they raised their eligibility for primary care to 50% of the FPL, 100% of the FPL, 125% of the FPL, 150% of the FPL, and 200% of the FPL. The counties should then, extrapolating present data from primary care services utilized in its own program, determine what the county's estimated additional cost would be if it raised eligibility for primary care services to individuals in each of the above income groups based on anticipated utilization. It is important to remember that many more residents will qualify for a county's CIHCP than will actually utilize it in any given year. For example, consider Travis County. In 2000 21,425 people were enrolled in the county's Medical Assistance or Community Health Center programs.<sup>463</sup> That is only 3.3% of the county's total population.<sup>464</sup> Again, only 5% of Travis County residents earning less than 200% of the FPL received primary care through community medical services and 14.7% through MAP in 2000.<sup>465</sup> Thus, merely looking at the potential number of enrollees in any given county will not provide a realistic picture of the actual number of residents who will likely utilize the program in any given year.<sup>466</sup> Rather, the number may be far less.

State law already allows matching funds to be credited for care provided to individuals earning up to 50% of the FPL.<sup>467</sup> Such individuals are only slightly less desperately impoverished than their peers whose income is only 21% of the FPL, and are nearly as likely to be without any other access to health care as the latter group.<sup>468</sup> An expansion of primary care services at least to this group would provide a greater number of residents with a basic minimum of health care.<sup>469</sup> It would also take the financial strain off emergency rooms, which would otherwise be stuck providing such care—

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463. See *supra* note 384 and accompanying text.

464. See *supra* note 384 and accompanying text.

465. See *supra* note 384 and accompanying text.

466. See *supra* notes 385-86 and accompanying text.

467. See TEX. HEALTH & SAFETY CODE ANN. § 61.023(b) (Vernon 2002).

468. See *id.* § 61.006.

469. See *id.* § 61.023(a)(3).

likely without any compensation at all—and could further help prevent minor conditions, such as a flu, from developing into more serious and costly ones, such as pneumonia.

#### *D. Other Pieces of the Safety Net*

In the absence of an available government program, whether at the federal, state, or local level, only a patchwork of other sporadic options exist for those who need health care but cannot afford to pay for it themselves.<sup>470</sup> Their availability is contingent upon location and other factors, leaving some areas without any additional resources while others have many.<sup>471</sup> Providers of low cost or free health care include nonprofit hospitals, individual health care workers, state hospitals and agencies, federally-qualified health centers, rural health clinics, free clinics, local health departments, and school health clinics.<sup>472</sup> Lastly, almost all hospital emergency rooms also inadvertently provide free care through their obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>473</sup>

##### *1. Not-for-Profit Hospitals*

It is financially advantageous to be a tax-exempt nonprofit hospital.<sup>474</sup> Such hospitals generally owe no income, property, or other taxes at both the state and federal levels.<sup>475</sup> But tax exemption comes with a price.<sup>476</sup> In addition to certain financial restrictions, nonprofit hospitals must also be organized for charitable purposes.<sup>477</sup> Although the provision of health care was once considered charitable in itself, it no longer generally is, now that health care has become a big business.<sup>478</sup> Rather, in order for a hospital to be considered charitable for the purposes of obtaining not-for-profit, tax-exempt status under Texas law, it must provide charity care to those unable to pay.<sup>479</sup> While a nonprofit hospital need not provide such care to all comers, Texas law provides an array of potential benchmarks, at least one of which a hospital must meet in order to be eligible for tax-exempt status.<sup>480</sup> Such care can be “reasonable in relation to the community needs, as determined through the

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470. See FENZ, *supra* note 353, at 22.

471. See *id.* at 31, 33.

472. *Id.* at 22.

473. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000).

474. See FENZ, *supra* note 353, at 23.

475. See TEX. TAX CODE ANN. §§ 11.18(a), 151.310(a)(2), 171.063(a)(1) (Vernon 2003).

476. See FENZ, *supra* note 353, at 23.

477. TEX. TAX CODE ANN. § 11.1801(a).

478. See Friedman, *supra* note 36.

479. TEX. TAX CODE ANN. § 11.1801(a).

480. *Id.* § 11.1801(a).

community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system."<sup>481</sup> It can be "provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue."<sup>482</sup> It can equal "at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax."<sup>483</sup> Or, it can equal "at least five percent of the hospital's or hospital system's net patient revenue."<sup>484</sup>

Nevertheless, it is uncertain how fixed these standards are. The statute itself expressly notes that the standards are not to be considered determinative of what constitutes a reasonable amount of charity care and provides an "out" for hospitals that can demonstrate that reductions in charity care are necessary in order for it to continue operations.<sup>485</sup> Hospitals participating in the DSH along with those located in counties designated as health professional shortage areas that have fewer than 58,000 people and those that provide both inpatient and outpatient care without seeking any payment and that subsist solely on charity alone are also exempt from these requirements when seeking tax-exempt status.<sup>486</sup>

Patients generally must apply for charity care in advance of service, providing information and supporting documentation concerning income, expenses, and obligations to the hospital.<sup>487</sup> If it chooses to provide charity care, the hospital will use the information provided to determine the amount of care that it wishes to write off for the patient.<sup>488</sup> The Texas Comptroller of Public Accounts estimates that in 1998 Texas hospitals spent over \$1 billion on charity care.<sup>489</sup> This figure reflects the cost of providing services, as opposed to the amounts charged; if the latter figure is used, then the amount of charity care provided nearly doubles.<sup>490</sup> But the Comptroller did not note what steps, if any, were taken to separate bad debt figures from genuine charity care, for which the hospital did not charge.<sup>491</sup>

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481. *Id.* § 11.1801(a)(1).

482. *Id.* § 11.1801(a)(2).

483. *Id.* § 11.1801(a)(3).

484. *Id.* § 11.1801(a)(4).

485. *Id.* § 11.1801(i).

486. *Id.*

487. See, e.g., *Methodist Health Care System, Policies: The Methodist Hospital*, available at <http://www.methodisthealth.com/guide/policies.htm> (last visited Sept. 9, 2002).

488. *Id.*

489. See TEX. COMPTROLLER OF PUB. ACCOUNTS, HOSPITAL CHARITY (Mar. 2001), available at <http://www.cpa.state.tx.us/specialrpt/hcs/pg64.html> (last visited Sept. 9, 2001).

490. *Id.*

491. *Id.* The statutory definition of charity care does not appear to require that hospitals designate a patient as "financially indigent" in advance of service and any attempt to collect payment. TEX. HEALTH & SAFETY CODE ANN. § 311.031(2) (Vernon 2002). Thus, it appears a hospital may be able to reclassify at least some bad debt as charity care after the fact. See TEX. COMPTROLLER OF PUB. ACCOUNTS, *supra* note 489.



## 2. Individual Health Care Providers

Individual health care providers were once a significant mainstay of charity care.<sup>492</sup> In the fee-for-service era, physicians could shift costs from impoverished clients to wealthier ones with relative ease, thus making the provision of charity care more economically feasible for the doctor.<sup>493</sup> Now, with most insurers imposing fee schedules on physicians and seeking to cut costs as much as possible, it has become more difficult for many physicians to provide free or discounted care.<sup>494</sup> Nevertheless, the Texas Comptroller estimates that in 1998 physicians still managed to provide over \$900 million in charity care to patients, or an estimated \$22,000 per physician.<sup>495</sup> Charity care imparted by physicians and other health care providers depends entirely on the generosity of the individual provider and is generally performed on a case-by-case basis.<sup>496</sup> Thus, while it is still an important part of the health care safety net, it is not something on which Texas can substantially rely in order to meet the health care needs of the indigent.<sup>497</sup>

## 3. State and University Hospitals

State and university hospitals have historically provided care to patients regardless of their ability to pay.<sup>498</sup> Among state institutions, the University of Texas Medical Branch at Galveston (UTMB) has historically shouldered the brunt of the burden.<sup>499</sup> In 2000 UTMB provided \$124 million in charity care (calculated at cost, and including hospital and physician professional costs).<sup>500</sup> UTMB contracts with numerous Texas counties and hospital districts to provide indigent health care services that the county cannot provide itself.<sup>501</sup> From September 2000 through August 2001, UTMB provided health care services, under contract, to thirty-one counties.<sup>502</sup> Counties that contract with UTMB to provide indigent care comprise only a small fraction of those from which UTMB's low income patients come, but residents of 236 of

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492. See Friedman, *supra* note 36.

493. See, e.g., *id.*

494. See, e.g., *id.*

495. TEX. COMPTROLLER OF PUB. ACCOUNTS, PHYSICIAN CHARITY AND BAD DEBT (Mar. 2001), available at <http://www.cpa.state.tx.us/specialrpt/hcs/pg65.html> (last visited Sept. 10, 2002). The Comptroller distinguished this figure from bad debt, which totaled an estimated \$1.1 billion in 1998. *Id.*

496. See FENZ, *supra* note 353, at 30.

497. See *id.* at 30-31.

498. See, e.g., *id.* at 24-25.

499. See *id.* at 24.

500. UTMB, UTMB OVERVIEW, available at [http://www.utmb.edu/president/presentations/UTMB OverviewOct01.ppt](http://www.utmb.edu/president/presentations/UTMB%20OverviewOct01.ppt) (last visited Sept. 10, 2002.)

501. *Id.*

502. UTMB, COUNTY INDIGENT CARE CONTRACT SERVICES (2001), at <http://216.239.35.100/search?q=cache:h0UGQ-iAqxwC:www.utmb.edu/utmbreports/indcare/lbb2001.pdf+indigent+care&hl=en&ie=UTF-8> (last visited Sept. 1, 2003).

Texas's 254 counties receive care through UTMB.<sup>503</sup> Other state institutions that provide general hospital care to low-income individuals include Texas Tech (in Lubbock, Amarillo, Odessa, and El Paso), the Texas Department of Health (through their tuberculosis hospitals in Harlingen and San Antonio), M.D. Anderson Cancer Center in Houston, and the Department of Mental Health and Mental Retardation (which operates psychiatric hospitals and community mental health and mental retardation centers throughout the state).<sup>504</sup> With the state's significant prison population, the Texas Department of Corrections also supplies a substantial amount of free or low cost medical care to inmates, many of whom require care for chronic, often socially transmitted diseases.<sup>505</sup> Because prisoners are not permitted, under federal law, to apply for federal or state public assistance programs, such as Medicaid, the state shoulders a significant financial burden in providing for the health care needs of its prison population.<sup>506</sup>

#### 4. Federally Qualified Health Centers

Texas has thirty-three FQHCs, which deliver services at 202 locations throughout the state.<sup>507</sup> In 1999 465,683 people utilized FQHC services in Texas.<sup>508</sup> Over half of these individuals were uninsured, with 84% being members of a minority group and 43% being children.<sup>509</sup>

#### 5. Rural Health Clinics

A significant majority of Texas counties are classified as "rural."<sup>510</sup> Forty-one Texas counties have only one or two physicians, and twenty-four Texas counties have no physicians at all.<sup>511</sup> To help meet the health care needs of rural residents, 170 licensed rural hospitals have been established.<sup>512</sup> Rural hospitals are entities that meet certain criteria in order to qualify for

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503. See UTMB OFFICE OF THE PRESIDENT, FINANCIAL MANAGEMENT SUMMARY (1999), at <http://www.utmb.edu/president/damp1/index.htm> (last visited Sept. 1, 2003).

504. See FENZ, *supra* note 353, at 25-26.

505. See *id.* at 26.

506. See *id.*

507. See TEX. ASSOC. OF COMM. HEALTH CTRS. (TACHC), EXECUTIVE SUMMARY AND STATEWIDE FACT SHEET, MEMBERSHIP DIRECTORY 8, 11 (2000).

508. *Id.*

509. *Id.*

510. See OFFICE OF RURAL CMTY. AFFAIRS (ORCA), TEXAS COUNTY DESIGNATIONS (Mar. 2002), available at [http://www.orca.state.tx.us/maps/pages/Rural-Metro%20County%20Designations%20Map\\_jpg.htm](http://www.orca.state.tx.us/maps/pages/Rural-Metro%20County%20Designations%20Map_jpg.htm) (last visited Sept. 10, 2002).

511. ORCA, TEXAS COUNTIES WITH ZERO, ONE OR TWO PRIMARY CARE PHYSICIANS (Mar. 2002), available at [http://www.orca.state.tx.us/maps/pages/Counties%20with%200-1-2%20Physicians\\_jpg.htm](http://www.orca.state.tx.us/maps/pages/Counties%20with%200-1-2%20Physicians_jpg.htm) (last visited Sept. 1, 2003).

512. See *id.*

enhanced Medicare reimbursement.<sup>513</sup> The provision of health care in rural areas can be more expensive, given the limited number of providers and frequently widespread populations involved.<sup>514</sup> Due to economies of scale, it can also be difficult to attract and retain physicians in such areas.<sup>515</sup> Thus, the federal government also created a special class of entities called rural health clinics, which would also qualify for enhanced Medicare and Medicaid reimbursement and could function primarily through the services of “physician extenders,” such as nurse practitioners and physician’s assistants.<sup>516</sup> These clinics provide primary health care services.<sup>517</sup> Presently, 381 rural health clinics exist in Texas.<sup>518</sup>

### 6. Free Clinics

Free clinics are health clinics that provide basic health care services to low-income individuals at little or no charge.<sup>519</sup> They are generally staffed by volunteer health care professionals using donated equipment and supplies.<sup>520</sup> It is uncertain how many free clinics exist in Texas or how much care they provide because they are not subject to any special reporting requirements.<sup>521</sup> Nevertheless, at least several Texas communities enjoy their existence.<sup>522</sup>

### 7. Texas Department of Health and Local Health Departments

Local health departments and, in smaller communities, the Texas Department of Health (TDH) provide certain health services largely to the uninsured. One hundred forty-eight local health departments throughout the state provide health care services in concert with the TDH’s eight regional offices.<sup>523</sup> Because 141 counties have no local public health presence, the TDH also provides public health services for them, again through its regional offices.<sup>524</sup> In addition to executing and enforcing public health laws, these departments and offices provide certain direct health services, including

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513. See, e.g., 42 U.S.C. § 1395ww(d)(5)(G)(iv) (2000).

514. *Id.*

515. *Id.*

516. CTR. FOR RURAL HEALTH INITIATIVES, RURAL HEALTH CLINIC STUDY 1 (1999), at <http://www.orca.state.tx.us/crhi/pdf/study.pdf> (last visited Sept. 1, 2003).

517. *Id.* at 2.

518. See ORCA, LICENSED HOSPITALS AND RURAL HEALTH CLINICS (Mar. 2002), at [http://www.orca.state.tx.us/maps/pages/Hospitals%20and%20Rural%20Health%20Clinics%20Map\\_.jpg.htm](http://www.orca.state.tx.us/maps/pages/Hospitals%20and%20Rural%20Health%20Clinics%20Map_.jpg.htm) (last visited Sept. 1, 2003).

519. See FENZ, *supra* note 353, at 28.

520. *See id.*

521. *See id.*

522. *See id.*

523. See TEX. DEP’T OF HEALTH (TDH), NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS (2002), available at <http://www.tdh.state.tx.us/ophp/2002nps/pospaper.htm> (last visited Sept. 11, 2002).

524. *Id.*

immunizations, cancer screenings, and treatment of sexually transmitted diseases.<sup>525</sup> They also provide preventative health care services for children up to age five, as well as family planning services.<sup>526</sup>

### 8. *School-Based Health Clinics*

Most schools provide basic first aid and health screening services for their students (such as height, weight, sight, and hearing examinations) and also administer medications.<sup>527</sup> Such services cannot substitute for primary health care for school children but rather supplement it. School Based Health Centers (SBHCs), which exist in a number of school districts, go beyond these basic services by providing full primary care to students.<sup>528</sup> At SBHCs students not only receive the basic services available at most other schools, but they can also receive screening for a variety of physical, mental health, and social conditions as well as treatment for them.<sup>529</sup> Such clinics are staffed not merely by nurses but also by nurse practitioners, social workers, and physicians.<sup>530</sup> They particularly serve an important role in those communities with a high number of low income and uninsured children.<sup>531</sup> In 1996 sixty such clinics operated at schools throughout Texas.<sup>532</sup>

### 9. *Emergency Medical Treatment and Active Labor Act*

Congress enacted the EMTALA in 1986 in response to reports of widespread dumping of uninsured patients from hospital emergency rooms.<sup>533</sup> The EMTALA provides that emergency rooms at all hospitals that participate in the Medicare program (i.e., virtually all hospitals) must screen all patients who request emergency treatment to determine whether an emergency condition exists.<sup>534</sup> The medical screening cannot be so cursory that it amounts to no screening at all<sup>535</sup> and must otherwise be consistent with the

525. See FENZ, *supra* note 353, at 29.

526. See, e.g., Kever, *supra* note 352, at D1.

527. INST. OF MED. COMM. ON COMPREHENSIVE SCH. HEALTH PROGRAMS IN GRADES K-12, SCHOOLS AND HEALTH: OUR NATION'S INVESTMENT 155 (Diane Allensworth et al. eds., 1997) [hereinafter IOM].

528. See TEX. SCH. HEALTH TASK FORCE, REPORT OF THE SCHOOL HEALTH TASK FORCE TO THE TEXAS BOARD OF HEALTH (1998), available at <http://www.tdh.state.tx.us/schoolhealth/tf%5F8b.htm> (last visited Sept. 3, 2003); IOM, *supra* note 527, at 155.

529. TEX. SCH. HEALTH TASK FORCE, *supra* note 528; IOM, *supra* note 527, at 155.

530. TEX. SCH. HEALTH TASK FORCE, *supra* note 528.

531. See generally IOM, *supra* note 527, at 153-236 (discussing SBHCs and including a detailed analysis of factors weighing both for and against them).

532. *Id.*

533. 42 U.S.C. § 1395dd(a) (2000).

534. *Id.*

535. See, e.g., Jackson v. E. Bay Hosp., 246 F.3d 1248, 1256 (9th Cir. 2001).

hospital's policies.<sup>536</sup> The screening must also be performed whether or not the patient is insured or can otherwise provide payment, and the hospital may not delay screening or treatment in order to inquire about payment or insurance status.<sup>537</sup>

After an appropriate screening, if the hospital finds no emergency condition, then its duty to the patient under the EMTALA has ended.<sup>538</sup> It need not provide any further care to a patient who does not have an emergency condition.<sup>539</sup> But if the hospital determines that an emergency condition does exist or that the patient is in active labor, then it has a duty to "stabilize" the patient,<sup>540</sup> that is, the hospital must ensure that "no material deterioration of the condition [or delivery of a child] is likely to result or occur" during a transfer from the facility or as a result of the transfer.<sup>541</sup> The hospital may not transfer an unstabilized patient unless the patient requests the transfer in writing, or unless a physician or other authorized health care professional certifies that the medical benefits of transfer to another facility outweigh the risks to the patient (and, in the case of labor, to the unborn child).<sup>542</sup> When a transfer is authorized, the hospital to which the patient will be transferred must accept the patient under the EMTALA, provided its emergency room is not on "drive by" status and the hospital otherwise has the capacity to treat the patient.<sup>543</sup>

The EMTALA helps ensure that even indigent patients get necessary medical care when faced with a health crisis.<sup>544</sup> As such, it arguably does a service for everyone. As noted earlier, health care is different from other consumer goods. Society expects everyone to be able to receive at least some degree of care, regardless of their ability to pay because it can mean the difference between a person's life and death or severe disability. Yet the EMTALA gets it wrong by mandating both public and private hospitals to foot the bill for all unpaid emergency medical services, without any government assistance. If federal law requires that all U.S. residents be entitled to emergency medical care regardless of their ability to pay, then the federal government ought to support this entitlement by helping to fund it. Otherwise, it places the burden of caring for those patients who cannot pay not only on the back of the public but also on the back of the private health care system. The health care system must in turn recoup its costs somehow, either by shifting them to those patients and others who are better able to pay or, in

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536. See, e.g., *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 798 (10th Cir. 2001).

537. See 42 U.S.C. § 1395dd(h).

538. See, e.g., *Jackson*, 246 F.3d at 1258.

539. *Id.*

540. See 42 U.S.C. § 1395dd(b)(1).

541. See *id.* § 1395dd(e)(3)(A).

542. See *id.* § 1395dd(c)(1).

543. See *id.* § 1395dd(g).

544. See generally *id.* § 1395dd.

extreme cases, by closing hospital emergency rooms. While the goal of the EMTALA is admirable and should be supported, the federal government abdicated its responsibility by dumping the entire burden of financing the obligation to screen and treat on the hospitals by default.

The EMTALA also gets it wrong by indirectly encouraging low income and indigent people to use the emergency rooms not as centers to treat medical crises but instead as primary care centers. It is now relatively common knowledge that emergency rooms cannot turn a patient away just because they are uninsured or may otherwise not be able to pay. This surely factors into some people's choice of where to obtain treatment for medical conditions. Physicians' offices require individuals to provide insurance information in advance of treatment and may decline to accept a person as a patient in the absence of satisfactory information. Emergency rooms, on the other hand, may not turn a person seeking treatment away until he or she has been screened to rule out the existence of a medical emergency.<sup>545</sup> Indirect encouragement of inappropriate emergency room use not only increases the financial burden on hospitals, but it also takes critically important resources away from diagnosing and treating those patients who genuinely need emergency services. Note that one study found that nearly 60% of patients in Texas emergency rooms are seeking primary care rather than emergency care.<sup>546</sup>

Yet it is clear that even if hospitals' EMTALA obligations ended tomorrow, significant problems would still exist with respect to the fair provision of emergency medical treatment and with respect to primary health care for the poor. With respect to funding for emergency health care for those who cannot pay for it, the federal government should solve this issue by helping hospital emergency rooms defray the costs of providing health care to the poor. For its part, Texas can help matters by implementing expanded primary health care for the indigent, as discussed above. By broadening the criteria for inclusion in county indigent health care programs and contracting the benefits mandated by law, Texas counties can provide for the primary health care needs of a far larger class of uninsured residents. In conjunction with this, Texas (or Texas counties) should also consider funding and staffing locations at which the indigent can receive primary health care after normal working hours. This will further help reduce the strain on emergency rooms, which are open twenty-four hours and therefore attract those who cannot take time off of work to obtain health care for fear of losing their jobs.

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545. See *id.* § 1395dd(a).

546. See, e.g., Steve Brewer, *Medical Emergency for 800,000*, HOUS. CHRON., Aug. 4, 2002, at A1.

## IV. CONCLUSION

County indigent health care and the patchwork providers of low cost or free care described above provide the last line of defense that the poor possess between having some access to health care and having essentially no access at all. Yet those who do not qualify for a federal or state program, such as Medicaid, or do not have insurance through their job often cannot obtain services through such means. These individuals are then left with little means of obtaining health care other than through whatever uncompensated services they can obtain through hospital emergency rooms, leaving strapped hospitals and physicians to bear the brunt of the economic burden.

Only 16% of Americans who make less than the federal poverty level and only 36% of those who earn between 100% of the FPL and 150% of the FPL have health insurance through their jobs.<sup>547</sup> Many of the lower income uninsured are uninsured for only part of a year, as they move—or, particularly in economic downturns, are moved—from one job to another. While Medicaid provides coverage for some of these individuals, it only covers those in certain categories, such as pregnant women, children whose families earn less than a certain percent of the federal poverty level, and families receiving Temporary Aid to Needy Families.<sup>548</sup> Texas's CHIP covers a broader range of children but only children.<sup>549</sup> This leaves most able-bodied adults who earn virtually any income out of the picture. The indigent health care programs run at the county level are their only real hope for consistent, reliable health coverage. Yet because the program usually covers only those who earn 21% of the FPL or less, it is of little help to most uninsured Texans.<sup>550</sup> By expanding the primary care portion of each locality's mandate to assist the indigent, Texas can provide at least the most basic health care services to those who presently must do without.

Twenty-one percent of Texas's population received Medicare or Medicaid in 2001.<sup>551</sup> These individuals were entitled by law to receive the health benefits they enjoyed. For many if not most of these Texans, their enrollment in either Medicare or Medicaid allowed them financial access to health care, when they would otherwise be without. Yet nearly an equal number of Texans have no health insurance at all and, as such, have limited means of financial access to health care.<sup>552</sup> This great disparity in financial

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547. Judith Feder et al., *Assessing the Combination of Public Programs and Tax Credits*, in COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED 52 (Elliot K. Wicks ed., 2001).

548. *Id.*

549. See FENZ, *supra* note 353, at 5.

550. Feder et al., *supra* note 547.

551. See U.S. Census Bureau, *Health Insurance Coverage Status and Type of Coverage by State: All People: 1987 to 2001*, available at <http://www.census.gov/hhes/hlthins/historic/hihist4.html> (last visited Oct. 28, 2002).

552. See *id.*

access to health care among nearly half of Texas residents raises a question of equity. Texas can better affirm the dignity and worth of each of its residents by striving to close these significant gaps in financial access to health care among different segments of the population, where small differences in income or variations in family composition mean the difference between obtaining or not obtaining necessary diagnosis, treatment, and preventative care.

Yet lack of financial access to health care is not the only problem facing many Texans. Rather, even those of us who enjoy access to private health insurance, Medicaid, Texas's CHIP, or another program face issues concerning how—and whether—health care can be accessed. While many of these issues are largely out of its control or influence, resting instead with consumers, employers, insurers, or the federal government, the Texas Legislature has options that could help implement a more patient-centered health care system.

1. *Consider studying potential benefits and drawbacks of coverage floors for all small group market "bare bones" and catastrophic health insurance plans.*

Texas already requires health insurance carriers in the small-group market (groups of two to fifty people) to offer basic and catastrophic insurance plans in addition to any other plans they offer.<sup>553</sup> Under this mandate, the Commissioner of Insurance sets minimum standards for a basic and a catastrophic insurance plan.<sup>554</sup> But if an insurance carrier wishes to offer additional plans, including additional basic or catastrophic plans, the additional plans need not meet these requirements.<sup>555</sup> While both mandated options have generally been poorly subscribed, it appears that catastrophic plans, at least, may begin to become more popular (in conjunction with Medical Spending Accounts) as the premiums of more widely subscribed plans with richer benefit packages continue to rise. In conjunction with this trend, Texas has been hearing more calls to roll back or make exceptions to state health insurance mandates. Given the foregoing, the legislature may wish to consider studying the issue of bare bones or catastrophic coverage health insurance policies with the aim of determining a "coverage floor." It may be desirable to establish such a floor to prevent the offering of health insurance plans that provide protection to subscribers in name only. Significant underinsurance, resulting from grossly inadequate health insurance plans, not only results in economic waste but also may result in financial ruin for some subscribers who may incorrectly assume that even the most minimal

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553. See *supra* notes 171-73 and accompanying text.

554. See *supra* notes 171-73 and accompanying text.

555. See *supra* notes 171-73 and accompanying text.



of coverage offers them protection in the event of a medical catastrophe. Underinsurance may also result in additional costs for the rest of Texans, who may get stuck with the tab for an increased amount in unpaid medical bills. On the other hand, mandating a coverage floor that is too high may prevent insurance carriers from marketing certain plans that may in fact be both adequate and cost-effective for many consumers.

2. *Discourage penalty-free jumping between catastrophic and comprehensive coverage.*

To discourage employees who intend to retain catastrophic coverage only until they fall ill, at which time they intend to switch to comprehensive coverage, employers may wish to institute a mandatory period during which employees must go without coverage in switching from either a catastrophic or bare bones plan to a comprehensive coverage plan. This would not, in itself, require any change in federal law. A mandatory waiting period also mimics provisions presently in place to discourage parents from switching their children from private health insurance coverage to coverage under Texas's CHIP.<sup>556</sup> But it is probably not advisable to condone this step on the part of employers. Such a requirement would leave employees completely at risk should any health problems arise during the exclusion period. Depending on its length, such a waiting period may also require them to forfeit significant continuity of coverage protections otherwise afforded by federal law under HIPAA by remaining uninsured for longer than sixty-three days.<sup>557</sup> Instead, the legislature might consider studying other means of further avoiding this adverse selection problem, including the enactment of a special pre-existing condition exclusion period for people switching from a catastrophic to a comprehensive health insurance plan while continuing to work for the same employer.<sup>558</sup>

3. *Continue with Medicaid enrollment simplification.*

With respect to Medicaid, Texas could consider taking the following steps to simplify the enrollment process: (1) eliminate the face-to-face interview requirement, (2) accept mail-in applications, (3) reduce the complexity of the application form, (4) simplify verification requirements, and (5) eliminate the assets test. These measures will improve the enrollment process not merely for applicants but also for case workers, and will not likely lead to a significantly increased number of applicants receiving Medicaid who are actually ineligible to do so.

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556. See *supra* Part III.B.2.

557. See 42 U.S.C. § 300gg(2)(A) (2000).

558. But this latter option would require a change in presently existing federal law.

4. *Delink the Medicaid enrollment process from TANF and food stamps.*

Texas might also consider disconnecting the continued link at the application level between Medicaid and TANF. It is no longer necessary that an applicant be eligible for TANF in order to apply for Medicaid and, in fact, has not been necessary for several years now. Moreover, Medicaid is not a “handout” but instead is a health insurance program that can be accessed by certain low income working families that can help members of those families keep their jobs and thereby encourage self-sufficiency. As such, case workers and others should not discourage people from applying for Medicaid (as they may do with respect to TANF) but instead should encourage them to enroll. Disconnecting the application processes will also be necessary to simplify the Medicaid application.

5. *Provide greater and more effective publicity to encourage Medicaid enrollment.*

Thousands of Texans who are eligible for Medicaid remain uninsured.<sup>559</sup> To help remedy this issue, the state might consider more broadly publicizing its Medicaid program. Toward this end, it could widely publicize that Medicaid and TANF are no longer linked and—once it is accomplished—that the application process for Medicaid has been simplified. The state could target its campaign toward communities and locales that are likely to have large numbers of individuals who may be eligible for Medicaid. It also could consider publicizing the benefits of the program and the importance of enrolling while healthy in order to make the best and most economical use of preventive and primary care options and allow the quick and efficient delivery of care should an illness or injury arise. Toward this end, the statute might also consider promoting more cost-effective use of care. The new information sessions for all first-time Medicaid enrollees are a good step in this direction, but more can be done in order to encourage the use of a regular, nonurgent primary health care provider and discourage the use of emergency rooms for nonemergent health care needs.

6. *Withstand fiscal pressures to cut Medicaid provider reimbursement levels.*

The Texas Legislature may wish to consider avoiding the temptation to keep provider reimbursements stagnant or to reduce reimbursement altogether. For the Medicaid program to work, providers must receive at least enough

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559. See FENZ, *supra* note 353, at 4.

revenue from the program to not only meet their bare expenses but also to make at least a small profit. This is elementary, yet it can be forgotten when budgets grow tight. Moreover, Medicaid reimbursement rates affect not only services for Medicaid patients, but also services in the SCHIP and CIHCPs.<sup>560</sup> Thus, more is at stake here than just Medicaid. It may be advisable, instead, for the legislature to seek to restrain and recoup costs by stepping up the detection and prevention of Medicaid fraud and abuse by providers.

7. *Increase publicity and outreach for Texas's CHIP.*

With respect to Texas's CHIP, the legislature may wish to provide for increased public promotion of the program. While enrollment is growing, there are hundreds of thousands of children who may qualify for the program and lack insurance yet still do not participate in the program.<sup>561</sup> By investing in the health of its children today, Texas may be able to help put its populace on the road to future good health. Increased CHIP enrollment not only improves immediate primary and preventative care access for children but can also help improve the state's public health. The publicization should be focused not merely on enrolling new children but also on retaining the enrollment of those who already participate. As with the Medicaid program, additional campaigns could also focus on emphasizing the importance of selecting and retaining a single primary health care provider and using that provider rather than urgent care centers or emergency rooms for day-to-day health care needs.

8. *Consider revamping county indigent health care mandates.*

With respect to county indigent health care programs, the Texas Legislature might consider allowing counties to offer only primary and preventative health care services but to a broader economic spectrum of individuals—those earning up to 50% of the FPL to start. This would not only take some of the burden off of counties with a limited medical infrastructure, but it would also allow them to provide basic services to more residents. If the legislature does not wish to take this step, then it should instead seek a HIFA waiver to expand Texas's Medicaid program to a broader spectrum of uninsured, low-income adults. This would qualify the program for federal matching funds—an option which is not directly available through indigent health care programs at the county level.<sup>562</sup> The 77th Texas Legislature's passage of a demonstration plan that would have accomplished exactly this—but for the governor's veto—shows that most of Texas is behind such an

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560. See, e.g., 25 TEX. ADMIN. CODE § 14.203(c)(1)(A) (Vernon 2003).

561. See *supra* Part III.B.2.

562. See *supra* Part III.C.

option.<sup>563</sup> When the time is right, the legislature might again consider attempting to pass a similar bill.

9. *Work with local officials and providers to offer health care services to low-income individuals on evenings and weekends.*

Finally, the legislature may wish to consider providing for the coordination of providers and funds among programs for low-income individuals at both the state and county levels to offer health care services in the evenings and on weekends. Many low income individuals who are served by Medicaid and Texas's CHIP, as well as uninsured individuals who may or may not qualify for any public program, cannot take time off of work to see a physician or take their child to a physician without a significant risk of being fired or losing a precious day's wages. People should not have to make this kind of decision. Instead, health care should be provided when the beneficiaries are able to receive it without placing their livelihood in substantial jeopardy. Toward this end, the state and counties could work together to identify and recruit health care providers who are willing to see patients in clinics outside of normal business hours. They could also work together to compile a list of these providers in each area and publicize their services to both individuals and families with public health insurance and in those areas with high levels of uninsurance. Such a plan would benefit not only the state and counties by reducing costly emergency room use but would also benefit both individuals by allowing them access to regular primary health care at a time when they can utilize it as well as participating providers by providing them with both publicity and a steady stream of patients.

Some of the foregoing steps, such as increasing publicity for Texas's Medicaid and CHIPs, may ultimately result in the expenditure of more government resources on health care for low-income individuals. In a time of strained budgets, this may counsel against taking such steps. But presently uncompensated care for the poor is absorbed as best as possible by hospitals, physicians, and other health care providers. Rather than merely resulting in a lower income or profit for the affected health care providers, or driving them out of business, many of those costs are then passed back to paying health care consumers in the form of increased fees for services and correspondingly higher health insurance rates. Thus, an insufficiently aggressive public approach to the problem of the uninsured does not result in less expenditure of money overall but rather in hidden costs that are passed on to both paying health care consumers and taxpayers. Care for the poor should be a community issue, rather than one to be shunted off onto private entities. The

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563. See Demonstration Project Division of Medical Assistance to Certain Low-Income Individuals, 77th Leg., 1st Sess. (Tex. 2001) (vetoed by governor), available at <http://www.capitol.state.tx.us/tlo/bill/text/HB02807.HTM> (last visited Sept. 21, 2003).

legislature and many counties have already taken some strides to address this issue.<sup>564</sup> By taking even more responsibility in this regard, the legislature could further turn the question of how to pay for the care into an open, public matter for debate, rather than allowing it to remain hidden and subject to the vicissitudes of private individuals and entities.

Self-reliance and autonomy support such a result. Pursuing the proposed options should encourage public debate and active community participation in determining how best to ameliorate an issue that each Texas community faces—how to improve access to health care for all. Just like everyone else, low-income and uninsured individuals sometimes need medical care, and they will usually get at least some medical care, even if often insufficient or offered too late, whether they can pay for it or not. Right now Texas largely lets the health care system deal with this problem as best it can. But this is not a problem for the health care system to decide. The private health care industry is neither designed nor equipped to determine how best to address this issue. Its function is to deliver health care, and that is what it is largely set up to do. Asking it to determine hard questions of social policy as well is ill advised. While the proposed options, even if fully embraced and enacted, will by no means definitively solve all of Texas's problems concerning access to health care, their consideration will at least start the process moving forward.

The problem of the uninsured and under-insured is a problem that all Texans must confront. The costs of dealing with the problem are, right now, passed on to the entire community in the form of increased medical bills and overcrowded and financially strapped emergency rooms. Texas needs to continue working to solve this problem at the level of the community by taking the steps suggested above. By facing the problem squarely, Texas can help extend health care options to those who presently lack them while preserving worthy options that presently exist.

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564. See, e.g., TEX. HEALTH & HUMAN SERVS. COMM'N, *supra* note 268; Brewer, *supra* note 546.

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