

CODE RED

THE CRITICAL CONDITION OF HEALTH IN TEXAS

The Summary

PROBLEM: TEXAS HAS THE HIGHEST PERCENTAGE OF UNINSURED IN THE NATION.

SOLUTION: NOW IS THE TIME FOR TEXAS TO TAKE BOLD STEPS.



[PREFACE]

On behalf of the entire Task Force on Access to Health Care in Texas, we want to make a few points as a preface to the Report. First, the Task Force is eclectic and brings diverse backgrounds, experiences and expertise to bear on the problems associated with the uninsured and underinsured in Texas. Indeed, this diversity enriched the deliberations and recommendations of the Task Force, who served without compensation. Second, while diverse with regards to expertise, etc., the Task Force is singular with regard to the importance and magnitude of the problem that inadequate health insurance poses, not only to the physical and mental health of the residents of Texas, but also to the financial well being of the state.

The Task Force is unanimous in its emphasis that this is not a problem of the future, but one that is already here. Third, the Task Force feels that the Report is, in so far as possible, an evidence-based, objective, non-partisan effort with six well prepared commissioned papers and an independent review by a group of experts. The Task Force recognizes that long-term solutions to the challenges of our health system will require a national effort and new national approaches. However, its charge is to confront the challenges within Texas.

The IO academic health institutions in Texas that provided support for the Report exerted no control over the activities of the Task Force or its conclusions and recommendations. The views of the Task Force represent those of the individual members and not those of the entities and institutions of which they are a part. And finally, the Task Force recognizes that some of its recommendations will be controversial and trigger debate. We hope that such debate occurs. It will only serve to further education about the nature and depth of the problem, and we hope it leads to implementation of the recommendations.

A major driver leading to the increasing rates of uninsured and underinsurance is the rising cost of health care. Throughout the Report, the Task Force underscores the responsibility all health professionals and providers have in addressing this basic issue. Texas leads the nation in the percentage of its residents who are uninsured. The Task Force hopes that Texas will also be a leader in developing solutions to this challenge.

Neal Lane, Chairman
Jack Stobo, Vice Chair

[TASK FORCE MEMBERS]

ACCESS TO HEALTH CARE IN TEXAS: CHALLENGES
OF THE UNINSURED AND UNDERINSURED

NEAL F. LANE, PH.D.

Chair

Malcolm Gillis University Professor of
Department of Physics and Astronomy
Senior Fellow of the James A. Baker III
Institute for Public Policy
Rice University
Baker Institute
Houston, Texas

JOHN STOBO, M.D.

Vice Chair

President,
University of Texas Medical Branch at Galveston
Galveston, Texas

HECTOR BALCAZAR, PH.D.

Regional Dean of Public Health at El Paso
Professor of Health Promotion and
Behavioral Science
University of Texas at Houston
School of Public Health
El Paso Regional Campus
El Paso, Texas

KIRK CALHOUN, M.D.

President,
University of Texas Health Center at Tyler
Tyler, Texas

DAVID F. CHAPPELL, ESQ.

President
Chappell Hill, L.L.P.
Fort Worth, Texas

PATRICK J. CROCKER, M.S., D.O.

Chief, Brackenridge-Children's
Emergency Services
Chief of Staff, Brackenridge Hospital
Brackenridge Hospital Emergency Department
Austin, Texas

CHARLES HALEY, M.D., M.S.

Medical Director
TrailBlazer Health Enterprise
Dallas, Texas

GEORGE B. HERNÁNDEZ, JR., ESQ.

President-Chief Executive Officer
University Health System
San Antonio, Texas

WINELL HERRON, M.B.A.

Group Vice President to Public
Affairs and Diversity
H-E-B
Houston, Texas

RICHARD W. JOHNSON, JR., M.A.

Director, Division of Medical Economics
Texas Medical Association
Austin, Texas

[TASK FORCE MEMBERS]

WM. FRED LUCAS, M.D.
Cypress Creek Hospital
Houston, Texas

MICHAEL MCKINNEY, M.D.
Senior Executive Vice President and
Chief Operating Officer
University of Texas Health Science Center at Houston
Houston, Texas

KATHY MECHLER, M.S., RN, CPHQ
Director of Medical Services
The Texas A&M University System
Health Science Center
Rural and Community Health Institute
College Station, Texas

ELAINE MENDOZA
President and Chief Executive Officer
Conceptual MindWorks, Inc.
San Antonio, Texas

ROB MOSBACHER, ESQ.*
President
Mosbacher Energy Company
Houston, Texas

*Resigned as of October 18, 2005

STEVE MURDOCK, PH.D.
State Demographer of Texas
Director of Institute for Demographic and
Socioeconomic Research
University of Texas at San Antonio
San Antonio, Texas

BETSY SCHWARTZ, M.S.W.
Executive Director
Mental Health Association
of Greater Houston
Houston, Texas

DAVID C. WARNER, PH.D.
Wilbur J. Cohen Professor of Public Affairs
Lyndon B. Johnson School of Public Affairs
University of Texas at Austin
Austin, Texas

M. ROY WILSON, M.D.
President
Texas Tech University Health
Science Center
Lubbock, Texas

[TASK FORCE MEMBERS]

SENIOR ADVISOR

KENNETH I. SHINE, M.D.
Executive Vice Chancellor
for Health Affairs
University of Texas System
Austin, Texas

CONSULTANTS

J. MICHAEL HUDSON, M.A.
The Health Policy Group
Washington, D.C.

MANDA WONG, M.A.
The Health Policy Group
Washington, D.C.

STAFF

KIRSTIN MATTHEWS, PH.D.
Project Officer
Postdoctoral Research Associate
James A. Baker III Institute for Public Policy
Houston, Texas

MAGGIE R. FLOORES
Project Staff
Administrative Associate
Office of Health Affairs
University of Texas System
Austin, Texas

AMY SHAW THOMAS, ESQ.
Project Staff
Associate Vice Chancellor and Counsel
for Health Affairs
Office of Health Affairs
University of Texas System
Austin, Texas





[THE SUMMARY]

Texas faces an impending crisis regarding the health of its population, which will profoundly influence the state's competitive position nationally and globally. The health of Texas, economically, educationally, culturally and socially depends on the physical and mental health of its population. Quality of life for individual Texans and the communities in which they live depends critically upon health status. Texas has a rapidly growing population, which has an increasing propensity to obesity, hypertension, diabetes, heart disease and cancer (Murdock et al., 2003). At the same time 25.1 percent of its population is without health insurance, which is the highest in the nation (15.3 percent) and growing (US Census Bureau, 2005). The increasing discrepancy between growing health needs and access to affordable health insurance coverage creates the conditions for a "perfect storm". Poor health negatively impacts education, and educational attainment is directly related to health status (see Appendix E of the Report).

Increasing numbers of uninsured individuals place extraordinary economic and service burdens upon health care providers, hospitals, trauma centers and the communities which provide funding for health services. Fiscal pressures on taxpayers in communities that provide care for rapidly increasing numbers of uninsured individuals continue to grow and compete negatively with other community needs. These pressures are exacerbated by reductions in reimbursements to hospitals, physicians and other providers in the Medicaid and Medicare programs and by the fact that large public and nonprofit

hospitals in central cities often become the de facto provider of services for the uninsured from broad geographic regions.

In view of these serious challenges, ten academic health institutions in Texas (Baylor College of Medicine, Texas Tech, Texas A&M, North Texas and the six health institutions of The University of Texas System) created a Task Force on these issues. Task Force members also included small and large business employees, health care providers, insurers and consumers. All represented their own personal perspective and did not represent groups or organizations with which they are associated. Financial support for the project came solely from the academic health institutions. Administrative support was provided by staff at Rice University's James A. Baker III Institute for Public Policy and The University of Texas System.

The Task Force is unique in many ways. It is the first broad-based group of its kind to be created in Texas whose membership was not determined by governmental or political considerations. The project has been predicated upon an objective, evidence-based analysis, which depended heavily upon commissioned papers from experts providing in-depth analysis of relevant subjects. This report, which represents a consensus of the Task Force, was subject to independent expert peer review.

The Task Force was chaired by Neal Lane, Malcolm Gillis University Professor and Senior Fellow of the James A. Baker III Institute of Public Policy at Rice

University, who has a long and distinguished career in science and public policy, but whose personal activities and programs at Rice University do not involve health care delivery. In addition, Jack Stobo, President of the University of Texas Medical Branch at Galveston, served as the Task Force vice chair. During its proceedings, the Task Force conducted five plenary meetings in locations across the state and a series of subcommittee meetings. The six papers commissioned by the Task Force appear as appendices to this report. The names of members of the Task Force and their titles, provided for identification purposes only, are also attached along with the names of staff that supported the project (Appendix A).

Fundamental changes in access to health care will require changes in federal policies and federal resources. However, this study was focused on actions within the control of the state of Texas and its institutions.

In this summary, we describe the characteristics of the uninsured and the consequences of such populations. We then summarize the Findings and Recommendations of the Task Force.

WHO ARE THE UNINSURED?

Health insurance in Texas is usually obtained through employment or individual purchase. Health insurance is also available through publicly sponsored plans including Medicare, Medicaid and the State Children's Health Insurance Plan (SCHIP). The uninsured lack either private or public insurance coverage.

The rate of uninsurance varies substantially among racial and ethnic groups. In Texas, 40 percent of

the Hispanic population was uninsured in 2004 compared to 24 percent of the African American population and 14 percent of the Caucasian population. New immigrants are largely uninsured, but represent only 18 percent* of the overall uninsured population (IOM, 2001). Over 60 percent of uninsured Americans live in families with children. In Texas, 22 percent of children are uninsured (Families USA, 2003). This is extremely high compared to the national average of 12 percent. Though overall statewide rates of uninsured are highest among minorities in Texas, the majority (68 percent) of non-poor uninsured Texans are White non-Hispanic males (TDI, 2003).

While some individuals may be uninsured over the entire course of the year, many people move in and out of uninsured status when they transition through the workforce or when their eligibility for a public plan changes. It is important to recognize that 79 percent of uninsured adults in Texas are part of the workforce or have one or more family members in the workforce (TDI, 2003). Two out of three have incomes less than 200 percent of the current federal poverty level (FPL), and 56 percent of Americans below the FPL were uninsured during some part of the year in 2001-2002 (Stoll, 2004).

For a family of four at the FPL, which is approximately \$20,000 a year, the average cost of private health insurance, \$9,100 in 2005, is close to half of their income. For individuals at 200 percent of FPL, i.e. \$40,000 per year for a family of four, their health insurance premium would be 23 percent of their family income (Stoll, 2004). Although there are individuals in higher income brackets who

* These are uncertain estimates. Some suggest a figure up to 24% (PEW Hispanic Center, 2005)

wish to be self-insured or assume the risks of no insurance, for the overwhelming majority of the uninsured, health insurance is an issue of affordability.

With rapidly rising premium costs, increasing numbers of employers no longer offer health insurance to their workers. Nationally, 61 percent of employers offered health insurance coverage in 2004, down from 64 percent in 2002 (TDI, 2003). More important for Texas, however, is that employers who have 50 employees or less, i.e. “small employers”, find it difficult to offer insurance to their employees, and when they do the rates are so high many employees cannot afford them or cannot afford to cover their dependants. Only 35 percent of employees working for small employers who were offered insurance actually enrolled, in comparison to 63 percent of employees for large employers (TDI, 2003).

Programs such as Medicaid and SCHIP are important sources for the provision of health insurance to segments of the Texas population. In 2003, 2.5 million Texans were enrolled in Medicaid and 460,000 were enrolled in the SCHIP program (Murdock et al., 2003). While these programs cover a large portion of the uninsured, an additional 5.6 million Texans were still uninsured in 2003 (US Census Bureau, 2005). Because eligibility for Medicaid and SCHIP offers the opportunity for insurance coverage to those previously uninsured, policies that maximize Medicaid and SCHIP capacity are examined in this study.

COSTS OF UNINSURED POPULATION

The Uninsured

There is abundant and convincing evidence that not having health insurance contributes to increased morbidity and mortality. Uninsured women with

THE HEALTH OF
TEXAS, ECONOMICALLY,
EDUCATIONALLY,
CULTURALLY AND
SOCIALY DEPENDS ON
THE PHYSICAL AND
MENTAL HEALTH OF
ITS POPULATION.

25.1 PERCENT
OF TEXANS ARE
WITHOUT HEALTH
INSURANCE. THIS
IS THE HIGHEST
PERCENTAGE IN
THE NATION.
THE NATIONAL
AVERAGE IS
15.3 PERCENT.

breast cancer have a 30 to 50 percent higher risk of dying than those who have health insurance. For colorectal cancer the risk is 50 percent higher (IOM, 2002). Based on analysis from the Institute of Medicine of the National Academies (IOM), evidence suggests that as many as 2,500 Texans die each year as a consequence of being uninsured.

Equally important is the effect a lack of health insurance has on the quality and productivity of non-health related dimensions. For example, absenteeism by children with inadequately managed asthma impairs a child's education and deprives the school district of funding related to school attendance. In addition to poor health and increased mortality, health care economic burdens are the single most common cause of family bankruptcy due to costs of a serious or prolonged illness (IOM, 2002).

The Health Care Systems

The most expensive forms of health care are those provided through hospital emergency rooms and those involving hospitalizations. In contrast, preventative services, including immunizations and effective management of chronic illness provided on an ambulatory basis, are far more cost effective (IOM, 2002). Inefficiencies in the care of those who are uninsured further exacerbate these costs and diminish quality. For example, uninsured patients are much more likely to have episodic care, return to multiple emergency rooms, receive a multitude of repeated tests including X-ray procedures and blood tests each time they seek care, and often do not complete a course of treatment in order to be completely cured (IOM, 2002). The Federal and State Emergency Medical Treatment and Active Labor Act (EMTALA) regulations require that patients be carefully evaluated at the time of an emergency room visit, further adding to these costs,

resources and personnel time. Some patients give different names and Social Security numbers when seen for health care.

Uninsured individuals commonly go from one health care institution to another, often from one emergency room to another. In the absence of an electronic medical record, significant numbers of laboratory tests, X-rays and other expensive medical procedures are repeated at each visit. In the absence of coordinated care, conditions are left untreated until they have progressed to a more advanced stage and impaired health, as well as required costlier intervention. The lack of health education and preventative medicine means that conditions such as hypertension and diabetes are not prevented, but progress to expensive complex diseases.

As a result, a major and increasing burden of providing care for the uninsured is borne by emergency rooms and hospitals, which must find a way to pay for uncompensated care or go bankrupt. In trauma centers, 32 percent of all patients in Texas were uninsured (Bishop & Associates, 2002). In 2003, Texas hospitals spent approximately \$208 million treating uninsured trauma patients (EMS, 2005). The University of Texas System health institutions provided over \$1.4 billion in uncompensated care in 2005 (The University of Texas System, 2006). For 2001, the IOM estimated that nationally over \$99 billion was provided for uncompensated care to uninsured individuals. Of this amount 35 percent or about \$34 billion was paid from funding sources within the hospitals (IOM, 2001).

Until recently the cost of uncompensated care was offset through a cost-shifting subsidy provided by payments from Medicare and private insurance payments. Due to the unreimbursed cost

for health care for the uninsured, private health insurance premiums for Texas families are estimated to be \$1,551 higher annually than they would be otherwise (Families USA, 2005). As pressures have increased to reduce health care expenditures, Medicare and private insurers have reduced or eliminated payments in excess of actual costs, diminishing or eliminating cost-shifting subsidies. As a result, hospitals are more unstable financially, particularly those providing care to significant numbers of uninsured individuals. In addition, there are dramatically increased pressures to obtain tax support to compensate health care institutions and providers for lost revenue. Consequently, increased taxes that are used to provide substantial amounts of indigent health care make communities less attractive to business and to potential migrants to such communities.

The cost of care to the uninsured must be paid from some source if hospitals are not to go bankrupt. The increasing burden of uncompensated care has led to the closure of emergency rooms and trauma centers in order to reduce the exposure to uninsured patients. Some tertiary care hospitals have developed strategies to minimize accepting transfers of uninsured patients for costly or highly specialized services. This could destabilize the economic viability of health care providers, such that they may be forced to leave the community. They would then be unavailable to provide services not only to the uninsured, but to all members of the community.

FINDINGS

After reviewing and considering extensive evidence, the Task Force concluded that in the absence of aggressive initiatives to deal with the increasing number of individuals without health insurance, the state will be at significant risk of a substantial

decline in the health and productivity of its citizens and the vitality of its economy. This could result in the following conditions:

- An unhealthy, poorly educated workforce resulting in lower productivity and reduced state economic power;
- The loss of many important community institutions including emergency rooms and hospitals;
- Degradation in the quality and accessibility of health care for all Texans;
- Budget crises, for both the state and particularly in high population counties in the state; and
- A negative image, which will decrease business retention, investment, development and workforce recruitment.

The Task Force concluded that critical solutions to the challenge of the uninsured must arise out of a shared responsibility for the problem by a broad diversity of participants, including health care providers, patients and their advocates, policy makers, businesses, community organizations, and state and federal governments. The Task Force also determined that additional resources and the more efficient and effective use of resources will be required in order to provide appropriate services to the uninsured. These must include methods for improving the efficiency and effectiveness of health care as well as efforts to control the rate of increase in overall health care costs.

THE SPECIFIC TASK FORCE FINDINGS INCLUDE:

- The overall health status of Texans is poor, particularly in comparison to other states in our country, and is likely to decline further without major and immediate interventions.
- Texas has the highest proportion of uninsured individuals in the United States, which has a major impact on the health and economy of the state.

- Strategies to control the cost of health insurance or to subsidize payments by employers and employees are needed, particularly for those working for small employers.
- Current trends in the delivery of health care will exacerbate problems associated with an increasing number of uninsured Texans.
- Emergency rooms provide an important, but expensive and inefficient method for providing care to the uninsured and underinsured.
- Texas communities are making great efforts to improve access to health care, particularly for the uninsured.
- Expansion and strengthening of ambulatory (out-patient) services is an essential and necessary step to achieve high quality, cost effective care for the uninsured and those on Medicaid and SCHIP in Texas.
- The continuing rise in Medicaid and health care expenditures in Texas is unsustainable and has deleterious effects on the ability to fund other critical state needs.
- The State of Texas has not taken full advantage of federal matching funds for health care to the uninsured.
- The current county-based approach to health care in Texas is inadequate and inequitable.
- There is a significant shortage of health care professionals in Texas, which limits the capacity to provide care, particularly to the uninsured and Medicaid recipients.
- Educational attainment and health are inexorably linked in Texas.
- Care of people with mental illness remains a major unresolved problem for Texas.
- The solution to adequate access to health care for the uninsured and underinsured is a shared responsibility where partnerships are crucial.





These findings and significant consequences clearly establish the need to address the problems of uninsured status and large uninsured populations. A rational solution to many of the issues in health care would be a state-wide system for an integrated program of health care to the uninsured, rather than a county-based system. While the Task Force recognized that the creation of such a system is extremely challenging, significant reform must be part of the long-term solution to the problem of access to adequate health care. To address and ameliorate these findings and significant consequences, the Task Force developed the recommendations presented below. Each recommendation includes findings in support of the recommendation.

Recommendation 1:

Texas should adopt a principle that all individuals living in Texas should have access to adequate levels of health care.

FINDINGS:

- 5.6 million non-elderly individuals living in Texas, or 25.1 percent of the population, were without health insurance in 2004 (US Census Bureau, 2005).
- The uninsured have poorer health and increased mortality (see Chapter Three of the Report – Consequences of the Uninsured and Underinsured for more details).
- Universal access to health care is an essential and necessary component in a successful society.
- Adopting the policy of universal access will result

in a better skilled and more productive workforce, strengthen the Texas economy and reduce long-term health costs.

- Health care should be consistent with the recommendations of the IOM, i.e. care that is effective, efficient, safe, timely, patient-centered and equitable (IOM, 2004).

As detailed in Chapter Three of the Report – Consequences of the Uninsured and Underinsured – the consequences of substantial numbers of uninsured individuals include:

- Poorer health status that interferes with education and work;
- Damage to community resources such as hospitals and emergency rooms;
- Family disruptions including bankruptcies;
- Higher health care costs borne by those who have insurance;
- Rising tax burdens; and
- Less attractive business environments.

A successful health care system for Texas must create the conditions which meet the six aims as described by the IOM (IOM, 2004). It should be effective, efficient, safe, timely, patient-centered and equitable. In an environment of limited resources it is especially important that this system be cost effective. It should maximize efforts to provide accessible ambulatory care and to minimize the use of emergency rooms and other high cost venues. Of particular importance is a continuum of care so that patients receive appropriate preventative measures and do not have tests,

procedures or evaluations repeated over and over again as they seek health care at multiple sites. The medical records of patients must be accurately identified even if the patient gives an inaccurate address and/or Social Security number. Appropriate care should be provided at the least expensive site and by the least costly personnel and procedures as is feasible. This includes the appropriate use of nurse practitioners, physician assistants and other non-physician personnel. An electronic health record or smart card with accurate patient identification is an essential part of any system of this kind.

This does not exclude variations in health care benefit packages, or some limitation on the choice of drugs and procedures, but it does imply that services are to be provided “based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit” (IOM, 2004). In an environment of rapidly rising health care costs, services should be provided which offer high-quality care in the most cost effective manner. Accomplishing these goals requires an adequate number of health care providers, efficient and effective health care delivery systems, and adequate financial resources. Preventative programs, especially those for school sites, are essential for success.

The Task Force is aware that a significant number of individuals living in Texas are not legal immigrants. The control or regulation of illegal immigration is not in the charge to the Task Force. However, the Task Force believes that the overall health of the state depends on development of methods to provide effective and cost efficient health care to all individuals living in Texas. Disease has no boundaries, nor should health care. The health status of illegal immigrants in Texas impacts the health status of all Texans.

FUNDING

The Task Force recognizes the significant fiscal constraints on the state of Texas and the growing financial burdens created by rapidly rising Medicaid costs, along with other demands on the state budget. However, the Task Force is convinced that additional investment is required to make the health care system more effective and efficient. Under the current system, care for the uninsured is borne by society through a variety of cross subsidies, public venues and philanthropy. These costs are certain to grow unless systematic efforts are made to control the rate of increase. Health professionals and providers must also contribute to controlling these rising costs. Academic health institutions should be charged to aggressively conduct health services research on the control of health care costs and other characteristics of a high quality and efficient health care system (see Recommendation 9). While some increased investment from general funds of state and local government will be required, the Task Force believes that substantial additional resources can be obtained by better leveraging state monies to maximize return from the federal government.

Recommendation 2:

Texas should provide more adequate resources and aggressively seek more efficient and effective methods to support health care to the indigent and uninsured with the goal of reducing rising health care costs.

Recommendation 2.1:

Texas should authorize and encourage efforts to move indigent health care from a county-based model to a model based on regional multi-county health districts, while increasing the state-wide federal poverty level (FPL) to 100 percent from 21 percent for indigent care responsibility in Texas counties.

FINDINGS:

- Indigency in Texas is currently defined as those living at 21 percent FPL or less for determining county responsibility for providing indigent health care. 21 percent FPL is less than \$1,700 a year for a single adult (TDSHS, 2005).
- Texas requires counties to create county indigent health care programs (CIHCP), using 8 percent of their general revenue tax levy to provide indigent health care in order to receive state funds (Canton, 2000).
- Larger metropolitan counties such as Harris (Houston), Dallas, Tarrant (Fort Worth), and Bexar (San Antonio) are using more than 8 percent of their ad valorem tax levy and providing health care to individuals at levels above 21 percent FPL (Cookston, 2004; Dallas County Medical Society, 2006; Wilson, et al., 2005). While others choose to spend far less than 8 percent.
- While counties such as Bexar, Harris, Dallas, and Tarrant exceed the state requirements for the delivery of indigent health care, other neighboring counties choose to provide minimal levels of care, including only serving those at 21 percent FPL (Cookston, 2004; Dallas County Medical Society, 2006; Wilson, et al., 2005). This creates an inequitable and inefficient system where the uninsured migrate from their home counties to larger counties to seek medical care, often in already overcrowded emergency rooms, where they are subsidized by the taxpayers of the larger county.
- Current county policies that limit support to those persons living at 21 percent FPL or less provide inadequate support for indigent health care to residents of their counties. The burden of funding indigent health care is increasingly shifted to taxpayers in large metropolitan counties where patients, often from surrounding counties, come for care.

- This is an unfair subsidy which jeopardizes the care for all who seek it in these metropolitan areas.
- Action is needed to promote change from a system of county-based indigent care to a regional-based system of indigent care, where appropriate. This would ensure necessary care for all populations, regardless of their county of residence, with more equitable financing. Regionalization would concentrate limited or expensive health services locally within an area, while dispersing primary care and less complex services broadly through each region. To be successful, any regional plan must recognize the great diversities among Texas counties and regions by allowing broad and flexible principles to be tailored to a region's specific needs, rather than a rigid uniform policy.

REGIONAL HEALTH CARE GOVERNANCE:

One possible system might employ the existing 22 trauma service areas (or combinations thereof). Each county would be classified into one of four classes based on their tertiary capacity regarding the following specialized services:

- Medical Intensive Care Beds
- Pediatric Intensive Care Beds
- Obstetrical Beds
- Burn Intensive Beds
- Trauma Center Beds
- Coronary Care Beds
- Neonatal Intensive Care Beds

The state could establish a tertiary care regional hospital infrastructure organized around three hospitals classes: Lead, Core and Rural. The planning structure would include representation from primary care providers, Regional Advisory Councils (RAC), regional physicians and business/consumer representatives. Each board would consider

THE UNINSURED PLACE
EXTRAORDINARY
ECONOMIC AND
SERVICE BURDENS
UPON HEALTH CARE
PROVIDERS, HOSPITALS,
TRAUMA CENTERS AND
THE COMMUNITIES
WHICH PROVIDE
FUNDING FOR
HEALTH SERVICES.

a regional plan for the delivery of care that best fits the region's individual needs and identifies the best funding sources for the region's particular priorities, under the auspices of the Health and Human Services Commission. Each board would have the authority to implement its regional health care plan and link identified dollars to the plan.

FUNDING REGIONAL HEALTH CARE:

There are three primary missions for regional funding:

- Preserve comprehensive tertiary services for all Texans
- Increase coverage for the uninsured
- Improve health services for rural patients

In addition, a minimum 8 percent of general revenue tax levy (GRTL) on county expenditures should be mandated for indigent health care services. Funding could be established through Medicaid IIII5 or HIFA waivers on a region-by-region basis to encourage new and comprehensive state approaches that decrease the number of uninsured individuals, as described below. If these GRTL funds were collected by the state, they would be eligible for a federal match of \$1.50 for each \$1 collected and result in significantly more funds for care (TDSHS, 2004a).

Recommendation 2.2:

Texas should redouble its efforts to aggressively pursue Medicaid and other federal reimbursement programs for which a state investment will result in substantial federal matching and supplementary reimbursements.



FINDINGS:

- Texas taxpayers are subsidizing other states such as California and New York, that aggressively pursue federal matching and receive a substantially greater share of federal funds than Texas.
- The 79th Legislature approved an application for a Medicaid Family Planning Matching Act Program Waiver.
- This waiver would provide \$90 of federal money for every \$10 of state money expended.

As outlined in Chapter Four of the Report – Medicaid and SCHIP in Texas – Texas has not taken full advantage of federal matching programs to fund and provide care for the uninsured. The Task Force concludes that maximizing federal support is essential to expand coverage and improve reimbursement to health care providers for care of the uninsured, but equally important is the need to introduce methods that will increase the efficiency and cost effectiveness of care. Texas has remarkably disadvantaged itself in comparison to the amount of federal monies flowing to other states to provide health care.

State leadership should consider covering family members under the poverty level, reinstatement of the medically needy program including a reinstatement of the medical spend-down to eligibility provision, and possibly experimenting with limited expansion to the poor population that does not live with indigent children. Texas has failed to take full advantage of federal matching funds for Medicaid.

Current levels of Medicaid coverage and reimbursement mean that, in addition to very high local

property taxes to support indigent health care, virtually all of the disproportionate share hospital (DSH)* funds are devoted to partially reimbursing shortfalls of caring for the uninsured and underinsured at Texas hospitals (THHSC, 2004; HSCSHCE, 2004). Because of the large number of uninsured patients and the relatively low levels of reimbursement from Medicaid and other state sources, DSH monies are essentially entirely used for reimbursing shortfalls. As a result, little DSH money is available for innovative coverage initiatives such as the three share program, (see Recommendation 4.1) which is the case in other states.

Recommendation 2.3:

The state should develop and adopt tax policies and initiatives that encourage and enable employers (especially small employers) to provide health insurance to their employees.

Recommendation 2.4:

State and local governments should give preferential treatment to contractors and subcontractors who offer health care coverage for their employees. Those seeking funding through the Texas Enterprise Fund and similar public programs should be included in this requirement.

FINDINGS:

- Seventy-nine percent of uninsured adults in Texas are employed or in families in which a member is employed (TDI, 2003).
- Workers in construction, manufacturing, and wholesale and retail trade account for 53 percent of all uninsured individuals in Texas (TDI, 2003).

* DSH monies are federal funds to assist hospitals that care for a disproportionate share of uninsured patients.

Texas spends a considerable amount of tax dollars with contractors who build roads and other major public facilities in the state. Many of these businesses do not currently offer health insurance coverage to their employees (TDI, 2003). If the state would require all contractors and subcontractors to state and local governments to provide reasonable employer sponsored insurance, especially in the construction industry, there would be a significant decrease in the uninsured population in the state. Furthermore, as business tax structures are modified by the Texas Legislature, attention should be given to a tax credit for small employers who provide health insurance to their employees.

Preferential consideration for public contracts could occur in the course of scoring or by financial addition to the contract. Health insurance coverage should be available to all employees of the business. Eligibility of special programs such as the Texas Enterprise Fund should also include this provision providing preferential consideration to employers that provide reasonable employer sponsored health insurance. Of course, additional consideration should be given to small employers and programs that facilitate and encourage them to offer health insurance to their employees (see Recommendation 4.1).

Recommendation 2.5:

Texas Leadership should actively work with federal officials to maximize opportunities for initiatives and new policies expressly intended to provide for the most efficient delivery of health care services to broader numbers of uninsured individuals living in Texas.

A succession of federal statutes adopted over many years, intended to provide greater flexibility to states to administer Medicaid programs, have instead produced federal micromanagement of program administration and resulted in less state opportunities or willingness to pursue innovative approaches to access, financing and delivery of health care services.

The Task Force urges Texas to adopt the best of sweeping advances in medicine, health care delivery and systems technology, as the Medicaid population and surging health care costs challenge the state's ability to provide critically needed health services. Texas policy makers at all levels of government should work toward new commitments from Washington that allow Texas to modernize its Medicaid program. However, the Task Force does not believe block grant funding for Medicaid is a safe and effective way to provide federal support in Texas.

Recommendation 3:

*A Quality Assurance Fee (called a provider tax in some states) of 3 percent should be assessed on revenues of all hospitals and free standing surgery centers in order to obtain a federal match to enhance overall finances for provider reimbursement and enhancement of the quality and efficiency of health care to the uninsured.**

FINDINGS:

- A 3 percent fee on revenues of all hospitals and surgery centers is likely to produce about \$1.1 billion in state general revenue (Warner, 2006).
- The federal match provides \$1.50 for each state dollar (TDSHS, 2004a).

* One dissenting opinion on this recommendation, Mr. Richard Johnson. (See Appendix K of the Report.)

68 PERCENT OF
NON-POOR UNINSURED
TEXANS ARE WHITE,
NON-HISPANIC.
INDIVIDUALS.

- A quality assurance fee on these entities could bring the state in the range of \$1.7 billion additional dollars annually from the federal government (Warner, 2006).
- Thirty-five other states have some form of a quality assurance fee or provider tax and many have multiple such taxes (Smith, et al., 2005).

There are a number of challenges facing the health care system in Texas:

- Texas has the highest percentage of uninsured in the country (US Census Bureau, 2005).
- Medicaid is limited in numbers covered and provider reimbursement (see Chapter Four of the Report—Medicaid and SCHIP in Texas for more details).
- EMTALA and the Texas Constitution make hospitals and counties responsible for some of the uninsured (for more details see Chapter Eight of the Report—Trauma Care in Texas).
- The Legislature is confronting challenges to reduce local property taxes and increase education spending.
- Urban taxpayers are at their limit in providing additional property taxes to support indigent care, and public and community hospitals that care for Medicaid recipients and the uninsured have exhausted all the DSH funds and much of their upper payment limits (UPL), and are limiting services that are not mandated (for more details on DSH and UPL see Chapter Four of the Report—Medicaid and SCHIP in Texas).

Many states have implemented quality assurance fees (Smith et al., 2005). It is attractive to policy makers, because, if devoted to expanding Medicaid, it is one of the few taxes which has the capacity to substantially increase funding to the sector being taxed. The use of provider taxes and assessments has been increasing broadly in other

states. A number of states have increased their reliance on this form of financing and in FY2005, 35 states had one or more provider taxes in place (see Table I for a summary of state provider taxes and assessments). Texas currently imposes a quality assurance fee on intermediate care facilities/mental retarded (ICF/MR) facilities, and taxes Medicaid health management organizations (HMOs).

The net impact of a quality assurance fee on a particular provider depends not only on the type and amount of the fee, but how the proceeds of the fee are used. In Texas, a 3 percent fee on all hospitals and free standing surgery centers would yield more than \$1.1 billion in direct state general revenue, which could possibility draw down an additional \$1.7 billion in federal matching money if used for Medicaid (Warner, 2006). Some of the tax receipts could be used to replace local property tax dollars, although it would diminish the net increase in funds.

The limited Medicaid coverage impacted the drawdown of non-Medicaid federal funds, because it reduces eligibility for Medicare DSH reimbursement for many hospitals. It has also made it difficult to attract federal funding for a number of Federally Qualified Health Centers (FQHCs), because it is hard to show they are financially viable. Lack of Medicaid funding for direct graduate medical education (GME) expenses at hospitals has reduced the attractiveness of expanding GME at many institutions. A quality assurance fee is an approach many states have taken. It is attractive to policy makers, because, if devoted to expanding Medicaid, it is one of the few taxes which has the capacity to substantially increase funding to the sector being taxed. The Task Force proposes that the proceeds from

Table 1
State Provider Taxes and Assessments in
FY2005 and FY2006

Provider Type	Prior to 2005	New in 2005	New in 2006	Total in 2006
Nursing Home	23	5	4	32
ICF/MR	12	5	2	19
Hospital	12	2	2	17
Managed Care Organization	6	3	3	15
Pharmacy	3	0	0	4
Home Health	2	0	0	2
Practitioner	2	0	0	2
Other	1	2	2	4

Source: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, and Molly O'Malley, "Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50 State Survey," Kaiser Commission on Medicaid and the Uninsured, October 2005, p. 38



a quality assurance fee be used to maximize the drawdown of federal funds to have the capacity to enhance efficiencies in the overall provision of care to Medicaid recipients and the uninsured. Hospitals which provide unsponsored charity care (not bad debt, uncovered services, services lacking medical necessity, deductibles, co-pays, Medicaid, SCHIP or any other care coverage that does not completely cover costs) might receive a partial tax credit against the 3 percent gross receipts tax; although, any tax credits for taking care of the uninsured would substantially reduce the yield of such a fee.

A recent survey of Medicaid financing by the Kaiser Commission on the Uninsured stated that “the federal statute defines a tax or licensing fee, assessment or other mandatory payment as a ‘provider tax’ if 85 percent or more of its burden falls upon health care providers. In order to be allowable as a Medicaid revenue source, a provider tax must be broad based, (i.e. it must cover at least all non-federal non-public providers in a class.....and it must be imposed uniformly upon every provider in the class.)” In addition, the state cannot guarantee that every taxpayer will be made whole.

It is the mission of the Task Force to not only identify sources of funds to increase health care to the indigent and uninsured, but to encourage a broader range of providers to participate in the provision of indigent care. We hope a quality assurance fee will decrease the impact of adverse risk selection and increase incentives to provide uncompensated care and enrollment in Medicaid. The goal is to increase health care coverage and make cost-shifting more transparent.

STATE EXPERIMENTATION

Recommendation 4:

The state should significantly increase its capacity and commitment to conduct experiments in health care delivery and funding.

FINDINGS:

- Texas has not taken adequate advantage of opportunities to obtain federal waivers in order to experiment with better ways to provide health care (see Chapter Four of the Report – Medicaid and SCHIP in Texas)
- The state currently has no 1115 Waiver for research and demonstration projects and has made limited use of other types of waivers.

Resolution of the problem of access to health care is extremely complex. The family planning waiver for Medicaid offers real opportunities for enhanced resources in the care of women. The three-share approach discussed in Recommendation 4.I, or some variant of it could be useful to employed individuals working for small employers. There are other categories of individuals such as students, recent high school or college graduates, those who are disabled and/or completely unemployed, and those who are in and out of the workforce, for whom specific programs might be designed.

Since many of these approaches have unintended consequences and the interactions are complex, the key is to experiment and provide opportunities for varying ways to leverage resources and maximize efficiency and cost effectiveness while preserving quality of care. Providing incentives for prevention rather than treatment, and making the ambula-

tory setting the center for medical care rather than emergency rooms and hospitals, are among important areas that can be explored.

The state must take proactive approaches to these kinds of experiments. While the Centers for Medicare and Medicaid Services (CMS) generally requires that waived programs be revenue-neutral, there is considerable latitude in how and which revenue is applied, and what outcomes can be achieved (HHS, 2001). If Medicaid expansion increased hospital reimbursements and thereby reduced the need for DSH, these funds could be employed in initiatives without any additional federal approval.

One example of experimentation involves Mexican nationals living in Texas. Many are not receiving preventative health care, have limited access to health services for acute episodes, and have difficulties controlling chronic health problems. Mexican nationals living in Texas frequently use emergency departments as their last recourse or return to Mexico to receive the health care they need. As a result, the health status of the Mexican population in Texas is sub-optimal and negatively affects the well-being and economy of both countries. The Mexican Consulates have discovered that recent immigrants feel comfortable seeking services and advice from the Consulates. Enhancing the services offered at the Mexican Consulate to include primary health care is a significant change that would be welcomed by Texas-based Mexican nationals. More detailed information on this proposal is provided in Appendix H of the Report.

TEXAS HOSPITALS
PROVIDED
\$7.7 BILLION IN
UNCOMPENSATED
CARE IN 2003.



Recommendation 4.1:

Experimentation with employer premium subsidies should be undertaken with the use of Disproportionate Share monies, Medicaid funds and other federal programs.

FINDINGS:

- In Texas, 73 percent of all businesses are small employers (less than 50 employees) (TDI, 2003).
- Only 37 percent of small employers in Texas offer health insurance (TDI, 2003).
- Of the small employers who offer insurance, only 35 percent of their employees enroll compared to 63 percent of employees from large employers (TDI, 2003).
- A significant contributor to the high percentage of uninsured individuals in Texas is the proportion of small employers providing health insurance in comparison to other states (described further in Chapter Two of the Report – Uninsured in Texas). Small employers have the greatest difficulty in obtaining health insurance for their employees at a cost that businesses and/or employees can afford. There is desperate need for experimentation within the state to find ways to help small employers obtain affordable health insurance (TDI, 2003).
- Many experiments have been undertaken to create opportunities for small employers to purchase insurance for their employees, usually through some kind of purchasing pool. While there is room for further experimentation in this area, purchasing pools have been negatively impacted by adverse selection, i.e. employers with employees who have significant health problems preferentially enroll in such pools while employers who have very healthy populations are unwilling to participate. In order to overcome this adverse selection, one approach would be to add small business employees to the public employer pool.

This would place them in a larger group with more choices and better rates.

- Another particularly interesting approach to increasing small employer coverage is the so-called three-share approach. The basic benefit package is provided to employees with relatively low premiums, which are divided equally among employer, employee and a state subsidy. While recent federal law prohibits the use by the state of unused SCHIP monies to investigate the feasibility of this unique model for promoting insurance coverage, its goal is compelling. However, state funds available from leveraged resources provide an opportunity to understand if health insurance coverage can be offered and provided to employees around the state. Such pilot programs are not only worthwhile, they are urgently required.
-

Recommendation 4.2:

Health care providers must work to improve the quality and efficiency of care provided to the uninsured and underinsured and, in collaboration with community partners, to assist patients so that they can better navigate the health care system.

FINDINGS:

- SETON Healthcare System found that using a telephone call center staffed by nurses redirected 62 percent of callers intending to use the emergency departments (Seton, 2005).
- The “Urgent Matters” project, sponsored by the Robert Wood Johnson Foundation, demonstrated that patient visits in the emergency room could be reduced by over 40 percent with more effective organization (Wilson and Nguyen, 2004).
- Diversion time (i.e. periods where the emergency room does not accept patients) by hospitals could also be decreased by 40 percent by this

more effective organization (Wilson and Nguyen, 2004).

- Increasing efficiency decreased the number of patients who left the emergency room without being seen from 21 percent to 7 percent (Wilson and Nguyen, 2004).

Sick uninsured individuals often see emergency rooms as an important source of primary care provided by excellent physicians, with the best equipment and all the resources required for treatment. At the same time they dread long waits and variable degrees of courtesy and inefficiency in their care. For this reason they often delay care (described in Chapter Three of the Report – Consequences of the Uninsured and Underinsured). Focus groups conducted with a wide variety of uninsured individuals are almost all aware of the availability of emergency rooms, but not other community health services (Rosenbaum, 2005). “Active engagement” of hospitals and medical schools with community health sites and better community education regarding the availability of services could significantly reduce the pressure on emergency rooms (Rosenbaum, 2005). While the increasing number of patients using the emergency room has placed enormous pressure on them, it has also been clear that internal organizational elements such as surgical schedules, management of intensive care unit capacity, and other determinants of hospital patient flow are essential to the solution of this overcrowding.

Brackenridge Hospital in Austin and The University of Texas Medical Branch at Galveston found that emergency room utilization, which is expensive and inefficient, can be dramatically reduced by effective programs of telephone

and emergency room triage. This is facilitated by identifying high emergency room users and instructing them on how to get advice by telephone. It is also helpful to use this information at the time the patient reaches the emergency room.

Recommendation 4.3:

State and federal laws on emergency medical treatment and active labor act (EMTALA) as well as their interpretation by CMS, should be clarified so that individuals who are non-emergent in emergency rooms may be more quickly referred to ambulatory sites if access to an ambulatory site is assured.

FINDINGS:

- Primary care-related visits constitute between 42 to 56 percent of the visits in major Texas hospitals (Parkland, Ben Taub, Memorial Hermann, and Brackenridge were polled) (Bishop & Associates, 2002).
- The uninsured constitute 23 to 48 percent of the primary care-related visits in these hospitals (Bishop & Associates, 2002).

EMTALA, often referred to as the ‘anti-dumping law’, created the requirement for medical screening and stabilization of patients with emergencies (described in detail in Chapter Eight of the Report— Trauma Care in Texas). Over the 20 years since it was passed, EMTALA has led emergency rooms to become a part of a community’s safety net of health care providers, because hospitals have the only legally mandated “open door” policy. The reliance on hospital emergency rooms for basic care contributes to emergency room overcrowding problems.

76-82 PERCENT
OF THE UNINSURED
IN TEXAS ARE U.S.
CITIZENS;
NON-CITIZENS
COMPRISE 18-24
PERCENT OF THE
UNINSURED IN
TEXAS.

Treating patients with non-emergent health issues in an ambulatory clinic would alleviate emergency room overcrowding, and improve trauma care. This will provide better delivery and care for both the non-emergent and emergent patients.

Full implementation of both the assessment and disbursement aspects of the Driver Responsibility Program along with further strengthening of the regional strategic planning and monitoring infrastructure of the Regional Advisory Councils and/or other regional planning bodies, would substantially strengthen emergency care in Texas.

VIRTUAL INTEGRATED CARE MODEL FOR THE UNINSURED

Recommendation 5:

The concept of virtual care coordination for the uninsured (including these patients in a structured system of care) should be developed by local communities and by the Texas Health and Human Services Commission.

A virtual health care coordination model would be valuable not only for those without health insurance, but for all patients to have an easy identifier allowing health care providers quick access to medical records. For this model to be effective, a system of community-based ambulatory care sites would be required across the state. These ambulatory care sites would include FQHCs, hospital outpatient clinics, hospital-supported community ambulatory centers, and clinics supported by community organizations such as churches, non-profits and community centers. At the site of first health care contact, whether inpatient or ambulatory, each patient should be assigned an electronic health record with

a unique patient identifier. Such records should be accessible by secure internet-based technology so that the patient record can be retrieved wherever the patient is seen.

To be most effective, methods that improve quality of care such as disease management of patients with diabetes, asthma, high blood pressure and lung disease should be utilized. Patients in the virtual care coordination system would be enrolled in programs designed to improve their health management, increase their function and minimize their need for hospitalization. Once patients have been identified, it would be feasible to provide reminders about immunization status and other preventative measures that can be implemented at the time of their next contact with the health system.

In conjunction with virtual care coordination should be the development of high quality electronic health records (EHR) that can use provider time more efficiently than paper records, decrease redundant evaluations, tests, X-rays, and other procedures, and provide information to multiple providers (IOM, 200X). In spite of initial capital expenses, the EHR is increasingly becoming part of health care in Texas. For uninsured patients who often go to several emergency rooms, multiple clinics, or other providers, the EHR can decrease costs of care.

DISEASE MANAGEMENT

Recommendation 6:

Health care institutions and other providers must contribute to increasing community based ambulatory care, which includes integrating the latest developments in disease management and other cost effective models of health care delivery that seek to improve the quality of patient care while decreasing the cost of care.

FINDINGS:

- Ten percent of patients account for 80 percent of health care expenses (Longley, 2004).
- Individuals with chronic illnesses such as diabetes, heart failure, chronic lung disease, asthma, and hypertension make frequent visits to the emergency room and often require hospitalization.

Ambulatory (outpatient) care has an increasingly important role in patient care. Properly developed and integrated disease management programs involving nursing, specialists and primary care providers can significantly reduce emergency room visits, hospitalizations and re-hospitalizations. Such programs can improve quality of life for patients with debilitating chronic conditions such as diabetes and congestive heart failure. Various disease management methodologies, the focus of a major Medicare demonstration initiative undertaken by the US Department of Health and Human Services in 10 regions around the country in 2004, rely principally on the role of multidisciplinary teams in which non-physicians play an extremely important role. These various team models can include 24-7 access to nurses for the monitoring of patient condition and care coordination, improved patient education and awareness of the disease and condition, pharmacists who facilitate better use of medications, nutritionists who facilitate proper diets, as well as the principal physician for the patient, who is in charge of the overall care and condition of the patient.

Creating effective disease management programs at community sites, including FQHCs and other clinics, would be a central feature in improving the quality of care and reducing health care expenditures.

Recommendation 6.1:

Behavioral health care (both mental health and substance abuse) services should be accessible to all Texans with mental illness and additional public funding should be appropriated.

FINDINGS:

- 3.1 million adults and 1.2 million children in Texas have a diagnosable mental illness; of which 1.5 million have an illness that impaired their ability to function (MHA Texas, 2005).
- At least 55 percent of individuals living in Texas are uninsured or underinsured for behavioral health care; thereby forcing their dependence on a significantly underfunded public system (MHA Texas, 2005).
- The total economic cost of mental illness in Texas was \$16.6 billion, including \$13.3 billion in lost income due to reduced workforce participation, \$2.6 billion for mortality costs and more than \$700 million for lost income due to family care giving (MHA Texas, 2005).

Current behavioral health care eligibility requirements leave many individuals living in Texas without access to appropriate care (see Chapter Two of the Report – Uninsured in Texas – for more details).

The overall consequences of untreated mental illness manifest themselves in poor school performance, juvenile/criminal justice involvement, unemployment, homelessness and suicide. Only when public mental health is more accessible, committed and effective will patients receive beneficial treatments. Furthermore, behavioral health care services must be based upon medical advances that allow for the greatest chance of recovery; such services usually include medication, appropriate housing and case management.

The Task Force endorses and recommends that Texas acknowledge and follow the six goals outlined

by President Bush's New Freedom Commission on Mental Health (2003):

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family-driven.
- Disparities in mental health are eliminated.
- Early mental health screening, assessment and referral to services are common practice.
- Excellent mental health is delivered and research is accelerated.
- Technology is used to access mental health care and information.

In addition, the Task Force believes that public funding for behavioral health care should increase. An increase in state funding would result in less cost-shifting to local governments, reduction in the jail and prison populations of people with behavioral health problems, as well as reduction in the number of homeless individuals and the overcrowding of emergency rooms. Furthermore, the Task Force believes that mental health coverage should be a part of any health care package, with the same benefits as those for physical illnesses.

HEALTH CARE PROVIDERS

Recommendation 7:

Texas must increase investment in the education and training of health professionals who will provide significant amounts of care to the uninsured and underinsured.

Recommendation 7.1:

Texas should increase the number of physicians annually graduating from its medical schools by 20 percent over the next decade with special emphasis upon creating a workforce representative of the state population.

FINDINGS:

- Texas has an inadequate number of physicians who are disproportionately located in large metropolitan areas.
- Nationally, there are approximately 220 direct care physicians per 100,000 people. Texas averages 152 per 100,000 (TSHCC, 2004).

The Association of American Medical Colleges (AAMC) and American Medical Association (AMA) have recommended that the number of physicians educated in our country's medical schools be increased by 15 percent (AAMC, 2005). Some experts recommend an increase of 30 percent. The need for physicians in Texas is substantially greater than the AAMC and AMA recommendation, in view of the current physician shortfall and the much greater rate of population growth anticipated in Texas than the national average.

Recommendation 7.2:

Texas should expand medical school loan repayment programs for graduates of Texas medical schools working in Texas to include up to 500 physicians per year. One-third of student debt up to \$35,000 per year should be forgiven for each year of service in a public hospital or in a clinic in which the patient population equals or exceeds 50 percent Medicaid and uninsured patients.

FINDINGS:

- The average medical school debt is over \$100,000 for a public medical school (AMA, 2006).
- The number of physicians who see uninsured patients or patients covered by Medicaid has declined in the past 15 years (TMA).

MORE THAN 1.8
MILLION UNINSURED
TEXANS RESIDE IN
FAMILIES WITH
INCOMES ABOVE 200
PERCENT OF FPL.
– TDI (2003)

Increased opportunities to educate physicians should be coupled with the need to provide care for underserved populations in both urban and rural communities. The average medical school debt is a major barrier for students from underserved communities and ethnic groups to aspire to obtain a medical degree. Substantial expansion of the medical school tuition loan repayment program should be undertaken for graduates who provide care in public institutions or who work in institutions whose patient population includes more than 50 percent Medicaid and uninsured patients. Such loan repayment programs would be available at the completion of residency training.

Recommendation 7.3:

State support of medical residency programs should allow an increase in residency positions by 600 per biennium for the next decade. Since the average residency is four years in duration, this would increase the number of physicians graduating from residency programs by 750 per year, or by 50 percent annually in 2017.

FINDINGS:

- The total number of residency positions in Texas is substantially below other states (Texas 5,900, California 9,500, New York 14,000) (ACGME, 2004).
- For a graduate of a Texas medical school who obtains a residency within the state, the probability is 85 percent that the physician will practice in Texas (AMA, 1999).
- Approximately 45 percent of graduates of Texas medical schools obtain residencies outside of this state (Shine, 2004).
- In a 2004 survey, approximately 135 graduates who went out of state for residency training indicated a desire to remain in the state if a quality residency had been available to them (TMA).

A very cost effective way to increase the physician supply in Texas and to improve access to medical care is the expansion of medical residency programs. Not only is the cost of education for residents substantially lower than that for educating a medical student, but a high proportion of residents enter into practice in the community where they train. Experience in east, south, and west Texas emphasizes that physicians who complete their residencies in underserved parts of the state have a high likelihood of remaining and entering practice in those areas.

Restoration of Medicaid funding of graduate medical education is essential to hospitals caring for large numbers of uninsured patients and would benefit from increased federal matching funds such as procurement by the Quality Assurance Fee.

The 79th Texas Legislature issued a joint resolution urging CMS to raise or eliminate the cap in the total number of residents receiving federal graduate medical education support (HB 2420). Success in that regard would allow for the expansion of residency programs with federal support. Expansion of programs with state support would have an additional advantage in that residents could spend a greater proportion of their time at ambulatory sites providing care to Medicaid and uninsured patients in programs designed to reduce re-hospitalization and the use of emergency rooms.

NURSES

Recommendation 7.4:

Texas should increase funding to support 2,000 more undergraduate nursing students, approximately 50 percent of the eligible applicants who have been denied admission, and 200 faculty members necessary to train them. An estimated \$25 million per biennium in state General Revenue would need to be added to the funding formulas to reflect the increase in nursing student enrollment, and an additional \$30 million in additional General Revenue would be needed to cover the balance of costs related to the additional faculty members.

FINDINGS:

- There are over 8,000 vacant nursing positions in Texas hospitals (8.6 percent of positions) (TDSHS, 2004).
- By 2010, it is estimated that Texas will have a shortage of more than 52,000 full time equivalent (FTE) registered nurses (RNs) (HRSA, 2002).
- Texas would require an additional 39,000 nurses to achieve the national average in per capita nurses (TDSHS, 2004).
- In 2004, approximately 4,200 applicants could not be accommodated in Texas schools of nursing because of inadequate numbers of faculty (THECB, 2004).

Not only is the nursing shortage in Texas increasingly challenging for hospitals, but it also limits the number of nurses available for advanced practice nursing, including the provision of primary care and the effective application of team health care. Available research demonstrates that hospital mortality is significantly reduced when hospital nursing staff has higher levels of nursing education and training.

Interest in baccalaureate and graduate nursing education programs is high, but not all qualified applications are being accepted, due to a lack of capacity.

In fact, the American Association of Colleges of Nursing (AACN) found that more than 32,000 qualified applicants were not accepted at schools of nursing last year due primarily to a shortage of faculty and resource constraints (AACN, 2005). Furthermore, in Texas, nursing faculty salaries are not competitive with those in other parts of the country, or with private practice opportunities, so recruitment and retention of outstanding faculty members is limited.

In addition, Texas has a substantial shortage of pharmacists, dentists and allied health providers. These individuals are vital for an effective health care team. Careful analysis of the needs for these health professionals is required and efforts to expand the work force in these areas should be undertaken.

FEDERALLY QUALIFIED HEALTH CENTERS

Recommendation 7.5:

The state should continue to provide resources to assist community health centers to qualify for federal support and modify reimbursement methodologies to reflect multidisciplinary team care. Hospitals, medical schools, nursing schools and other health care provider organizations should work closely with community groups to provide adequate staffing for federally qualified health centers, with an emphasis on cost-effective programs, including disease management programs and community public health programs.

FINDINGS:

- FQHCs are community based sites for providing ambulatory care.
- If the site meets federal standards for the services provided and the required amount of community support, it qualifies for federal funding.



79 PERCENT OF
UNINSURED TEXANS
WORK FULL OR PART
TIME OR ARE MEMBERS
OF A FAMILY IN
WHICH A MEMBER IS
EMPLOYED.

• Texas currently has 37 FQHCs or 1.62 centers per 1 million people compared to 2.51 centers per 1 million people in Illinois, 2.18 centers per 1 million people in New York State, and 1.97 centers per 1 million people in California (US Census Bureau, 2005b; HRSA).

FQHCs provide some of the best examples of integrated ambulatory care available. In spite of the recent authorization for additional FQHCs in the state, Texas remains remarkably lacking in these centers. It is clear that the availability of state funding has been important in creating eligibility of health centers for federal qualification and funding, as demonstrated in the past biennium, but the organization of these centers is complex and often has not included crucial roles for medical and/or nursing programs. Although most communities in Texas that apply for FQHCs easily meet the requirements of the prospective clientele (with the high percentage of uninsured in the state), many cannot show they are financially feasible, even with federal aid, because of the extremely restrictive Medicaid program.

Furthermore, staffing FQHCs is challenging. The Task Force believes that special emphasis should be paid to increasing the role of medical residents providing physician services, establishing loan repayment programs which encourage physicians to work at such sites, and increasing the number of advanced practice nurses who can manage programs in collaboration with physicians. In addition, reimbursement should be modified to pay for visits to groups of physicians and to change the definitions of providers to include social workers, health educators and nurse practitioners.

The President's FY 2007 budget request proposed \$1.963 billion for FQHCs. (This is \$163 million

more than what was appropriated for FQHCs for FY 2006.) The budget anticipates that this funding level will enable the Health Resources and Services Administration (HRSA) to establish 300 new or expanded FQHC sites in FY 2007. Of the new or expanded sites, 80 sites are expected to be in high poverty countries.

PHYSICIAN AVAILABILITY

Recommendation 7.6:

The Task Force recommends that efforts be undertaken to ensure that each physician provide a fair and reasonable amount of care for Medicaid, Medicare and uninsured patients, as well as share the responsibility of being on call to emergency rooms.

FINDINGS:

- In Texas, medical schools receive approximately \$47,000 annually from state funds for each medical student. This totals approximately \$200,000 in general revenue over a four-year period (Shine, 2004).
- The overall costs associated with medical education have been estimated at \$400,000-\$800,000 per graduating physician (Jones and Korn, 1997).

A continuing challenge in Texas is the availability of physicians to care for Medicaid recipients and the uninsured. This is particularly exacerbated in emergency rooms, because of the reluctance of many specialists to take call, i.e. see patients in the emergency room upon request from the staff. In addition to the professional responsibility physicians have to care for the sick and the significant debt which they often incur upon completing a medical education, the Task Force emphasizes the substantial societal investment in physician education. These investments imply that physicians accept responsibility for care

of all patients and taking call in emergency rooms. Careful consideration should be given to connecting physician licensure renewal to evidence of active participation in the Medicaid program or treatment of uninsured patients. Alternatively, students educated in Texas medical schools could be asked to provide a specific amount of time to care for these populations.

EDUCATION

Recommendation 8:

The Task Force recommends implementation of an integrated approach to school health including an emphasis on nutrition, exercise, dental health, and disease management of such problems as asthma. It recommends an expansion of the School Breakfast Program, that Texas schools increase their physical activity requirements to 60 minutes a day, and that they adopt asthma management education for affected children and support staff.

FINDINGS:

- Failure to eat breakfast has been shown to adversely affect children's ability to problem-solve in school and potentially has long-lasting effects on a child's cognitive development and performance in school (Pollitt, 1995, 1982, 1981).
- Incorporating fitness or skill training for 75 minutes a day, compared to traditional physical education offered for 30 minutes three times a week, increased math scores and improved classroom behavior, while having no significant reduction in reading test scores (Sallis, 1999).
- Asthma management programs have been shown to reduce absenteeism and improve test scores (Evans et. al., 1987).

In the face of rising health costs and poor health status in Texas, a crucial opportunity for prevention that

can decrease the rise of health care costs and improve health exists in the K-12 educational system. The interactions between K-12 education, health status, health promotion and prevention are extensively documented in Chapter Nine of the Report – Education and Health. The evidence is compelling that success in education is closely linked to health status. Those who are better educated are healthier, creating an environment of health behavior, which includes proper nutrition, physical exercise and a healthy lifestyle. Education about the risks of unhealthy behavior, including cigarette smoking and illegal drug use, can be included as well as disease management programs to address issues of chronic illness including mental health. Programs in dental hygiene may also be very valuable in view of the prevalence of dental disease. More effective integration of school health programs with other aspects of the curriculum is valuable not only for the student, but also the community.

HEALTH CARE RESEARCH

Recommendation 9:

Academic health institutions, state and local governments, and communities, foundations and the private sector should support the development of health science research programs to study cost effective health care and other characteristics of a high quality and efficient health system.

FINDINGS:

- Annual US health expenditures per person have increased from \$143 in 1960 to \$6,040 in 2004 (CMS, 2004).
- As a percentage of the gross domestic product (GDP), health expenditures have increased from 5.1 percent in 1960 to 15.4 percent in 2004 (CMS, 2004).

The cost of health care continues to rise at a rate significantly greater than overall inflation. While the Task Force was not specifically constituted to analyze the elements in rising health care costs, it believes that a number of its recommendations can decrease the rise of these costs. This requires the efficient delivery of the right care, at the right place, by the right people. The right care implies appropriate cost-effective preventive health measures. For example, the effective treatment of high blood pressure is significantly more cost effective than treatment of advanced heart failure or stroke. The use of a properly constructed formulary relying heavily on generic drugs can produce excellent care at significantly lower costs. The organization of care so it is delivered more effectively includes the use of disease management programs for chronic conditions such as diabetes, congestive heart failure and asthma. In each of these cases the proper use of medications under supervision of a multidisciplinary health care team can reduce visits to the emergency room and admissions to the hospital, thereby reducing costs.

Other studies by the Texas Department of Insurance (TDI) could determine how medical loss ratios are established by insurance companies and health plans to ensure those ratios accurately reflect the portion of premium dollars that are actually used to finance health care provided to enrollees and beneficiaries. In addition, TDI could facilitate local initiatives to develop, use, and evaluate the benefits and privacy risks of establishing a unique patient identifier (as suggested in Recommendation 5), including biometrics, for the creation, maintenance and access to patient health records.

Recommendation 10:

Texas should adequately invest in public health programs (including research and community health) at the state and local level.

FINDINGS:

- Texas ranks 47th of the 50 states in vaccine coverage for children aged 19 to 35 months (TDH, 2003).
- The percentage of women over 40 who had a mammogram within the previous two years was 69 percent in Texas compared to 76.3 percent in the United States (TFFPHT, 2005).
- In 2004, Texas spent \$49 per citizen per year on public health activities and services compared to the national average of \$98 (CPPP, 2003).

The health status of Texans does not compare well with the rest of the United States. Immunization rates, mortality from cancer, the prevalence of diabetes, obesity, and hypertension in the population as a whole, and particularly in certain ethnic groups, bode poorly for the future health of Texans. Furthermore, steadily rising health care costs place increasing pressure on individual state and local budgets. Programs of prevention that include public education and behavior modification on issues such as smoking cessation, substance abuse, and poor nutrition, are likely to be the most cost-effective way to reduce the prevalence of illness and mitigate against rising health care costs. Texas spends 50 percent of the average amount spent among the 50 states for public health. A commitment to increase this level of funding to 75 percent of the national average over five years would provide a minimal start in support of effective programs of public health, which would have long-term positive impacts upon health and the control of health care expenditures.

73 PERCENT OF TEXAS
BUSINESSES ARE SMALL
EMPLOYERS WITH LESS
THAN 50 EMPLOYEES.
37 PERCENT OF THESE
SMALL EMPLOYERS
OFFER HEALTH
INSURANCE. ONLY
35 PERCENT OF THEIR
EMPLOYEES ENROLL,
PRIMARILY DUE
TO LACK OF
AFFORDABILITY.



Now is the time for Texas to take bold steps to address the significant and pervasive problems associated with the lack of health insurance coverage and health care access in Texas, and to protect and assure the economic vitality and health of the state. Texas has the highest uninsured percentage in the United States and the population is predicted to continue to rapidly increase over the next 20 years. As it increases, so will the number of uninsured and potentially their percentage in the population. In addition, Texas will begin to look even less appealing to businesses that will be affected by high health insurance rates.

Achieving the recommendations of the Task Force will require a combination of bold steps, effective organization, health workforce development and financial resources. Properly implemented, these recommendations will improve the health of patients, families, institutions and communities while reducing the rise of health care costs. By increasing access to health care and insurance, improving current health care delivery models, educating an adequate and diverse health care workforce, and reducing absenteeism in schools and the workplace, Texas will provide for and protect the health of its people and the strength of its economy.



[REFERENCES]

- Accreditation Council for Graduate Medical Education.** (2004). ACGME Resident Physician Population by Specialty and State – Academic Year 2003-2004. Website: http://www.acgme.org/acWebsite/CMS/resPopData_state03-04.pdf.
- American Association of Colleges in Nursing.** (2005). New Data Confirms Shortage of Nursing School Faculty Hinders Efforts to Address the Nation's Nursing Shortage. *Press Release, March 8, 2005*.
- American Medical Association.** (1999). Masterfile. Website: <http://www.ama-assn.org>.
- Association of American Medical Colleges (AAMC).** 2005. "The Work Ahead" AAMC President Jordan J. Cohen's Address 2005. Website: <http://www.aamc.org/newsroom/pressrel/2005/051106.htm>.
- American Medical Association (AMA).** (2006). Medical Student Section: Medical Student Debt. Website: <http://www.ama-assn.org/ama/pub/category/5349.html>.
- Bishop & Assoc.** (2002). Texas Trauma Economic Assessment and System Survey. *Save Our ERs*. Website: <http://www.saveourers.org/BishopsReport.pdf>.
- Canton, F.** (2000). Providing Health Care to the Uninsured in Texas: A Guide to County Officials. *The Access Project*. Boston, MA
- Center for Medicare and Medicaid Services (CMS).** (2004). Website: <http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp>.
- Center for Public Policy Priorities (CPPP).** (2003). Website: <http://www.cppp.org/files/3/hc-primer-web.pdf>.
- Cookston, R.E.** (2004). Harris County Community Access Collaborative. *Gateway to Care*. Website: <http://www.utsystem.edu/hea/taskforce/Media/Cookston121404.pdf>.
- Dallas County Medical Society (DHCP).** (2006). Website: <http://www.dallas-cms.org>.
- Emergency Medical System (EMS).** (2005). Uncompensated Trauma Care District Hospitals. *Texas Department of State Health Services*. Website: <http://www.tdh.state.tx.us/hcqs/ems/August262005DSHSUncompensatedTraumaCareDistrHospitals.xls>.
- Evans, D., Clark, N. M., Feldman, C. H., Rips, J., Kaplan, D., Levison, M. J., et al.** (1987). A school health education program for children with asthma aged 8-11 years. *Health Education Quarterly*, 14(3), 267-279.
- Families USA.** (2003). Who's Uninsured in Texas and Why? *Families USA*: Washington, D.C., Website: http://www.familiesusa.org/site/DocServer/Texas_uninsured.pdf?docID=2404.
- Families USA.** (2005). Paying a Premium: The Added Cost of Care for the Uninsured. Website: http://www.familiesusa.org/site/DocServer/Paying_a_Premium.pdf?docID=9241.
- Health Resources and Service Administration.** Website: www.hrsa.gov.
- House Select Committee on State Health Care Expenditures (HSCSHCE).** (2004). Interim Report 2004: A Report to the House of Representatives, 79th Texas Legislature. Austin, Tex. Website: <http://www.house.state.tx.us/committees/reports/78interim/healthcareexpenditures.pdf>.
- Institute of Medicine.** (2001). Coverage Matters: Insurance and Health Care. *National Academies Press*: Washington, D.C. Website: www.nap.edu.
- Institute of Medicine.** (2002). Health Insurance is a Family Matter. *National Academies Press*: Washington, D.C. Website: www.nap.edu.
- Institute of Medicine.** (2004). Insuring America's Health: Principles and Recommendations. *National Academies Press*: Washington, D.C. Website: www.nap.edu.
- Jones R.F., and Korn D.** (1997). On the cost of educating a medical student. *Academic Medicine*;72:200-210.

- Longley, D.** (2004). Working Together for a Healthy Texas: Study of the Uninsured in Texas. *Presentation to the Task Force on December 14, 2004.*
- Mental Health Association in Texas.** (2005). Turning the Corner: Toward Balance and Reform in Texas Mental Health Services. Website: <http://www.mhatexas.org/TurningtheCorner.pdf>.
- New Freedom Commission on Mental Health.** (2003). Achieving the Promise: Transforming Mental Health Care in America. Department of Health and Human Services. Pub. No. SMA-03-3834. Rockville, MD. Website: <http://www.mentalhealthcommission.gov/reports/reports.htm>
- PEW Hispanic Center, Unauthorized Migrants: Numbers and Characteristics.** (2005) Website: www.pewhispanics.org
- Pollitt, E.** (1995). Does breakfast make a difference in school? *Journal of the American Dietetic Association*, 95(10), 1134-1139.
- Pollitt, E., Lewis, N. L., Garza, C., & Shulman, R. J.** (1982). Fasting and cognitive function. *Journal of Psychiatric Research*, 17(2), 169-174.
- Pollitt, E., Leibel, R. L., & Greenfield, D.** (1981). Brief fasting, stress, and cognition in children. *American Journal of Clinical Nutrition*, 34(8), 1526-1533.
- Sallis, J. F., McKenzie, T. L., Kolody, B., Lewis, M., Marshall, S., & Rosengard, P.** (1999). Effects of health-related physical education on academic achievement: Project SPARK. *Research Quarterly for Exercise and Sport*, 70(2), 127-134.
- Schneider, A. and Rousseau, D.** (2002). The Kaiser Commission on Medicaid and the Uninsured. Chapter III: Medicaid Financing. *Kaiser Family Foundation*. 108.
- Seton Healthcare Network.** (2005). Coordination of Care and Cost Savings Impact – The SETON Experience.
- Shine, K.** (2004). *Presentation on April 8, 2004 to Texas Senate Subcommittee on Higher Education.*
- Smith, V., Gifford, K., Ellis, E., Wiles, A., Rudowitz, R., and O'Malley, M.** (2005). Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50 State Survey. *Kaiser Commission on Medicaid and the Uninsured.*
- Stoll, K. and Jones, K.** (2004). One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003. *Families USA: Washington, D.C.* Website: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641.
- Task Force on the Future of Public Health in Texas (TFFPHT).** (2005). The Future of Public Health in Texas. *University of Texas System.* Website: <http://www.utsystem.edu/health/publichealth.pdf>.
- Texas Department of Insurance.** (2003). Working Together for a Healthy Texas Final Report: Texas State Planning Grant. *Texas Department of Insurance - State Planning Grant Division.* Website: <http://www.tdi.state.tx.us/general/pdf/spgfinalreport.pdf>.
- Texas Department of Health (TDH).** (2003). Overview of the Texas Department of Health. *Texas Department of State Health Services.* Website: <https://www.tdh.state.tx.us/functionalreview/overview.pdf>.
- Texas Department of State Health Services.** (2004). Hospital Nursing in Texas: Findings of the Register Nurse Hospital Staffing Survey 2004. Website: <http://www.dshs.state.tx.us/chs/cnws/staffrep.pdf>.
- Texas Department of State Health Services.** (2004b). Nursing Workforce in Texas - 2003: Demographics and Trends. Website: <http://www.dshs.state.tx.us/chs/cnws/NuDemo03.pdf>.
- Texas Department of State Health Services.** (2005). County Indigent Health Care Program. Website: <http://www.dshs.state.tx.us/cihcp/default.shtm>.
- Texas Health and Human Services Commission (THHSC).** (2004). Texas Medicaid in Perspective, 5th ed. Website: <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>.
- Texas Higher Education Coordinating Board.** (2004). Website: <http://www.thecb.state.tx.us/>.
- Texas Medical Association.** Website: <http://www.texmed.org/>.
- Texas Statewide Health Coordinating Council.** (2004). 2005-2010 State Health Plan: Innovative Approaches to Health Workforce Planning in Texas. Website: <http://archive.tdh.state.tx.us/legacytdh/texasshcc/stateplan2005/intro2005.pdf>.

The University of Texas System. (2004). Annual Financial Report of the University of Texas System Health Institutions.

US Census Bureau. (2005). DeNavas-Walt, C., Proctor, B.D. and Lee, C.H. Income, Poverty, and Health Insurance Coverage in the United States: 2004. in *US Census Bureau, and Current Population Reports*, Washington, D.C.: US Government Printing Office. Website: <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

US Census Bureau. (2005b). Annual Estimates of Population for the US and States, and for Puerto Rico: April 1, 2000 to July 1, 2005. Population Division.

US Department of Health and Human Services (HHS). (2001). Medicaid and SCHIP Waivers: Promoting Flexibility and Innovation. Website: <http://www.os.dhhs.gov/news/press/2001pres/01fsmedicaid.html>.

Warner, D. (2006). Wilbur J. Cohen Fellow in Health and Social Policy, Lyndon B. Johnson School of Public Affairs. Personal Communications.

Wilson, M., Shin, P., Regenstein, M., & Jones, K. (2004) An Assessment of the Safety Net in San Antonio, Texas. *Urgent Matters: The George Washington University Medical Center, School of Public Health and Health Services*. Website: http://www.urgentmatters.org/pdf/SNA_files/Final_SanAntonio.pdf.

Wilson, M. Nguyen, K. (2004) Bursting at the Seams. *Urgent Matters: The George Washington University Medical Center, School of Public Health and Health Services*. Website: http://www.rwjf.org/files/research/Learning_Network5.pdf.

[RECOMMENDATION:]

react

