Chapter 3. Panel on Public Sector Options

KENNETH APFEL: You've just heard from an excellent panel regarding private-sector options for the uninsured. I think it is very clear to all of us that public programs also need to be part of a long-term solution in this area. There are many issues that relate to expansions in the public arena and I'm sure this panel will touch on several. I hope and expect that this panel will address three broad issues. One is how do we ensure that more people who are now eligible for CHIP and Medicaid receive CHIP and Medicaid? There are hundreds of thousands of Texans who meet the eligibility criteria for these programs but do not receive help. What we need to do is institutionalize some of the outreach activities and the advertising activities that have been underway to ensure that more people receive public coverage. How do we make sure that more of the elderly who receive Medicare but are also eligible for Medicaid receive that added coverage? And how do we simplify the Medicaid system to ensure that more individuals who are eligible get through the door?

The second issue area relates to incremental options that are available under current law to expand Medicaid and CHIP to reach more of the uninsured. There are a number of options that could be instituted to provide some modest incremental expansions in the areas of expanded public insurance or possibly premium assistance. This could related to kids, to the disabled, and the elderly, as well as working adults.

Thirdly, are there broad-based solutions that are possible in Texas? Some states have addressed the uninsured issue from a much broader perspective, such as BadgerCare in Wisconsin and TennCare in Tennessee. Do these states provide lessons for Texas in this area? A central question here is the following: in return for added Medicaid dollars or added federal dollars, are there other sources of funding or creative financing solutions that could be developed to provide broad-based solutions in Texas in the public arena?

To start us on this journey today, we have five extraordinary speakers, starting off with Jocelyn Guyer, who will provide a national overview of some of the activities that have gone on throughout the country in many of these areas. Jocelyn is a national health expert with the Center on Budget and Policy Priorities in Washington, D.C. She has a masters degree from the Woodrow Wilson School at Princeton, sister school to the LBJ School, and it's almost as good a school as the LBJ School. [Laughter] And after Jocelyn, moving on from the national to the state perspective, we have the Honorable Garnet Coleman, Texas State Representative from District 147 in Houston. He serves as the vice chair of the House Public Health Committee as well as a member of the Blue Ribbon Task Force on the Uninsured. And I think everyone in this room knows he has been over time one of the real leaders throughout the state and the country on financing issues in the health arena. Third, we're going to move from the state perspective to some of the local perspectives. We will hear from Dee Briones, the county judge from El Paso, who will speak to us from her perspective about the impact of the uninsured on county budgets and her experience with the public hospital in El Paso. I think her comments will be very informative for us in terms of the perspective of an area with a major indigent

care population and with major costs associated with it. We will then move on again to another local perspective and hear from David Lurie, the Austin Travis County Health and Human Services Department director. He will discuss initiatives for the uninsured in the Austin metropolitan area, with a particular focus on the Indigent Care Collaboration, which has established mechanisms in a three-county area to try to find regional ways to deal with this issue.

Then wrapping up the panel is someone whom I believe everyone in this room knows, Anne Dunkelberg, one of Texas' health gurus from the Texas Center for Public Policy Priorities. Anne, who spent time in the Medicaid office in Texas before her service at the Center, is clearly one of the most remarkable people I've met since I've come back to Texas, and probably most importantly, she's a graduate of the LBJ School of Public Affairs. [Laughter] So to lead off in our discussion this morning, here's Jocelyn Guyer.

JOCELYN GUYER: Thanks so much for having me. I want to start by saying that I really am thrilled that this panel is part of today's discussion. And I think it goes back to one of the points that Dean Clancy made, which is that if we look at the issue of the uninsured, we're clearly going to need a range of responses. I think it is quite clear that it will be critical to have expansion of public programs as we think about how we are going to deal with the uninsured.

Just to give you one example of why I think this is going to be particularly important: if you look at the tax credit proposals that are out there, typically they offer families $2,500 to go out and purchase coverage. The National Association of Health Underwriters, which is the association in D.C. that represents the folks who sell individual insurance policies, just did a 50-state study. They looked at this scenario: if we gave a healthy mom, nonsmoking, very personally responsible, with two healthy kids, $2,500 and sent her out in each of the 50 states, could she get health care coverage? They found that she actually could get health care coverage in all but eight states. In eight states, there simply was nothing available for $2,500. But upon looking a little bit deeper at the kind of coverage that was available for a mom like that, I was quite shocked at the level of deductibles that many states had in their policies for that price. I'll give you a couple of extreme examples: Alabama and Rhode Island. She would have had to meet a *$15,000 deductible* before she could actually get any health insurance coverage. That's obviously an extreme case. Much more typical are $1,000 or $2,000 deductibles.

But part of what that says to me is that if we look at the folks who are uninsured who are in that low-to-moderate income range, that kind of insurance coverage, while it may protect against the catastrophic events like a car accident, really isn't quite what folks mean when they think about providing health insurance for Americans. I think it actually goes back to the point that the previous panel made, which is, are we talking about insurance or are we talking about coverage? I think for a healthy mom with two kids, part of what we want is for her to be able to go in if her kids develop asthma, before meeting that kind of deductible. Part of what that means is particularly for those uninsured folks who are in the lower part of the low-income range, we're going to need to be looking at public programs, which historically have offered both a reasonable array

of benefits and also far more modest cost-sharing, specifically because of concerns that if you have either high deductibles or lots of cost-sharing, people will not actually be able to use coverage. This really is going to be a critical piece of what happens over the next couple of years.

The good news is that with the bipartisan enactment of the State Children's Health Insurance Program in August of 1997, we've really seen a transformation in how state officials, advocates, and policymakers everywhere think about public programs. We've seen some incredible movement in a number of different areas. I think probably the most basic reason is because the State Children's Health Insurance Program really aimed to move coverage further up the income scale to low-income working families. Albeit Medicaid has always served a lot of working families, and it will continue to do so, but SCHIP was clearly intended to push public programs a little further up the income scale. With that expansion came all sorts of simplifications. We want to make these programs work for families who are working. These are families that may not have time to go to a welfare office; we need to let them mail in their applications. We're no longer going to ask about assets and other things. I know Texas is still very much struggling with some of these issues, but in general the trend across the nation as a whole is toward very impressive simplification and making it much easier for working families to enroll in public programs.

The bottom-line good news is that last year marked the first time in about five years that we saw a decrease in the number of kids without health insurance. We saw one million fewer uninsured kids last year. Some of that is because of our extraordinary economy, but clearly the biggest piece of that is due to the success of the State Children's Health Insurance Program and also the tremendous work people have done in helping kids who are eligible for Medicaid get enrolled in those programs. So I think that gives us a strong base from which to work on thinking about how we can take some next steps and go beyond just covering kids in low-income working families and think about some of the other family members who may need health insurance coverage.

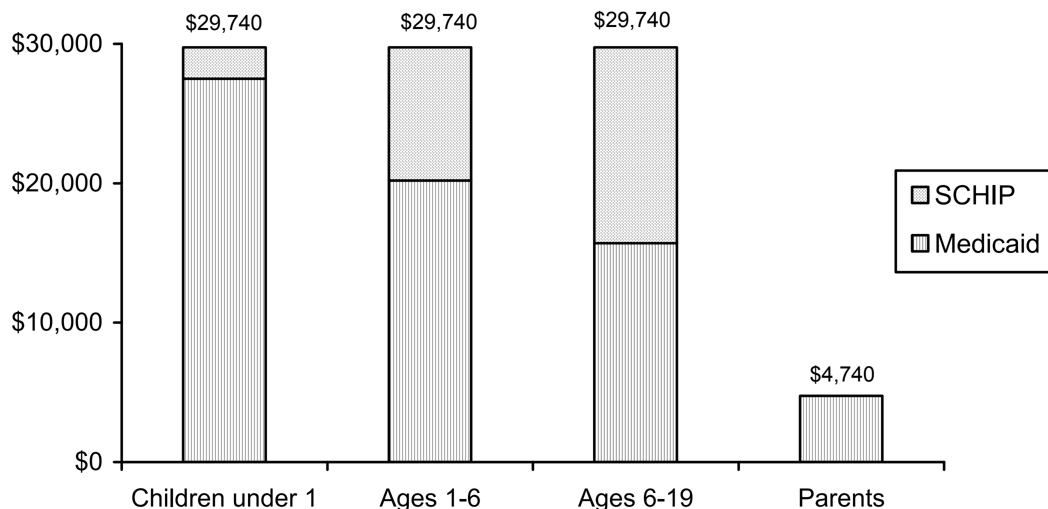
The next thing I want to talk about is what some of the options are out there and what we're seeing from states across the country. There are two major tools that states have if they're thinking about expanding coverage; this is all under current law, so it's not dependent upon what Congress might do this year. One is that you can take advantage of the existing Medicaid program which, in Texas, picks up 61 percent of the cost of expanding coverage for folks in certain categories—that's the big caveat. Under the Medicaid program, the only way you can qualify is if you fit a certain profile, which is basically everyone in the United States except for adults without children. If you're a parent, if you're elderly, if you're disabled, if you're a child, then you can potentially qualify for Medicaid.

The next issue is, obviously, whether you fall within the income range. States not only want to determine that you fall into certain categories but also that you meet the income criteria for the state. Those income criteria, which really dictate how many people can get coverage, are entirely determined by the states. At this point, Congress has decided

that it wants to give states the flexibility to decide how far up the income scale they want to go, what's appropriate for their states. The option you have is to look at where your state is currently in terms of coverage for parents, elderly, disabled, and if you want to go ahead and expand further up the income scale, the federal government will match that expansion. In the case of Texas, it will pick up 61 percent of the cost.

I want to just show you one slide, because I think it would be my recommendation if you're thinking about next steps; in terms of what could you do about the uninsured, this is what I think of as the "low-hanging fruit." And this is the one thing I want you to remember. This is a chart that shows how much a mom with two kids can make and get her kids signed up for Medicaid or SCHIP, vs. how much she can make if she herself wants to enroll (see Figure 3.1). The rules in Texas vary as to whether a kid qualifies for Medicaid or SCHIP, depending on the age of the child, but the bottom line is that any child under 19 years of age, whether it's an infant, a kid who's 1-6, or a kid who's 6-19 years old, can get either Medicaid coverage or SCHIP coverage, as long as the family's income is below 200 percent of poverty, which is about $29,000 for a family of three. So our mom with two kids can sign her kids up if her income falls below $29,740. If she herself needs health care, her only shot at getting coverage that is not available through her employer—and if she doesn't have the resources or the wherewithal to figure out the individual insurance market, which most of us don't—is to drop her income below $4,740 per year in earnings.

Figure 3.1.
Income Eligibility of Children and Parents for Medicaid and SCHIP



Adapted from: Jocelyn Guyer, presentation on March 23, 2001.

Notes: Like most states, Texas cuts off health coverage for parents in working families at significantly lower income levels than apply to children. This table shows now much a working family can earn on an annualized basis and still be found eligible for health coverage in Texas. It takes into account Texas' earnings disregard policies, but not other disregards and deductions. Earnings thresholds are based on a family of three. To qualify for Medicaid, but not SCHIP, families must also meet a $2,000 asset test.

I want you to think about that. If you're a mom with two kids and you need health care coverage your best shot is to quit your job or to really reduce your hours. I think this is the "low-hanging fruit" and the area where we should look next in terms of expanding public programs. What a lot of states have done, and I'll give you some specific examples in a minute, is to decide that they are going to do family-based coverage. Instead of just focusing on the kids whom we're covering up to $29,000, which is obviously critical and a first priority, let's also think about covering the entire family. There's been a number of reasons for that. One is what I just said, which is that there's a terrible work disincentive by stopping coverage at such a low income threshold that you really can't work and retain health care coverage through public programs. The other thing that I think has moved a lot of states in this direction is emerging research that shows if you can cover families as a unit, if you can tell a family that you can sign up everyone in the family for coverage, families are much more likely to enroll their kids in coverage. A side benefit is that when we pick up the parents, we see improvements in the percentage of eligible kids who are enrolled in Medicaid or SCHIP.

It is very easy to do just a straight Medicaid expansion to pick up the parents of kids who are already eligible for Medicaid. You can do it with something called a state plan amendment. Rhode Island did it: it filed its state plan amendment, and two weeks later it was approved. It's a very, very simple process. And the federal government will pick up 61 percent of the cost. In today's workshop, I can go into the background details on why its so easy, but it's very easy. The other major option that you have if you're thinking about building on public programs is to go what we call the waiver route. We call it the Section 1115 waiver route. Section 1115 is the section of the Social Security Act that creates waiver authority. That essentially is the authority for the Secretary for Health and Human Services to say that, on an experimental basis, he is going to waive federal Medicaid rules and let the state have more flexibility to change, for example, who it's covering.

There are two significant things to think about with waivers. One thing you can do with a waiver that you cannot do just under straight federal Medicaid law is to pick up those adults without kids. It can be a complicated process—unlike just expanding Medicaid for parents, it can be a pretty complicated process to negotiate with the Secretary of Health and Human Services what the terms of that waiver will be. It absolutely can be done, and I'm going to give you an example later of a state that's done it. The trickiest part is that the federal government doesn't like those waivers to cost it more than it would cost just to operate your regular Medicaid program. So you have to somehow show that through this waiver project you've taken on, you're generating some savings through one part of the project that you're using to help finance the cost of expanding coverage to childless

adults, which is a group that Congress really never envisioned the Medicaid program covering.

The other waiver option that I want to mention to you, because I think it's actually a relatively straightforward one, and something we're seeing a lot of states examining, is to look at using state SCHIP funds for parents. The reason you need a waiver for that is that Congress is very clear that the State Children's Health Insurance Program is a program for kids. So there's nothing in the law that lets you use that money for parents. I think because of that research I mentioned earlier showing that if you can do family-based covered you get a lot more kids enrolled, the previous administration, and I believe very much the current administration, is interested in seeing states take some of that SCHIP money, to the extent they don't need it just to cover the kids—clearly you've got to cover the kids first—and get a waiver to get around the congressional restriction that says this money is just for children, and provide family-based coverage. In the case of SCHIP waivers it's a little bit easier than in the Medicaid context, because at least in the prior administration—and again, we're still operating in a little bit of an unknown territory because Tommy Thompson really hasn't had enough time yet to lay out his policies in this area—if you had unspent SCHIP funds, you could use those for parents without having to go through this somewhat tortuous process of showing savings in one part of your program to cover the cost of picking up parents. So the bottom line is that you can use unspent SCHIP funds to cover parents if you take the waiver route.

One of the major advantages of doing that rather than just taking the existing Medicaid option is that you get that special enhanced match that's available under SCHIP. Folks probably know that in Medicaid the federal government picks up 61 percent of the cost of providing coverage. In your State Children's Health Insurance Program, the federal government picks up 73 percent of the cost. If you get a waiver to use your SCHIP funds for parents, the federal government will pick up 73 percent of the cost of covering those parents. One really important point is that if you take that route and use your SCHIP funds for parents, the federal government, at least to date—and again, we're in a little bit of unknown territory—has been delighted, pleased, and willing to let you use your enhanced SCHIP funds to add parents to Medicaid or to your separate state program.

A lot of times, people hear SCHIP waiver for parents, and think that must mean the parents are just going into a separate state program, but that's not the case. The state could have gotten these waivers and generally used their SCHIP funds to add parents of kids who are on Medicaid to Medicaid and then also add the parents of kids on SCHIP to SCHIP. You can see why it would be a little bit awkward to add all of the uninsured parents making above $4,740 per year to SCHIP, because right here you have many parents who have kids on Medicaid. Do you really want to split that family up and add the parents to SCHIP and essentially fracture the family? So that's one reason to think about the option of using SCHIP funds to add parents to Medicaid at that special enhanced match, and then to the extent that you have additional funds, add the parents of SCHIP kids to the separate SCHIP program.

I just want to give you one more example before I leave, because I think sometimes it's hard to think about these things in the abstract. The best example is probably Tommy Thompson's efforts while in Wisconsin to transform his state's child programs into family-based programs. They've done it through a program called BadgerCare, and essentially he decided to cover entire families, including both the kids and the parents, to 185 percent of poverty. They've done it through a Medicaid waiver and a SCHIP waiver, so he made sure that he got that enhanced match for Wisconsin. It's been a very, very successful program. One thing he added that I think can be important to state policymakers thinking about this is that basically he said we only have a certain amount of money that we can spend on this program, and if we start to reach our limit, I want the flexibility to roll back and say I really can't continue to provide coverage to everyone to 185 percent of poverty. So he secured that flexibility. That's an option for all states across the country. Another example is Arizona, which through that special Medicaid waiver I mentioned now covers all adults, including childless adults, to 100 percent of poverty. It's going to be implemented in April 2001.

The bottom line is that you really have lots of flexibility. I think there's a great deal of work we can do to build on the success of the SCHIP program, and I think particularly with Tommy Thompson at HHS, who has had such success with family-based coverage, that that is going to be an area where he's very encouraging of state efforts to expand along those lines. Thank you.

KENNETH APFEL: Thank you Jocelyn. Let's turn to the Honorable Garnet Coleman.

GARNET COLEMAN: That was really good, because those are our options. And believe it or not, we're working on those options. But I want to make clear that when you hear other states making those leaps, they did some of their leaps a long time ago, and we have not. For a woman who has her children covered and wants to be covered as well, our TANF coverage is at 17 percent of poverty. So that number was 17 percent of poverty for a family of three. Now if you look at most other states, their populations and what they cover for assistance can go to 100 percent of poverty, some up to 200 percent of poverty for a family of one, two, three. They even had single adults in their TANF coverage, or what they would call general assistance. So one of the problems with the debate about welfare and/or Medicaid across this country is that every state really has a different program, and every state starts at a different place. And because a lot of our Medicaid eligibility was based on TANF and we had a very, very low percentage of poverty with which somebody could go into Aid to Families with Dependent Children or Temporary Assistance to Needy Families, our thresholds of income are extremely low, except when it comes to covering pregnant women and children, or the disabled or elderly. So I want to make that very clear, because when I go to these national meetings with the people from Wisconsin and they brag, I say, "Yeah, but you didn't have as far to go. You were already up there and you just went a little higher. We're down here and we've got to go way up to here."

So I want to lay that out as one of the challenges for Texas. One, when we talk about these other states—Rhode Island, for example—there are more people in the county I live

in than in Rhode Island, and actually more people in the county I live in than in Arizona! When you talk about a state with 21 million people, these changes are extremely difficult to make, particularly when you look at the age group of the people who live in a particular state compared to another state. I'm glad those folks have blazed the trail, but they make it look easy because they're dealing with small populations and small geographic areas, and I make that argument all the time, whether it's with the reforming states group, whether it's at National Conference of State Legislatures, or anywhere else.

The other thing is that they've been able to do things differently from us because of the block granting of TANF funds. They were among the high-benefit, low-population states that got block grants which left their funding at a high level, so they've been able to use that money throughout their budgets in different ways. We were a low-benefit state that got block-granted at a low level of funding, and we're having a problem funding things with our TANF funds because we actually received very little, and, over time, our population has grown. I throw those things out to you because I want you to know that I'm optimistic, but at the same time, the states' situations are very different because it depends on where you start.

We had started on some form of expansion for children and adults in 1995 when we passed Senate Bill 10 by Judith Zaffirini, and we went through the process of looking at an 1115 expansion waiver, which was never approved for various reasons. You can read *Time* magazine or the *Houston Chronicle* for the scenario on that and why that was never approved. Senate Bill 10 would have brought in children in Medicaid up to a higher percentage of poverty than we have now. Now that we have SCHIP, it doesn't really matter. The other piece it would have done was to bring in adults up to—it shrank to 45 percent, but originally it was over 100 percent of poverty. That was in 1995. It's now 2001, and we still have done neither of those things. So there are different options to do that now on family coverage, and I think that's the first step, to use what was laid out: family coverage either under a CHIP waiver or family coverage under a plan amendment under Medicaid.

The real question is, how do we pay for that? We've got a $576 million hit just to keep the current population of Medicaid funded. That doesn't include doing simplification and bringing in the additional children, which would be another number that's about $330 million over the biennium. So if you start adding all this up over the biennium, you're getting into a billion plus in state funds, give or take a little bit. I had hoped that we would be able to come into this session, do simplification and also look to see if we could do expansion of family coverage, but where we really are is to the point where we can do simplification, and family coverage is something for which we'll have to just lay the groundwork, if that's something we desire to do in this state. Because even with that expanded match under the Children's Health Insurance Program, we just don't have the funds to do it now.

What we can do is to establish a pilot program, if the feds will allow us to file it under an 1115 waiver—an expansion program in one or two counties. I have a bill that would allow us to do that under an 1115 waiver, with CHIP and Medicaid, and see if we can't

do that in some rural counties where we can afford it, and see how that works. There is a certain point in this state where it's clear that we're going to have families without insurance, and that's a burden to them and to you, in the county programs that pick up the emergency care and the urgent care for those adults who do not have insurance. Regardless, we pay for this, either through the counties with no matching federal funds, or through the state with a match of federal funds. So right now, the counties are taking the brunt of the uninsured situation because that's paid with local property tax dollars, and their hit is getting higher and higher as the number of uninsured goes up.

I'll give you an example. In Harris County—and that's why I mentioned Arizona—we have 837,000 uninsured people in our *county*. That's more than in many states. So when you start looking at that population, in a property tax-funded hospital district, the hit on that is hundreds of millions of dollars annually. Now the good thing about it is that you can actually do local government fund transfers into the Medicaid program to expand Medicaid to help cover some of that population. We tried to do that in 1995 with our 1115 waiver, but we never got there.

We never got there because there's one factor that becomes really important to those hospitals within those hospital districts and county programs, and that's disproportionate share. The hospitals basically get paid a bonus for seeing a lot of indigent, but particularly Medicaid, patients in their hospitals, and we use the county's money to draw down the disproportionate share funds. If we've already matched that funding for disproportionate share, so as soon as disproportionate share is rolled into an insurance program, we can't double match it for both insurance and disproportionate share. So then we have to convert the money used for disproportionate share into the insurance program under Medicaid. But with Medicaid saying that you have to have patient choice, the money then goes out to all the other hospitals and providers and it comes out of their budgets. That's what we're extremely afraid of, and I think we all should be afraid of that because our indigent system is the safety net. And if you do anything to damage that, you literally will have no place for the uninsured to go, and that's an important part of what we're doing.

So let me briefly go over some things that we're trying to do this session. We really want to do Medicaid simplification for children. If we do anything this session, we want to leave here having done that, and having done it in the right way. What I mean by that is we want Medicaid to be the same as SCHIP, or substantially the same, in terms of how a family enrolls in the Children's Health Insurance Program. Not much hassle, delinked from the TANF and the food stamp program, with case management in the sense that the DHS workers who are now doing enrollment under that program can help families deal with the logistics of enrolling their children into Medicaid. Enrollment will be handled by people who understand that the Medicaid program has been and always will be a health coverage program for children and some families, as well as for the elderly and the disabled.

Targeted expansions for particular populations are really important. We have essentially four bills running. One is a women's health services waiver where we can get a 9-1

match on family planning and cervical cancer and those kinds of programs that can expand health coverage for low income women up to 185 percent of poverty. The second is a mental health waiver that can allow people up to 200 percent of poverty to get drugs or medications for schizophrenia and bipolar disorder—that's an 1115 waiver. An HIV waiver would be an expansion through a demonstration project for those individuals who have mental health problems and HIV, and would partly make use of the Medicaid buy-in program for those folks who are on Supplemental Security Income. It would essentially mean expanding coverage for the disabled who are in the workforce. So what we're going to do is say you can go to work, you don't lose your benefits, you can pay into Medicaid, and continue your health benefits that keep you functional and in the workforce. That's a really important proposal.

I think the most important tasks for this session, after simplification, are to lay the groundwork for the things that were discussed and to make sure we're ready to move to the next step in providing those programs that can ensure that some of that 4.9 million uninsured in the state of Texas have an opportunity to get into some form of health coverage. That's real, whether or not we assist in paying premiums, or whether or not we actually have the coverage under the Medicaid program.

There is one more thing I want to say. I think Tommy Thompson would agree with me, I think that many governors across the country would agree with me, and I think that ultimately the administration of President Bush would agree with me. The Medicaid program started off as a program for certain groups of people, a safety net for poor people. And then you have the Medicare program, which is a safety net for everybody who gets older. But the world has changed. The problem of the uninsured is not going away, it's being passed on to the county folks here in Texas. Right now, because of waivers obtained by different states, the Medicaid program is essentially a health coverage program for working people. It has changed into that in Wisconsin and Tennessee, in Massachusetts, in Rhode Island, and many other places. Federal policy should be set in such a way that that becomes the program's purpose. That's what we've changed the program into, and let's take the next step, and make sure that we use it that way. And we can take that next step not only through a waiver allowing the use of the CHIP match rate but literally by changing the match rate. If this is a global for the whole country, then the match rate of federal dollars to state dollars in Medicaid should become even more favorable in terms of bringing in new populations, creating a match rate that allows states to expand coverage. Otherwise, a big state like Texas, with historically low funding of everything, cannot make that leap without more help from the federal government because we have so many people.

I'll say one last thing. When you look at our Medicaid rolls, they dropped from 1996 until about December or November of 1999, and then they started ticking up a little bit. What most people would tell you is that we now have a Medicaid crisis, but the reality is that we took all that money from those people that dropped and went and spent it on something else. We took that out of the budget and spent it on whatever else that people wanted to spend it on: it might have been a tax cut, it might have been giving teachers increases, whatever it is we spent it on. But that money's gone. It's being spent on

something else. So now we're forced to put some of it back. As a consequence, people say we have a Medicaid crisis. No we don't. The reality is, we took that money out of the program because there wasn't a need there and spent it somewhere else.

But now, there is a need, and people are complaining. Why are they complaining? I don't know. We actually decreased the costs in Medicaid over the years, but now that the need has come back, we have to make a commitment to providing the services for the people in this state who need them, particularly children. And that's the argument. But don't let anybody tell you that the Medicaid program is out of control, because it surely isn't. We are not even back to the pre-1996 levels of individuals enrolled in the Medicaid program. So I think that as we move forward, we have to look at our options and create the groundwork for taking care of our citizens in the most reasonable-cost way possible. We have to make sure that Texas, because of its size, its young population, and its traditionally frugal budgets, is not left behind as the country continues to improve the lives of people who work very hard every day and help them make ends meet. Those are my comments.

KENNETH APFEL: Thank you. Let's turn next to Judge Briones.

DOLORES BRIONES: Thank you. I'm County Judge Dolores Briones, and I'm going to try to be dispassionate about my remarks. [Laughter] I'm going to talk about the border and then El Paso County, and then what I really want to talk about. I do want to say that we live in interesting times, especially here in Texas. I'm a native El Pasoan. I went to Stanford University, and then I came to U.T. for graduate school, and got my masters in social work. I've known David Warner since those days. I'm not a lawyer, and you don't have to be one to be the chief executive of county government in Texas. I was also an administrator at the hospital district in El Paso for nine years, doing government affairs in the days when we were creating a formula for disproportionate share, and I headed up the family planning clinic for the hospital. So I've had a lot of experience with agencies and government entities, and how they arrive at regulations and formulas.

Historically, the border regions of the state suffer from an inadequate medical infrastructure. These areas, including El Paso, constitute one-fourth of the state's population. They simply have too few health care providers to fill the needs for health and medical services required by Texas' growing border population, with its unique demographics. And that's another thing: this is a whole new era, not just for health care but in terms of demographics, and Texas is closing its eyes to these facts. The border has a birth rate that is 25 percent higher than the rest of the state, 67 percent of the population speaks Spanish at home, compared to 13.4 percent for the rest of the state, and the unemployment rate is nearly double, if not double, the state's rate, and per capita personal income is 37 percent below the rest of the state. All these statistics that so starkly reflect the contrast between our border population and the rest of the state are mirrored in the availability of medical and health services throughout the border counties, across the entire spectrum of medical and health services.

For years, we've been speaking with Senator Hutchison about creating a border program like the Public Health Service, a border health service corps to draw medical personnel to the border. This region's inadequate infrastructure, compared to the size and needs of the population, has severely limited access. Besides an insufficient number of specialists and other health care providers, the eligibility and program enrollment policies of the state of Texas have also created barriers to access to health care. Social and economic issues compound this, often resulting in patients obtaining health care services across the border in Mexico, and in our case, also in New Mexico. So it should be no surprise to anyone that when the services are not available they cannot be utilized. This fact was unfortunately ignored, however, when the state designed and implemented its managed care pilot project.

I've been working on this issue for two years since I took office in 1999, and I've spoken before many task forces and committees. One time the title of my testimony was, "Medicaid Managed Care—Dead on Arrival Due to Pilot Error." [Laughter] Commissioner Gilbert himself, in testimony before the House Committee on Public Health this session, finally said that the state's shift from a fee-for-service to a capitation system, otherwise known as managed care, perpetuated historical issues and problems along the entire Mexico-Texas border. I want you to know that I think that he and other commissioners and I have become more friendly over the last two years. There was a time when Commissioner Gilbert challenged me to prove to him that the way they were rolling out the Medicaid managed care program affected access to care. And I finally got smart and I said, "No, you're the czar, you tell me how it doesn't." And now, I think that we're discovering that there's some truth to this, and it's very serious and more costly for Texas to do it this way.

When the state rolled out managed care without proper planning and consideration of critical and unique border issues, it created a vicious cycle for an already acute problem. The state's formula-driven capitation rate came out significantly lower for El Paso County and other counties along the border, and rates that low will not attract medical and health care providers. Today in El Paso, we have the same number of pediatricians as we did 20 years ago, and we are the youngest community in the state, the second-youngest in the country. One-third of El Paso County's population is under the age of 18. The economics simply do not add up for El Paso County and other border counties. If supply is not a problem, as in Dallas perhaps, and Houston, then managed care makes more sense. But in El Paso and along the border, supply is a problem. So managed care is not the answer. And at the reimbursement rates allowed, it's part of the problem. I want to give you an example of the average Medicaid reimbursement. In Houston it's $192.70, and in El Paso, it's $115.96. We're not talking about subtle differences. There is no less than a gulf between the way the state publicly funds its Medicaid programs in nonborder regions of the state compared to the border regions. I'm personally to the point where I understand the old saying, "Just because you're paranoid doesn't mean they're not out to get you." [Laughter] When it becomes so clear that the problem with utilization is that the services simply are not there, then the planners should conclude that the economic incentives are not there to attract enough service providers. The solution is simple: make the economic incentives higher.

There are some bills in this current session that are aimed at taking the state of Texas in the right direction, and I'd like to express my appreciation to El Paso's own Senator Shapleigh, Representative Norma Chavez, our state rep, Representative Coleman, and Representative Patricia Gray, to name a few. Their pieces of legislation are designed to move Texas in the right direction. If we don't address these issues in the state Legislature, either through legislation or administrative changes, what will probably happen is what has happened before in Texas, our unfortunate history of attempting to ignore public funding inequities. As a result, the solutions have been imposed on us by the courts. It happened with prisons, it happened with mental health and mental retardation, and it happened with public education, and I think it's going to happen with Medicaid. I'm doing my best to lay the groundwork for at least one lawsuit. [Laughter]

Let me tell you a little bit more about El Paso and then go on to what I really want to talk about. El Paso County is one of 43 border counties affected by this disparity. El Paso County is a strategic investment area, and we're also a federally designated urban enterprise community and an empowerment zone, so you know things must be really bad. El Paso County's poverty rate—and this is really important to me, I think that these are very important data that will be useful in the very near future—is over 31 percent, and its child poverty rate is over 43 percent. And remember, 33 percent of the population of the county is under the age of 18. For poor communities like ours, access hinges on public programs, and we do not have private health insurance opportunities. We are the most uninsured community in the country, proportionately—at least 33 percent of our population is uninsured. We support Medicaid simplification because we need to increase the enrollment. We have approximately 40,000 eligible children. We made a Herculean effort to enroll children in SCHIP. El Paso County has one of the highest enrollments in the state of children enrolled for SCHIP, but we have the same number of pediatricians today as we did 20 years ago. The number of health care providers in the geographic area impacts utilization. I'm really tired of talking about utilization and health care costs as if it were a legitimate basis for a formula in today's environment for this population. I'll give you a bit more data. The ratio of population per direct patient care physician in El Paso is 1,077.5 to 1, versus a state ratio of 699.3 to 1, and our ratio of population per general family practice physician is 2,641 to 1, while the state ratio is 1,561.5 to 1. So now I think I'll move on to what I really wanted to talk about.

We are charged with providing indigent health care, and we have a hospital district. All hospital districts in Texas are hurting. Our hospital district is facing a substantial deficit, and Harris County is trying to deal with it, Parkland is trying to deal with it, and we're trying to deal with it in El Paso, but we're also isolated. I'm not sure what this means, but at least in the central Texas corridor there are a lot of providers in that area. But in El Paso, we're 600 miles away from Austin. We're closer to Albuquerque than we are to Austin, Texas. And we're as close to Los Angeles as we are to Houston. The deficit is fueled by a 41 percent rate of uncompensated care to the hospital district, and a reduction in disproportionate share dollars and low reimbursement rates. I also wanted you to know that in terms of medical education reimbursement rates, El Paso has the lowest medical education reimbursement rates of anyone. So I think that this is just a huge scam.

We have a two-tiered health care system. The border counties and El Paso subsidize the rest of the state on the backs of poor women and children in Texas. And in Texas the poor are disproportionately people of color. I'll bet you that the state is out of compliance in regard to its health plan. And the reason that I talked about the child poverty rates and the economy of the border in Texas is because the 60.6 percent federal match that Texas draws for Medicaid and the 72 percent rate that it draws for CHIP are based on the child poverty rate, and it's based on the unemployment and poverty rate in Texas. And I've already shown you the distinction between the two levels. We are the "other" Texas, we are the ones with the unemployment and the poverty and the high child poverty rate. They take this money, they feel really proud that they draw this large federal match, and then they don't put it back in the border where they got it from.

I reject the formula. I appreciate the legislation that is tinkering with this formula as if it were legitimate. But time and time again, I've asked Commissioner Archer and Commissioner Gilbert to get a waiver if that's what it takes. I've made two trips to HCFA and HHS in Washington. I should say that I worked in the state legislature in another life, and I also worked on Capitol Hill, just for a short period. So these are the disparities, and it requires the same unpacking of the formula that we did with public education. You have to unpack the formula to see that the mechanism for the disparity is structural. I don't even want to unpack that, I just want to change the formula to be equitable in today's environment. Perhaps there should be a standard dollar rate. A woman in El Paso has to meet the same eligibility requirements for Medicaid and a child in El Paso has to meet the same eligibility requirements for CHIP as in Houston—all over the state, it's the same requirements. El Paso doctors have to have the same training and certification and licensing as anyone in the state, so I think that if you do a high-risk vaginal delivery in El Paso, you should be paid the same rate that they pay the doctor in Houston who does a high-risk vaginal delivery. I'm really serious about creating an equitable formula. Representative Garnet Coleman talks about laying the groundwork and I just want to let you know that I'm laying the groundwork for at least one lawsuit. If you take the child poverty rate and the poverty rate from the border away from the Texas rate, you'll see what happens. I think, if anything, if there's going to be an adjustment to the formula and you want to keep the formula, then give us what we draw down for you in the border when you reimburse us. Thank you.

KENNETH APFEL: Thank you very much, and we're now going to turn to David Lurie.

DAVID LURIE: Thank you. Good morning. I'm here representing the City of Austin and Travis County. We have a combined public health and indigent care system here locally. I'd really like to touch on three things this morning. One, to give you a perspective in terms of the amount of resources we have locally to provide health care for those who have very limited resources, and talk a bit about our community health assessment that will be released in a week or two. Also, I want to talk a bit about the Indigent Care Collaboration, which is a collaboration we've formed in this region, including Travis County, Williamson County, and Hays County, to look at the issue of

indigent health care, focusing on access and improvements in the health care delivery system, and also looking at long-term financing strategies.

I'd like to say that we really feel that this is a time of great opportunity for us. We're doing a lot of work locally, and there's been considerable attention focused on this issue. I think, as you've heard this morning, that there are some opportunities emerging at the state level, and although we have a very significant challenge, we think it is a time of great opportunity and great potential.

Just to give you another local perspective, it's certainly different from El Paso. In our region, we have approximately 200,000 folks without health insurance in Travis County, and about 84,000 who are below the federal poverty level. Our two major local programs to provide for indigent care, our local Medical Assistance Program and our Federally Qualified Health Centers, serve approximately 30,000 people combined in any given year. The major programs within Austin/Travis County include our Medical Assistance Program, which actually provides much greater coverage than the indigent care requirement at the state level. We provide coverage for individuals up to 100 percent of the poverty level, and for the elderly up to 200 percent of the poverty level who do not have Medicaid and to supplement Medicare and private insurance, and that is financed by strictly local funds. The combination of city and county resources for that program is about $20 million. In addition, we have the city-owned hospital, Brackenridge, which is leased to Seton. We provide most hospital and specialty care services to the indigent through this lease arrangement. And, finally, we have a network of 11 Federally Qualified Health Centers (FQHCs) throughout our city and county that provide primary care to the community. The total rough combination of net city and general funds for that system is about $47 million, and that doesn't of course include all of the resources that our other partners in the community are providing, a lot of the community-based clinics and the major health care systems in town. I might also add that the primary care system includes dental services as well.

We talk about closing the gap, and much of this you've heard earlier. I've just cited some of the things we're focusing on and where we see fairly significant gaps. One has to do with prescription benefits. Also in our Medical Assistance Program, we provide a supplemental prescription benefit for low-income Medicare recipients, because as you know, Medicare does not provide that benefit, so that is a pretty significant cost for us locally. Within the Medical Assistance Program, I mentioned to you the $20 million in that program. About a quarter of that, $5 million, is for pharmaceutical-related costs. We're experiencing cost increases of about 20 percent per year in that area, so any activity in the federal or state level to give us some relief on that—I know there are a number of bills under consideration at this time—would be extremely helpful to us at the local level.

The next area I reference is simplifying and expanding enrollment. I'm very appreciative of the work of Representative Coleman and his colleagues in terms of looking at ways that we can simplify the whole enrollment process for Medicaid and some of these other programs. And the more outreach we can do, the more successful we'll be in getting

folks enrolled. I heard in an earlier session a reference to the fact, and we've certainly experienced this, that most people coming forward to enroll and utilize our services locally are ill. They're in need of services at that time. That's why they're coming in. If we could close the gap and enroll many more people when they're healthy and get them into our primary care system, and provide them with more preventive services, we would gain substantially overall. And obviously people are going to gain personally because they're going to be able to maintain their health. But our system, and the costs associated with operating our system, would benefit as well.

Expanded eligibility—there have been some proposals relating to this. Representative Kitchen has introduced a bill that would provide for a possible pilot program to enable enrollment of adults in Medicaid up to some level much higher than what currently exists, using local resources to provide the match and draw down the federal dollars. And if you just think of it in simple mathematical terms, if we're investing $20,000 of resources in our medical assistance program, and we can draw another 60 percent match against that—that's not to say that everyone in that program would be eligible, but in some sense there is that potential—that could expand to a program that provides $50 million worth of services compared to our existing $20 million. That would potentially enable us to enroll many more people we're not currently reaching, maybe enroll them when they are in fact more healthy, and also assist us in dealing with some costs that are difficult for us to control, such as pharmaceuticals.

The other area I referenced is community collaboration. Our community has a rich history of collaboration—we're very proud of that, and it's been successful in many ways. I want to mention a couple of these: one is our Community Action Network, which is a broad-based collaborative group, including the corporate sector, the education community, and health and social service organizations. This network has done a lot of work assessing local needs, mobilizing resources, and increasing awareness in our community. We've just completed, through the work of the Community Action Network, a community health assessment, looking at the key health status indicators in our community. And the findings from that assessment on one level indicate a relatively healthy community; compared with several other communities throughout the country, Austin/Travis County is, as you probably would expect, relatively healthy, looking at lifespan, mortality and morbidity rates, chronic diseases, and so forth. But if you go beyond that and look at the differences within our community, particularly among racial and ethnic minorities, you will see substantial disparities. And that's very evident in this report.

That's not unique to our area; that exists throughout our country. Through this process, however, I think we're going to have a much heightened awareness of that fact in our community, and we're focusing on some strategies to get more preventive services, education, and support out into the community to help people to improve their overall health. Part of that report, of course, centers on the issue of access to care, and the need to improve overall access.

That leads me to the final component, which is the Indigent Care Collaboration; its mission statement is in the materials that we handed out. I'd like to read it to you: "The Collaboration is an alliance of health care safety net providers who work together to increase access, improve quality, and impact financing solutions to provide care to the region's medically indigent." To give you a picture as to who is participating or is represented in this regional collaboration, it includes the Seton Health Care System, our mental health/mental retardation system, St. David's Health Care System, People's Community Clinic, El Buen Samaritano, Volunteer Health Care Clinic, the City of Austin and Travis County, Planned Parenthood, the public health representation from Williamson County, the Director of Williamson County and Cities Health District, and a representative from the Central Texas Medical Center in Hays County.

Again, it's a regional approach, looking at the issue of access to care, and particularly how we can provide more services for the uninsured and make some systems improvements. We have a couple of major grants, one from the Robert Wood Johnson Foundation to examine systems improvements and long-term financing, and another major grant from HRSA at the federal level to develop an electronic information system. The latter is about a $1 million grant that's being matched by Ascension Health, of which Seton is part, to develop an information system among these providers. I know we talked earlier about when we go for these waivers and so forth, being able to demonstrate that we are making improvements to the system itself, not simply asking for more money to fill this gap but recognizing that there's a lot we can do to stretch the resources that are already in our system.

We are very fortunate here locally to have numerous agencies, organizations, and providers committed to indigent care and involved in providing these services, but in many respects it's been a relatively fragmented system. Part of the focus of this collaboration is to do a far better job of coordinating the care, providing for more continuity, and providing for more disease management and care management, and one of the first things we need to do to accomplish that is to develop an information network that connects all of these providers, and that is one of the major projects of the Indigent Care Collaboration.

The Collaboration also has undertaken a major initiative relative to the SCHIP program and SCHIP enrollment. The Michael and Susan Dell Foundation provided some funding early on to help us accelerate getting into that program. We now have some state funds to assist us and we're doing outreach all over the community. I'm very impressed by the SCHIP enrollment in El Paso. We're doing well, but I wouldn't say we're doing that well. Anyway, it has been a focus for us. We have an extensive dental sealant and treatment program in our schools that is part of this collaboration. Another major component of this collaboration's activities is behavioral health, integrating behavioral health into our primary care systems. That was also an important finding in the assessment I referenced earlier, the impact of behavioral health, particularly substance, abuse on the overall health status of our community. That is a critical component of our Indigent Care Collaboration. Finally, we are looking at some of the pilots that Representative Coleman referenced, and also at the possibility of being involved in a

pilot project, both in terms of simplification and possible expanded eligibility, on a regional basis. I know it's no surprise to all of you that folks move back and forth across these jurisdictional lines, and we really are a region with regional challenges, and ultimately we feel we need to have regional solutions to those challenges.

The last piece of this collaborative effort is looking at long-term financing. There has been much discussion over the years here in our area about the fact that we do not have a hospital district, we do not have dedicated, sustainable resources for indigent care. The Collaboration has taken a very serious look at the potential, long-term, to develop some sort of a financing structure that would help us even out the burden in terms of this challenge and, I think most importantly, have a dedicated resource that will be sustainable long-term.

Finally, I want to point out that we are also a public health agency, and encourage you that, when you're thinking about partnerships—we talk a lot about public and private and so forth, and I know the focus here is on the uninsured and the provision of care—to consider the tremendous value of prevention. We have many resources around this state, particularly through the public health system, that I think could be partnered more effectively with the health care delivery system to provide more outreach, education, and support for individuals within their communities who would like to have the resources and the support to make the necessary changes to maintain their health. So I see that as a really valuable resource in our system. Thank you.

KENNETH APFEL: Thank you. And to wrap up, we turn to Anne Dunkelberg.

ANNE DUNKELBERG: There are a number of things that I want to say in batting cleanup here. First, in terms of this panel about expanding public coverage, why are we looking at public solutions for this sector of the population? I always think it's important to look at the statistics, and we've talked about this in the Legislature in the context of the bills we're currently pursuing to simplify eligibility policy for children's Medicaid. According to census data, only about 17 percent of Americans with incomes below poverty actually get health insurance through employment, either through their own employment or through a family member's employment. So when we talk about why we need to open the doors or reduce the barriers, for example, for low-income children enrolling in Medicaid, one main reason is because it appears that there is very little likelihood that they will get health coverage any other way.

But having said that, I also want to point out that, while I am comfortable with and agree with moving from one bit of progress to the next—I'm comfortable with that incremental approach to a certain extent—and I agree that the next step for Texas will probably be looking at how we can take care of the parents of kids who are on Medicaid, it's important to keep in mind that there is nothing particularly magic or even meaningful anymore about our federal poverty income level. When you start trying to do the tricky analysis of what it takes for a family to really be self-sufficient in Texas today (and it does cost different amounts in different communities), even with the variation you come up with due to cost of living and different housing costs and that sort of thing, you still find that the self-sufficiency wage tends to be anywhere from 150 percent of poverty to

somewhere in the neighborhood of 200 percent of poverty. And that, in Texas, actually accounts for a lot of our population. I know when we were doing the work on the State Children's Health Insurance Program in the last session, it was important to remind people that about 51 percent of the children in Texas are in families with incomes at or below 200 percent of poverty. The percentage is a little lower when you start talking about adults, but it's still a very substantial part of our population. And certainly in a county like El Paso County, the percentage is going to be quite a bit higher, probably around 70 percent of the population (or at least of the children) being below 200 percent of poverty.

So in terms of looking down the road, what is the population that will not get access to private sector coverage, or for whom a large percentage won't get access to private sector coverage because the cost of the premium is so disproportionate to the wage that they're earning, even when there are one or more full-time workers in the household? We are going to have to look beyond that artificial barrier of the poverty guideline at some point, if we really want to get closer to universal coverage.

Obviously, barriers to Medicaid are an issue that we're all talking about a lot in Texas right now, and Representative Coleman wanted me to make sure I mentioned what we're talking about in the Legislature. We're currently looking at bills that would offer 12 months of continuous enrollment in Medicaid for children, which is the same policy we currently have in CHIP, that would allow application for Medicaid to be done without a face-to-face interview at the DHS office, and that would drop the assets test for children in Medicaid so that we would only be looking at family income as we do for the CHIP program. Because the fiscal note for potentially bringing in somewhere in the neighborhood of 500,000-600,000 children who are currently uninsured into Medicaid is substantial, as you would expect, the Legislature has been struggling to find ways to bring that cost down.

One of the things they're contemplating right now is possibly keeping the assets test, which allows you to have more children in CHIP and get a higher match rate there, but simplifying the assets test and making it a self-declared test where there's no additional documentation required. They just ask you questions about your assets and move on to enroll your children. It allows the mail-in application without a visit to DHS. Those are some of the things that we're talking about with regard to children's Medicaid, but one of the things that we've been talking about here today is how do we go a step beyond that to reach out to parents. I think it's important to remember that we will have work to do in terms of simplifying eligibility for that population as well, if we want to try to do something that allows our working poor parents to participate in Medicaid. There's some legislation that you may not be aware of before the Legislature right now. If you're interested in Medicaid simplification and you're interested in increasing adults' access to Medicaid you should probably be aware of it.

I'm not going to rattle off a list of bill numbers for you because I didn't come here with that intent today. But there are bills pending right now that would direct the state to exercise the flexibility that they have right now under federal guidelines to start using

telephone recertification for food stamps as well. That would be important because, as you probably know, food stamps are available to families up to 130 percent of poverty. If the family that now can do a mail-in or telephone-in application for children's Medicaid and recertification for Medicaid is also eligible for food stamps, but they still have to go back to DHS every three months to recertify for Medicaid, which currently is the applicable policy for most families with earned income, then our attempts to simplify Medicaid will certainly not support those families continuing to access the food stamp benefit. The Department of Human Services anticipates continuing to have the same high quality control with telephone recertification that they currently have, which reduces their error rates and gets them large financial bonuses from the USDA.

There's also legislation pending to exercise the flexibility we are given by the federal government to have a more generous vehicle standard in the food stamp program, which means that working families could have one decent vehicle and still get food stamps, because there's a recognition that that requirement (the current food stamp vehicle policy) is at cross-purposes with our alleged desire for people to be in the workplace. In addition, there is legislation that would also allow greater flexibility in general in resource-counting for food stamps. For example, instead of simply saying that if you have $2,000 worth of countable assets you are out of here, we have the flexibility to allow for some prudent savings, to allow people to be doing things such as having more savings for retirement or more savings in order to make a down payment on a house or even just to get into an apartment.

Another important piece of pending legislation would completely get rid of resource tests for the so-called qualified Medicare beneficiaries and specified low-income Medicare beneficiaries, QMBs and SLMBs. These are low-income seniors who don't qualify for Medicaid in Texas, whose incomes are below 120 percent of poverty, which I think works out to about $860 per month. Right now under federal policy, Medicaid picks up some of their Medicare cost-sharing. But some main barriers to participation in the program is the documentation that's required with the assets test, as well as the fact that, as with the other programs we've talked about, you can't have more than $2,000 worth of countable assets and still get the assistance. So that's an important piece of legislation in the area of reducing barriers.

Among other legislation that's pending are a number of different prescription drug bills. One that most likely will survive is a bill by Representative Patricia Gray, the chairman of the House Public Health Committee. It would provide a prescription drug benefit to those QMBs and SLMBs we just talked about, the folks who qualify for Medicare below 120 percent of poverty who currently don't get any kind of drug benefit. The price tag on that is very high. One of the benefits to passing this bill might be that if Congress does pass some kind of "Immediate Helping Hand" legislation, as has been discussed as sort of a short-term way to address the lack of prescription drug benefit, this bill could be a vehicle for taking those new federal funds and trying to get some drug benefits out to low-income seniors and people with disabilities who also qualify for Medicare.

Prescription drugs are another piece of the picture that needs to be addressed and not forgotten. One of the projects I've had the pleasure of working on over the last couple of years was funded by something called the Access Project, which is affiliated with Brandeis University. The Access Project worked with advocates and health care providers in about 11 mostly smaller Texas communities; the only major metro area included was El Paso. In many of these smaller communities, they don't even have a hospital district to resort to, so the access for people who are uninsured is even more limited. We heard story after story of seniors who are living on, say $1,200 or $1,500 per month, which you'd think in a small town in Texas might be enough to get by on as a retired senior. But because they are making that much money (and some of them are only making $700 per month) that means they earn too much for Medicaid, so they have no prescription drug coverage, and many of them have $500 and $600 per month of prescription drug bills. The way modern medicine works today, if you don't have prescription drug coverage, you really don't have health insurance. We've got to do something about the low-income seniors and people with disabilities who don't have access to that benefit.

I wanted to mention when Jocelyn Guyer was talking about the "low-hanging fruit" and the easy targets—and they are easy perhaps in terms of getting federal approval—that of course we all know that there's nothing easy about the budget situation we're dealing with in our current legislative session. I want to mention that one of the constraints on our ability to make progress in addressing the populations that we think will only be addressed through public solutions is going to be our revenue-generating capacity in the state.

For those of you who are not familiar with my organization, my colleague Dick Lavine put a piece up on our web page last week called "Why Isn't There Any Money?" It demonstrates graphically how the revenue-generating capacity of the Texas government with respect to each Texas citizen—our revenue-generating capacity per Texan—has been declining fairly steadily over the last 10 to 15 years. So if we care about all kinds of public services, we all need to start thinking about our revenue system and what we're going to do to make sure that we won't be struggling constantly just to fund current services in our budget, much less make room for any new initiatives. One obvious solution to that revenue dilemma, which has been mentioned by several speakers, is the notion of bringing more of the local funding (that we're kind of squandering by not drawing federal match for it) into the system. And about the only response I have to the comment earlier about the downside of recycling money through Washington is that, well, sometimes, that's the only way get our dollars back that we've sent there. Rep. Patricia Gray calls them "homesick Texas dollars" that we're giving away to other states by not optimizing these programs.

The local funding issue is very legitimate, but, as we all know, the hang-up has been, as Representative Coleman explained, a concern that if county government turns its money over to Medicaid, that money goes to any Medicaid provider and not necessarily back to the county. I think one of the things we might as well be blunt about in terms of discussion is that one of the kinds of new flexibility we could be looking at because of

possibly having a more favorable position with the administration is the idea that choice of provider may have to be given up in return for being able to have a locally funded Medicaid system. Right now, federal law in Medicaid managed care says you have to provide a choice among HMOs, at least in urban areas. One principal reason that our earlier request for an 1115 waiver was not approvable was that we were proposing to have basically a one-HMO choice per region.

This is an issue that I think everyone, from whichever perspective, has to grapple with. If I'm an advocate for low-income people, I have to grapple with whether it is better for me to have health care coverage for many more low-income people in Texas even if it means they don't have choice. Is that something I can live with? And another thing that we all have to be looking at is another form that so-called "flexibility" will take in terms of what the governors are looking for, that is, a reduction in the benefits to which people enrolled in Medicaid are entitled. I think that's likely to be one of the things on the chopping block. That's going to be a very, very serious issue to consider, particularly if you assume that for the poorest of the poor, if a benefit is not included in their package, they're just not likely to get it, because there won't be any money to pay for it. So I think it's important to recognize that those are some of the dilemmas with which we'll be grappling. I'm willing to consider the possibility that if we can get everybody in the boat, maybe a slightly less luxurious boat is okay. But it's going to be a very serious part of the debate.

And finally, we certainly have issues in terms of equity of reimbursement rates within our public programs that are also part of this whole picture. My perspective on this is that one problem we have is a real lack of disinterested capacity—and I mean "disinterested" in the sense of having no financial interest in the outcome—that can look at our reimbursement systems in these public programs and say, this is inadequate, this is not fair to the community or to the provider, or you're paying them too much, or people are making way too much profit off of this for a public program. And I think it's a real shortcoming in the public-interest world that we don't have the capacity and the expertise to do that in a disinterested fashion. And unfortunately, with all due respect to our institutions of higher education, most of them in Texas are now health care providers and are not disinterested in that sense. And the folks who work for the state are not exactly disinterested as they are subject to budget pressures and political pressures as well. So one of the problems I struggle with as an advocate in looking at these equity issues is that the more complex they become, the more layers we put between the state and the ultimate recipient of the funds like the HMOs, the less access I legally have to the data on what they're paying providers, and the less able I am to judge whether we're doing right by the clients for whom I'm supposed to be advocating. Thank you.

KENNETH APFEL: We'll have some brief questions, but remember that we do have five workshops, with open, active, and full discussion this afternoon. So we'll take just a few questions now.

PETER MARSH: I'm perhaps a duck out of water, because looking over the participants' list, I think after our speaker from the Texas Medical Association this

morning left, I may be one of the only medical doctors present. My reason for being here is not really direct and has not been directly addressed. I'm interested in getting a county health department started in a rural county, in Kaufman. This brings up another disparity that Judge Briones did not discuss, and that is, in counties such as Kaufman, where the indigent care program doesn't work—and I think in many of the rural counties this is probably the case—there are funds that the state has available that either stay at the state or get spent in Harris County and in Travis County and the big population centers. The less-populated areas of the state do not access the indigent care funding that's available to them because they never spend any indigent care dollars.

In Kaufman County, we spend a very small fraction of the budgeted indigent care program. This is partly because of lack of understanding in the commissioner's court and the idea that the counties really don't have responsibilities for health care. I think there's an old political feeling that the state should never have made us pay for these poor peoples' health care, and so what we'll do is just make sure that the phone doesn't ever get answered. That's what happens in our county. We have an employee who is inaccessible to the people from doctors' offices or the hospitals and so we spend almost no money. If anyone here has some experience that could help me—that's why I'm here. I usually work and make some money on Fridays, and I switched my calendar around to try to get here just so that I could learn, and everything I've heard here is almost a foreign language to me. But I think from Representative Coleman's perspective, if there's anything that can be done—

GARNET COLEMAN: Let me talk about that a little bit, because we did start the process last session with the passing of House Bill 1398, which primarily focuses on how indigent care counties, not hospital districts or counties with public hospitals, provide care. We literally increased the reimbursement to an indigent care county, which is one without a hospital district of any sort. We went from an 80-20 match, after 10 percent of the revenue of a county is spent on indigent care, to a 90-10 (state-local) match, after 8 percent of revenue is spent. We also increased what is reimbursable under the formula of revenue that a county spends to make up that 8 percent, and appropriated 34 million new dollars for this biennium.

By the way, none of that money goes to Harris County, because we're a hospital district. We don't get any of it. And none of it goes to Travis County and or Dallas County or any of those other large counties. The other portion that we put in there was called an out-of-county tertiary care fund, which goes to everybody, and that's to make up for people who come into a county on an emergency basis and go into an emergency room and have no money. Counties have access to so many more dollars than they had in the past, particularly those rural counties which tend to be indigent care counties.

Also, something else we changed was if a county tried to get out of that by forming a hospital district and then going to 11 percent of poverty as their threshold, guess what, they can't do that anymore. We leveled everybody out to 25 percent of poverty as the threshold. It's not perfect, but now that every county has to report through the tobacco settlement, we have an understanding of what counties are doing or not doing, in terms of

what our state constitution says, and what our statute says. I know it's not perfect and it isn't necessarily resolved, but we've made a substantial new contribution to solving the problem in trying to get counties to do more than what they were doing before. For some counties, that has worked. For other counties, they've decided they still don't want to participate.

PETER MARSH: This reasoning is similar to the situation that you were explaining about Texas starting at a low percentage as far as poverty level and the problem in going to a high percentage. When you have a county that's spent nothing on health care, or their highest budget item is what they pay their clerk to not answer the phone, to go up to 8 percent before they start getting reimbursement means that we have a long, long way to go before we'll access the changes in the legislation.

GARNET COLEMAN: I understand that. And let me tell you, what they're supposed to do is spend up to 8 percent of that levy. The ability to force counties to do that is not here yet. That's the problem.

JOCELYN GUYER: I just wanted to follow up on that, and I think you just commented on what I was going to say. Counties don't have to do it, and I think it's really important for communities to get active about what their counties spend their money on. Many of the counties that received significant tobacco settlement dollars did not spend their money on health care; they supplanted current spending, so that those counties got extra money, and they saw no extra benefit in their health care.

People have to get active. These county commissioners are elected. There are many different things a community can do, and I think we're going to have to have that kind of activity to get local services to respond to the community and help people out. And I think the biggest problem is that the people who are hurting the most are often the people who don't have time, or they don't have the knowledge of what they can do to bring about change. So you have to work with all different people in your community to make that happen.

GARNET COLEMAN: To add to that, just briefly, our chamber, the Greater Houston Partnership, never had an interest in indigent care before, but they led the charge to increase taxes for our hospital district, because it's an infrastructure need. When people and businesses consider coming to a place—and I agree with the county judge—they look to see if that health care infrastructure is there. They're not going to locate any business in a place where there's no health care infrastructure, whether it's for the upper middle class, the middle class, or guess what, the poor. They make decisions based on that. And our folks recognized that very clearly, and spent a million dollars on an ad campaign to persuade the public that we need to raise this tax. And it wasn't even a public vote.

KENNETH APFEL: Pablo Schneider. And this will be the last question for this morning's panel. There will be lots of time for active discussion this afternoon in the five workshops.

PABLO SCHNEIDER: First a comment. I'm on the board of the Border Health Foundation, and they have a sister foundation called the Rural Health Foundation. It's in Arizona, and maybe that would be a resource for you to look at to see what they've done in other rural areas along the border. I'll give you their phone number and contact information, so that's one suggestion.

My question is, in looking at various initiatives around the country, state and local initiatives, four of the ones I've identified that I think have had some impact are BadgerCare in Wisconsin, Minnesota Care, the Boston HealthNet pilot plan, and the Washington Basic Health Plan. Could any of you comment on leveraging existing models in other states around the country here in Texas? Maybe that's what Diane Longley's project is all about.

JOCELYN GUYER: I actually didn't mention many of those states because I figured Wisconsin was as much as I could push. Minnesota, Washington, and also Vermont have wonderful programs. They may not resonate in any way, and it sounds like even the Wisconsin example may be a stretch given the differences in the political and fiscal situation in Texas. But I'm really glad you raised it, because they are wonderful models. They combine a lot of key elements. They all essentially are expansions of our public programs beyond the traditional levels. Some have been in place for many, many years. Those states have all been very strategic and political about making sure that when they set up their programs, they maximize the amount of federal funds that come in to them. And I think Texas would actually be well situated, obviously, at this point, to take some more steps.

I think this relates to the issue that Representative Coleman raised earlier, that of highlighting the fact that we have enormous regional disparities at this point in terms of access to public programs. One of the charts in the handout sorts by state the income cutoff for parents, and all the states that are doing extremely well are concentrated in the northeast.

There are a couple of exceptions, which I think are important to highlight, because if you can find the political will, there are ways to do it. Those exceptions are Arizona, which was at 50 percent of poverty before and is going to 100 percent, and Missouri, which was at about 28 percent of poverty and went to 100 percent. So it can be done. But I think it is clear that at this point that the northeastern states, some of the Midwest states, and some of the western states are primarily leading the way.

I think it brings us back to Representative Coleman's point about whether we can access any additional federal funds so that we get more of an even playing field across the country. I think SCHIP really was a model. Before SCHIP passed, we had tremendous regional disparity in coverage for kids, and now 35 states across the country, including Texas, are at 200 percent of poverty for kids. In that case, what happened was that Congress stepped in and offered states this enhanced match to make it feasible across the country for states to take that step. And I think we may need something like that for parents and other populations as well.

GARNET COLEMAN: Let me piggy-back on what she said. Back in 1995, you will remember there was a proposal to do something called Medigrants, which means you block-grant Medicaid to a particular state. If you do that in Texas, you lock us in where we are now in terms of spending. That means Wisconsin will get locked in with their expansions, and we'll get locked in where we are, and then we can never expand. So I just want to make sure that people understand, block grants sound great, but it depends on what base year you use. If we used the base year of two years ago, we'd be locked in at our lowest Medicaid level since who knows when.

There will be debate on this. There will be people who will advocate for that in Congress. They'll advocate to block-grant SCHIP and Medicaid funding, and they'll advocate to block-grant all that funding. Let me tell you: be careful what you ask for, you just might get it. I just want to lay that out, because though the argument will be that block-granting gives you flexibility, it can also take away your flexibility. There's no flexibility when you have limited funds, and that's what block-granting would do.

KENNETH APFEL: I want to thank the panel, and I'm sure we're all looking forward to further discussion over lunch and during the afternoon workshops.