

# **Chapter 12.**

## **Hispanics and Health Insurance in Texas**

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### **Introduction**

There are many estimates on the demographics of the uninsured in Texas based on various state and national surveys. The exact percentage of certain groups of the uninsured differs according to the statistics and studies used. All results point to the same conclusion, however: the percentage of uninsured children and nonelderly adults in the state of Texas exceeds the levels of uninsured in every other state in the country.<sup>1</sup> About one out of every four nonelderly people in Texas is uninsured. This corresponds to approximately 4.6 million Texans (25 percent) being without health insurance. Nationally, 15 percent of the population is uninsured. Seven percent of the people in the United States live in Texas, but 11 percent of this country's uninsured live in Texas.

Among nonelderly Texans, certain groups of people are more likely to be uninsured than others. Although the uninsured include people of all racial/ethnic groups and income levels, Hispanics, low-income workers, young adults (ages 18-24), and children are the most likely to be uninsured. Twenty-six percent of all nonelderly adults in the state are uninsured. Fifty percent of the uninsured in Texas are Hispanic.<sup>2</sup> Compared with other states and the nation as a whole, Texas has one of the lowest rates of employer-sponsored health insurance and it is lagging further behind in offering public insurance to its citizens. While uninsured adults exist at all income levels, low-income adults are far more likely to lack coverage; low-income adults comprised 38 percent of the adult population in Texas in 1999, but accounted for 58 percent of the state's adult uninsured.<sup>3</sup>

Studies have shown that people without health insurance are far less likely to receive health care than those who are insured. The uninsured also have more stress, wait longer to seek treatment, and miss more days of school and work due to illness than those having health insurance.

A survey conducted by the Kaiser Family Foundation found that 57 percent of Americans believe that the uninsured in this country are primarily unemployed or from families with no one working.<sup>4</sup> The reality is quite different. The majority of the uninsured nationally (80 percent) are low-wage workers and their family members.<sup>5</sup> In Texas, Hispanics are uninsured at twice the rate of non-Hispanic whites. Immigrants, the poor, and children also tend to have extremely high uninsurance rates.<sup>6</sup>

### **General Characteristics of the Uninsured in Texas**

As mentioned, Texas has the highest rate of uninsured people in the country. It ranks second in the percentage of uninsured children and third in the percentage of low-income children (below 200 percent of Federal Poverty Level) with no insurance.<sup>7</sup> The most

severely affected areas of Texas are along the Texas-Mexico border in South Texas and El Paso. There also are large numbers of uninsured people in Bexar, Dallas, Tarrant, and Harris counties. These urban counties include the cities of San Antonio, Dallas, Fort Worth, and Houston, respectively.<sup>8</sup> These areas all have large Hispanic populations as well.

In Texas, as well as nationally, low-income people are at the highest risk of being uninsured. Nearly half of Texas' low-income population (47 percent) has no coverage, which is well above the national average (33 percent). Low-income Texans receive employer-sponsored insurance and public insurance at lower rates than national averages.<sup>9</sup>

The Urban Institute conducted the National Survey of America's Families (NSAF) in 1997 and 1999 to analyze states' progress primarily in the areas of health, income security, job training, and social services. Thirteen states throughout the country were surveyed, including Texas (2,103 households were surveyed in Texas in 1999).

Initial findings from the 1999 NSAF show that Texas is performing below (worse than) the national average in nearly all categories. Texas ranks far below the national average in the number of children with employer-sponsored or any other form of health insurance, and in the number of nonelderly adults with employer-sponsored, Medicaid/state, or any other form of insurance, as well as many other categories of social welfare indicators. Texas rated better than the national average in one category where: low-income adult Texans between the ages of 25 and 54 are significantly more likely than the national average to be employed.<sup>10</sup> In all of these categories a significant number of those affected are Hispanics.

Fifty-eight percent of all children in Texas were covered by employer-sponsored insurance in 1999, far below the national average of 66.7 percent. Sixteen percent of Texan children received public insurance in 1999, slightly below the national average of 16.4 percent for 1999. Twenty-three percent of children went without health insurance in 1999, almost twice the national average of 12.4 percent of children who are uninsured.<sup>11</sup> (See Table 12.1 for more details.)

**Table 12.1. Health Insurance Data for State of Texas**

<i>Type Of Insurance</i>	<i>All Incomes</i>			<i>Low-Income Families</i>		
	1997 - TX	1999 - TX	1999 - US	1997 - TX	1999 - TX	1999 - US
<b>Children</b>						
Employer-Sponsored	54.0%	57.6%	66.7%	27.6%	32.7%	38.7%
Public	19.6%	16.1%	16.4%	36.3%	28.7%	35.2%
None	22.0%	23.0%	12.5%	33.6%	36.7%	22.4%
<b>Non-Elderly Adults</b>						
Employer-Sponsored	63.8%	65.1%	72.3%	34.3%	39.2%	41.7%
Public	4.2%	3.6%	4.8%	11.1%	8.4%	14.7%
None	26.6%	26.0%	16.3%	49.4%	46.6%	34.9%

Adapted from: Urban Institute, *Snapshots of America's Families II: Data by State, Texas* (Washington, D.C., October 2000), p. 21.

Note: Low-income families are at 200% or below of the Federal Poverty Level.

Of the 13 states where people were surveyed as a part of the 1999 NSAF, Texas had the highest level of uninsured among low-income adults, was second from last in public insurance for low-income adults, and was third from last on employer-sponsored insurance and other private insurance. Only New York and California had lower rates of coverage in that category. Unlike Texas, however, both of those states have extremely high rates of public insurance coverage. New York's rate of public insurance coverage of low-income adults is three times higher than Texas, and California's rate is twice as high as the rate in Texas. For that reason both of those states have fewer uninsured people than does Texas. Massachusetts and Washington are two other states with broad public coverage that enables them to make up for a below-average level of employer-sponsored insurance while still maintaining a relatively low number of people without health insurance.<sup>12</sup>

### **Demographics of the Hispanic Uninsured in Texas**

Of the approximately 20.3 million people living in the state of Texas, it is estimated that 31 percent (6.3 million) are Hispanic.<sup>13</sup> The vast majority of Hispanic Texans (89.6 percent) are of Mexican descent.<sup>14</sup> Texas' Hispanic population is expected to grow significantly in the next 30 years. A study done by the Texas State Data Center projects that Hispanics will comprise 46.2 percent of the states' population by 2030, a larger population than non-Hispanic whites, who are projected to make up 36.4 percent of Texas' population in 2030.<sup>15</sup> (See Table 12.2 for details.) In the next 30 years a huge demographic shift in the population is expected to occur, which will have wide-ranging effects in many aspects of society, including the field of health.

**Table 12.2. Projected Population of Hispanics and Non-Hispanic Whites in the State of Texas**

Year	Hispanic Population	Percent of State Population	Non-Hispanic White Population	Percent of State Population
2000	6,302,361	31.0%	11,100,275	54.5%
2010	8,765,364	36.3%	11,670,349	48.4%
2020	11,870,242	41.4%	12,143,448	42.3%
2030	15,667,787	46.2%	12,351,852	36.4%

Adapted from: Steve H. Murdock, *Current and Future Patterns of Population Change in Texas: Implications for the Number of Uninsured in Texas* (College Station, Texas.: Texas A & M University, January 2000) p. 10.

Eighty-four percent of the Hispanics in the state of Texas live in five specific geographic regions. These regions are Lower South Texas (22 percent of the Hispanics in the state live in this area), the Gulf Coast (20 percent), Upper South Texas (17 percent), the Metroplex (15 percent), and the Upper Rio Grande Valley (10 percent).<sup>16</sup> Three of these regions also have the highest rates of people without insurance in the state. Thirty-four percent of Texans living in Lower South Texas, along the Texas-Mexico border, have no health insurance. The rate of uninsured is also 34 percent for Texans living in the Upper Rio Grande Valley, primarily in El Paso. Twenty-nine percent of Texans living in Upper South Texas are without health insurance (San Antonio is included in this region).<sup>17</sup> The cities of Dallas (Metroplex region) and Houston (Gulf Coast region) also have high rates of people without health insurance. As previously noted, both of these cities have a significant Hispanic population. (See Table 12.3 for regional details.)

**Table 12.3. Location of Hispanic Population in the State of Texas**

Region	Percent of Texas' Hispanic Population	Percent of Region's Hispanic Population
Lower South Texas	22%	80%
Gulf Coast	20%	27%
Upper South Texas	17%	51%
Metroplex	15%	17%
Upper Rio Grande	10%	77%
Central Texas	6%	20%
High Plains	4%	29%
West Texas	4%	39%
Northwest Texas	1%	17%
Upper East Texas	1%	5%
Southeast Texas	1%	6%

Adapted from: Texas Health and Human Services Commission, *Demographic Profile of the Texas Population Without Health Insurance Coverage* (Austin, Tex., April 2000), pp. I-7, I-8.

Information from the 1990 U.S. census shows that in that year approximately 17 percent of Hispanics in Texas spoke very little or no English.<sup>18</sup> With the large increase of immigrants into the state of Texas in the last ten years, it is likely that today the percentage of Hispanics who do not speak English is significantly larger than in 1990. It is challenging to find ways for this group to access health insurance, facing as it does not only monetary barriers, but language and cultural barriers as well. Even if members of this group are eligible for public insurance or employer-sponsored insurance, they often are unaware of this because of the language barrier.

Hispanics statistically have lower levels of formal education than do non-Hispanic whites or other racial/ethnic groups in Texas and the rest of the United States. Among Hispanics, those of Mexican descent have the lowest levels of education completion. Forty-six percent of Hispanics in the United States over the age of 25 have not graduated from high school. In comparison only 9 percent of non-Hispanic whites in the United States do not have their high school diplomas. In addition, only 9 percent of Hispanics have college degrees, while 29 percent of non-Hispanic whites are college graduates.<sup>19</sup>

Fifty percent of the approximately 4.6 million people without health insurance in the state of Texas are Hispanic (2.34 million).<sup>20</sup> Forty-one percent of Hispanics in the state do not have health insurance. In comparison, approximately 16 percent of non-Hispanic whites in the state are without health insurance.<sup>21</sup> In Texas, a Hispanic is 2.5 times more likely than a non-Hispanic white person to have no health insurance. These ratios are similar at the national level, where Hispanics comprise 12 percent of the total population but account for 25 percent of the uninsured population.<sup>22</sup>

Among low-wage workers, the largest racial/ethnic group without health insurance is Hispanics. The same is true for children without health insurance. There are more Hispanic children in this category than non-Hispanic whites or non-Hispanic blacks. This also holds true for the young adult category. This means that if there is success in increasing the rate of health insurance among low-wage workers, children, or young adults, this success likely will be felt within the Hispanic population as well. It also means that if we are to be successful within these three categories the Hispanic population must be given serious consideration when we consider ways to increase health insurance coverage in these groups.

Although there are disparities throughout the country between the percentages of non-Hispanic and Hispanics with health insurance, these differences are greater in Texas. Hispanics in Texas are less likely than those in other states to receive employer-sponsored or other private insurance (see Table 12.4). Hispanics in Texas also are far more likely than those in the rest of the country to be without health insurance.<sup>23</sup>

**Table 12.4. Insurance Rates for 0-64 Age Group**

Type of Insurance		United States	Texas
<b>Employer-Sponsored</b>	Hispanics	46.2%	38.2%
	Non-Hispanic whites	74.0%	70.5%
<b>Other Private</b>	Hispanics	2.8%	1.1%
	Non-Hispanic whites	6.0%	7.0%
<b>Medicaid/Other Public</b>	Hispanics	19.4%	20.0%
	Non-Hispanic whites	8.1%	6.3%
<b>Uninsured</b>	Hispanics	31.6%	40.8%
	Non-Hispanic whites	11.9%	16.2%

Adapted from: Urban Institute, *Snapshots of America's Families I: Texas State Data* (Washington, D.C., May 2000), table 4.

Thirty-two percent of Hispanic children in Texas (680,000) are without health insurance. Fifteen percent of non-Hispanic white children (388,000) are uninsured.<sup>24</sup> A Hispanic child in Texas is more than twice as likely as a non-Hispanic white child to be without health insurance. The differences that exist between the rates of all Hispanics with health insurance in Texas compared to the rest of the country also exist among children (see Table 12.5).

**Table 12.5. Insurance Rates for Children 0-17**

Type of Insurance		United States	Texas
<b>Employer-Sponsored</b>	Hispanics	41.7%	32.1%
	Non-Hispanic whites	73.8%	68.1%
<b>Other Private</b>	Hispanics	2.3%	1.1%
	Non-Hispanic whites	4.9%	6.9%
<b>Medicaid/Other Public</b>	Hispanics	33.2%	34.8%
	Non-Hispanic whites	12.4%	10.5%
<b>Uninsured</b>	Hispanics	22.8%	32.1%
	Non-Hispanic whites	8.8%	14.5%

Adapted from: Urban Institute, *Snapshots of America's Families I: Texas State Data* (Washington, D.C., May 2000), table 4.

There are 3.6 million Hispanics in Texas who are poor or near poor (200 percent of the Federal Poverty Level or less). This is 61 percent of the Hispanic population in the state.<sup>25</sup> Fifty-one percent of Hispanics in Texas who earn less than 100 percent of the FPL (859,000) are uninsured. In comparison, 43 percent of Hispanics in the United States who earn less than 100 percent of the FPL are uninsured. Thirty-six percent of uninsured Hispanics in Texas earn less than 100 percent of the FPL. Thirty-nine percent of uninsured Hispanics earn between 100 and 200 percent of the FPL. The remaining 25 percent of uninsured Hispanics earn more than 200 percent of the FPL.<sup>26</sup>

## **State Children's Health Insurance Program in Texas**

There are nearly 11 million children in the United States without health insurance. Texas has approximately 1.4 million uninsured children, second only to California.<sup>27</sup> Of those children, approximately 800,000 are Hispanic (around 56 percent).<sup>28</sup> In Texas, SCHIP insurance is available for children whose parents earn between 100 and 200 percent of the FPL. Children whose parents earn less than 100 percent of the FPL are eligible for Medicaid. The Texas Health and Human Services Commission estimates 62 percent of the children eligible for SCHIP are Hispanic.<sup>29</sup>

SCHIP began enrolling children in Texas in April 2000. As of April 9, 2001, there were approximately 314,360 children enrolled.<sup>30</sup> It is estimated that there are 478,000 children eligible for SCHIP statewide. The program aims to have 420,000 children enrolled by September 2001.<sup>31</sup> Although reporting ethnicity on the application is voluntary, approximately 84 percent have responded. From these responses, 57 percent of those enrolled in SCHIP are Hispanic.<sup>32</sup>

The initial lag in SCHIP enrollment seemed at first to be a problem of incomplete applications.<sup>33</sup> Failure to sign the application was the most common delay in getting applications processed. Some families also failed to include verification of income and to indicate a child's date of birth. These omissions delayed moving an application to eligibility determination and health plan enrollment. The application has since been slightly redesigned to highlight the necessity of signatures, verifications, and dates, and to point out their location within the application.<sup>34</sup> These modifications are continually monitored for their effectiveness.

As is common in the implementation of any large-scale project, some issues have arisen concerning the initial SCHIP implementation. There have been long wait times for people who call the customer service center. The biggest problem has been with the Spanish-speaking customer service line. Many people who have tired of waiting on hold to speak with a representative have hung up before obtaining the information they needed. These problems have been addressed, and the waiting time on the customer service line has decreased.

The SCHIP application process in Texas is continually improving to meet the needs of consumers. The state has tried to eliminate barriers related to language, access to assistance, time, and fear that may prevent parents from completing the SCHIP application. The applications are now shorter, easier to read, and offered in both English and Spanish. There are community-based organizations across the state helping families obtain and complete the application. Furthermore, the SCHIP call center is staffed six days a week to answer questions and assist in initiating the applications over the phone. The application itself has been refined to include more information, clarify which documents are needed, and assure families that the information they provide is confidential and will not be shared with the INS or IRS.

## Medicaid in Texas

Of the estimated 1.4 million children in Texas who are currently uninsured, approximately 600,000 are thought to be eligible for Medicaid. Again, these children are disproportionately Hispanic, with 56 percent of those eligible estimated to be Hispanic.<sup>35</sup> Of the 1.1 million children enrolled in Medicaid, 703,000 are Hispanic.<sup>36</sup> In Texas, unlike in some other states, most adults are ineligible for Medicaid. For example, a single mother with two children and a minimum-wage job working 16 hours per week would earn too much to qualify for Medicaid.<sup>37</sup>

Many believe the 1996 Welfare Reform Act adversely affected Medicaid enrollment. The act did not allow legal immigrants entering the United States after August 22, 1996, to enroll in the program until they had lived in the United States for five years. It also de-linked welfare from Medicaid, and many people no longer eligible for welfare benefits did not realize they were still eligible for Medicaid. While all of this holds true for the United States as a whole, Texas is one of the few states that saw Medicaid enrollment decrease between 1997 and 1999. Nationally, enrollment increased 2.3 percent between June 1997 and December 1999. During the same time period South Carolina, Oklahoma, and Massachusetts all increased Medicaid enrollment by over 30 percent. Texas was on the opposite end of the enrollment spectrum, with a 7.6 percent decrease. Only West Virginia had a larger decrease, with 12.1 percent fewer enrollees.<sup>38</sup> Extending the time period under examination back to January 1996 reveals that there was an 18 percent drop in the number of children on Medicaid in Texas (approximately 230,652 children). During this same period of time, Medicaid in Texas was expanded to make children between the ages of 15 and 18, up to 100 percent of the FPL, eligible for that insurance. Policy changes increased eligibility, yet the number of children receiving Medicaid decreased significantly.<sup>39</sup> This suggests that a serious outreach effort is needed to promote the program and let people below the poverty level know that their children are eligible for Medicaid.

Texas was recently found in violation of a 1996 consent decree that was an agreement to settle a 1993 lawsuit on behalf of indigent Texans who sought full access to the health care program. The judge's 175-page ruling in *Frew v. Gilbert* ordered Texas to find ways to make Medicaid more accessible to medically indigent Texans. The August 14, 2000, ruling was based on Texas' insufficient promotion of the Medicaid program, the limited access being provided to those enrolled in the program, and the failure to provide outreach to children who qualify for the program but are not enrolled. Attorney General John Cornyn has appealed the order, and has succeeded in putting a hold on submitting a plan for improving access to services until the appeal is decided.

The Center for Public Policy Priorities, the Blue Ribbon Task Force on the Uninsured, and many other organizations have pointed out the problems with Medicaid and their possible solutions. The most frequently recurring complaint concerns the extra steps required to enroll and retain children in Texas Medicaid. This process is far more cumbersome than the SCHIP application process. The Medicaid application process requires a face-to-face interview at a Medicaid application office to satisfy the initial

enrollment, an assets test to verify the limit of no more than \$2,000 in assets per family (with some exemptions), a lengthy application, between seven and 25 verifications, six-month reeligibility (as of December 2000, the Medicaid six-month demonstration of eligibility can be done over the phone or through the mail), and, in the case of an absent parent, potentially intrusive questioning by the Attorney General's office.<sup>40</sup> In addition, families are required to report any change in family income within ten days to the Department of Human Services.

In addition to all of these requirements, the stigma sometimes attached to Medicaid, the perceived unfriendliness at the DHS offices, complicated rules, and cultural differences can all be barriers to enrolling eligible Hispanic children into Medicaid.

There is also confusion regarding the separation between TANF and Medicaid. These programs are no longer linked, so when people are taken off TANF they may stay on the Medicaid roll if eligible. Many mistakenly believe that if the parent is not getting TANF, if the parent is working, or if there are two parents in the home, their children cannot receive Medicaid.<sup>41</sup> DHS employees must do a better job of explaining the entitlement to this population. This effort will require improving DHS capacity through staffing, funding, and planning enhancements. Focus groups have recommended separating Medicaid into another office or having separate specialists for Medicaid and TANF.

Community-based organizations (CBOs) have had initial success in promoting the SCHIP health insurance program in communities throughout the state. They are not contracted to do the same with Medicaid, however. The CBOs are able to help parents fill out a SCHIP application because it is far simpler than the Medicaid application. If it is determined that a child qualifies for Medicaid instead of SCHIP, he/she is referred to the Medicaid program. Only 25 percent of the parents who attempt to enroll their children in SCHIP and are subsequently referred to the Medicaid program go on to complete the Medicaid enrollment process. As of February 9, 2001, of the 91,574 children referred from SCHIP to Medicaid, parents of only 22,910 completed the Medicaid application, the face-to-face interview and assets test, met eligibility requirements, and now have their children enrolled on Medicaid health insurance.<sup>42</sup> In order to achieve higher enrollment rates, this process will have to be simplified and better coordinated. Several bills designed to simplify Medicaid have been introduced in the 77th Texas Legislature—see chapter 2 for more details.

## **Outreach Efforts**

The implementation of SCHIP in 2000 included a significant outreach effort to inform the public of this new health insurance program.

There are numerous outreach initiatives at the state level. Some of these specifically target the Hispanic population. The Health Resources and Services Administration (HRSA) has partnered with the Immigration and Naturalization Service (INS) to provide radio messages in areas with large Hispanic populations; these encourage listeners to call the toll-free hotline, and emphasize that utilization of SCHIP is not a public charge violation and does not affect parents' immigration status. Outreach organizers also are

placing print advertisements in local Spanish-language newspapers throughout the state. In addition, SCHIP brochures and applications are being distributed at schools throughout Texas and at PTA meetings to parents of children receiving free and reduced meals.<sup>43</sup> Television commercials promoting SCHIP are running statewide for 17 weeks, and at least 25 percent of these commercials air in primetime. Billboards located throughout the state also are publicizing the free and low-cost health insurance. Public-private partnerships are being developed: Southern Union Gas has agreed to include SCHIP literature in the monthly bills they send to their customers, and the Department of Health is attempting to develop partnerships with other large companies.

While much is being done statewide, the majority of outreach is carried out at the local level. The Department of Health has contracted with 54 community-based organizations (CBOs) throughout the state. The main objective of each CBO is to have as many children as possible enrolled in SCHIP; this is done primarily through outreach efforts as well as making sure SCHIP applications are filled out correctly. Each CBO has considerable discretion on how to provide outreach in its region.

In San Antonio, Laredo, and the Rio Grande Valley, areas with large Hispanic populations, enrollment has been high. A lot of this can be attributed to the outreach efforts of the local CBOs. These CBOs subcontracted a lot of their outreach efforts to local organizations within their area.<sup>44</sup>

In Laredo and the Lower Rio Grande Valley there are three outreach strategies: community, center, and corporate. The community strategy identifies key leaders and meeting areas in *colonias* and neighborhoods. *Promotoras* work with the key leaders to set up presentations for the community and offer one-on-one application assistance. These meetings generally are conducted in Spanish and all materials are available in Spanish. *Promotoras* also go door-to-door in *the colonias* and low-income housing areas. The center strategy targets school-based programs and sends SCHIP literature home from school with children. Presentations are made at school events and application assistance is offered. The corporate strategy provides presentations to employees of small businesses throughout the region.<sup>45</sup>

Outreach efforts are extensive in both San Antonio and the Valley. Presentations are given to as many groups as possible, and there is door-to-door canvassing in low-income areas. SCHIP information is distributed at the schools. CBOs have been working with faith-based organizations to help promote SCHIP through religious institutions. The CBOs are reaching many people and are having success with enrollment.<sup>46</sup> While it appears that outreach efforts for those eligible for SCHIP have been quite successful, Medicaid enrollment has not seen similar increases. This can be attributed to the amount of information the Medicaid application requires, and the program's required verifications and face-to-face interviews. Some state leaders believe that making Medicaid enrollment as easy as that for SCHIP would result in higher enrollment for Medicaid.

## Private Insurance

Private, or employer-sponsored, insurance plans are the main source of health care coverage for people under age 65 in the United States. This includes coverage of children and nonworking spouses (“dependents”), who typically are covered through a working family member’s insurance plan. Nationwide, 153.2 million people under age 65 (about 65 percent of the nonelderly population) are covered by employer-sponsored insurance.<sup>47</sup> In comparison, public insurance programs cover approximately 14 percent of the nonelderly population.<sup>48</sup> Forty-two million people under age 65, approximately 17 percent of this age group, are without any form of health insurance.<sup>49</sup>

This last statistic brings us to a major issue in health care policy today—the number of uninsured in our country. Because employer-sponsored health insurance is the main source of health care coverage in the United States, any examination of the problem of the uninsured should include an investigation into the problems presented by this type of health insurance.

Twenty-six percent of adult workers age 19-64 in Texas are uninsured. This is nearly twice the national average of 14 percent.<sup>50</sup> Among its low-income population, Texas has a significantly higher percentage of people employed (66.5 percent) compared to the national average (62.3 percent).<sup>51</sup> In Texas, 48.7 percent of private firms offer insurance. This falls below the national average of 53.2 percent. Firm size is directly correlated with whether or not insurance is offered: the rate of insurance being offered by firms in Texas with 99 or fewer employees is significantly less than the national average.<sup>52</sup> Approximately three of five Hispanics in Texas (60 percent) are in such a low-income category, and Hispanics also frequently work for small firms having 25 or fewer employees. Small companies fall into the lowest percentage of those offering health insurance to their employees (see Table 12.6).

**Table 12.6. Percent of Private Firms Offering Insurance**

Number of Employees in Firm	U.S. Average	Texas Average
Under 10	34.5%	27.5%
10 - 24	64.9%	45.6%
25 - 99	80.5%	72.1%
100 - 999	93.0%	91.8%
1,000 or more	96.8%	98.2%

Adapted from: James M. Branscome, Philip F. Cooper, John Sommers, and Jessica P. Vistnes, “Private Employer-Sponsored Health Insurance: New Estimates by State,” *Health Affairs*, vol. 19, no. 1 (January/February 2000), p. 140.

When employer-sponsored insurance is offered, the cost to Texans usually is slightly less than the national average for single coverage, but slightly higher than the national average for family coverage.<sup>53</sup>

Within the rubric of employer-sponsored insurance there is a specific concern that, regardless of work effort, not all workers face the same probability of having employer-sponsored health insurance. Even more worrisome is the fact that the majority of workers without employer-sponsored insurance collectively do not represent every wage range, education level, or even racial/ethnic group. Rather, this group, which often finds itself without any form of insurance, is heavily comprised of low-wage, low-education, minority workers—particularly Hispanics. Of all Hispanics under age 65 in working families nationwide, only 48 percent have employer-based coverage, compared to 59 percent of blacks and 75 percent of non-Hispanic whites in the same category.<sup>54</sup>

Small employers and firms that pay low wages are less likely to sponsor insurance plans than larger, higher-paying places of employment for a variety of reasons, including the cost (to employer and employee), and employees already being covered by their family members' health plans.<sup>55</sup> Hispanics tend to work for such firms and thus face a significantly higher rate of uninsurance. In 1999, only 48 percent of Hispanics under age 65 in working families received coverage through their own employer or a family member's employer compared with 75 percent of non-Hispanic whites receiving similar coverage.<sup>56</sup> When Hispanic workers are offered health insurance through an employer and are eligible for the plan, however, they enroll at a nearly equal rate to that of non-Hispanic whites and blacks. The differences in health insurance coverage between groups of people may have consequences. For example, differences in health status among racial/ethnic groups have been linked by some studies to a lack of health insurance coverage.<sup>57</sup> People in fair or poor health are less likely than those in better health to have private health insurance.<sup>58</sup>

There are a total of 30 million Hispanics under age 65 in the United States. Forty-six percent have employer-sponsored insurance (compared to 74 percent of non-Hispanic whites). In Texas, there are 6.3 million Hispanics, of whom 38 percent have employer-sponsored insurance (compared to 70.5 percent of non-Hispanic whites).<sup>59</sup>

Hispanics in the United States have a significantly lower rate of employer-sponsored health insurance coverage, even though 9 out of 11 million uninsured Hispanics are in families where at least one person works.<sup>60</sup> This proportion is similar to or exceeds that of other racial/ethnic groups.<sup>61</sup> The percent of uninsured (defined as those without any form of health insurance) Hispanics in working families (defined as a family where at least one person works) is 36 percent, compared to 13 percent for non-Hispanic white working families and 22 percent for black working families.<sup>62</sup>

Hispanic workers are more likely than any other racial/ethnic group to be employed in a firm with fewer than 100 employees.<sup>63</sup> They also are also twice as likely as the overall population to belong to a family where the primary wage earner makes less than \$7 per hour.<sup>64</sup> Workers in Texas are more likely to be uninsured if they work in personal service industries, jobs heavily occupied by Hispanics.<sup>65</sup> Personal service industries in Texas

have an uninsured rate of 57.3 percent. Other industries in Texas in which Hispanics frequently work are agriculture and construction, with uninsured rates of 47.6 and 44.3 percent, respectively.<sup>66</sup> In California, a state with demographics similar to those of Texas, workers are twice as likely as those in the rest of the country to be employed in the agricultural sector, one which typically is less likely than other industries to offer health benefits. Ten percent of Hispanic workers in California are employed in agriculture, and many work as outside contractors for larger firms that pay no benefits to contract workers.

Hispanics also are often employed as migrant workers. The National Agricultural Workers Survey defines a migrant farmworker as one who travels more than 75 miles to obtain a job in U.S. agriculture.<sup>67</sup> It is rare for migrants' employers to offer health insurance. They may intermittently be eligible for Medicaid, but among Medicaid's many requirements are recertification (for example, through face-to-face interviews) and regular reporting of income—both of which are very difficult for someone who travels to follow jobs and whose income varies through the year.

In general, Hispanics tend to have less formal education, have higher rates of noncitizenship or naturalized citizenship, and to come from countries where health insurance (as we know it) is uncommon and unfamiliar.<sup>68</sup> These factors all contribute to a pattern of Hispanics being employed in situations where statistically they earn less and are offered fewer benefits than are other ethnicities.

There are three primary reasons for some Hispanics declining to accept health coverage offered to them by an employer. Two of these are not particular to Hispanics: one is the possibility of better options elsewhere, for example through a spouse's employer. According to the Commonwealth Fund's 1999 National Survey of Workers' Health Insurance (NSWHI), this reason was cited by about 10 percent of working Hispanics.<sup>69</sup> The second reason is the cost of the coverage. According to the same survey, about 8 percent of Hispanics declined coverage because it was too expensive or the benefits were insufficient. For many workers, the employee's share of the premium is often too high. Sometimes this is due to a lack of information on the part of the employer. For example, the 2000 Small Employer Health Benefits Survey found that 37 percent of employers did not know that employees do not pay tax on the share of their premiums paid by their employer.<sup>70</sup> In contrast, workers who purchase health insurance directly from an insurer generally cannot deduct any of the premium from their taxable income. The third reason—often a particular problem for Hispanics—is a language barrier between many of them and their employers, which can prevent them from understanding all their options regarding enrolling in an employer-sponsored plan.

A quarter of Hispanics polled in the Commonwealth Fund's NSWHI indicated that they were not eligible for their employer's plan, most often because they did not work enough hours or were still in the waiting period.

Even though employer-based health insurance is the most common form of health coverage in the United States, of the 44 million Americans who do not have health insurance, 36 million (82 percent) are in a family with a worker. Sixty percent of

uninsured workers are employed by small firms (defined here as having two to 50 workers).<sup>71</sup> Most employers cite financial constraints and coverage available through a spouse as the reason they do not offer health coverage. Specifically, about one in ten businesses (this includes all businesses, large and small) cite the cost of coverage as their main reason for not offering health coverage.<sup>72</sup> On the other hand, nearly 70 percent of small employers not offering health benefits report that either a major or minor reason for not doing so was their business' inability to afford such coverage.<sup>73</sup> Studies show that many small employers are unaware of laws enacted by nearly all states and the federal government with the intent of making health insurance more accessible and affordable for small employers. More than 60 percent did not realize that insurers may not deny health insurance coverage to small employers even if their employees are in poor health.<sup>74</sup> Many insurance agents in Texas are being paid lower or no commissions for underwriting small businesses. As a result, they avoid (often illegally) offering insurance plans to these groups.

## **Comparison with California**

California is very similar to Texas demographically. It has high percentages of Hispanics, immigrants (many from Mexico), and low-income workers. It also has one of the highest rates in the country of people without health insurance.

Hispanics comprise 28 percent of the labor force in California and 50 percent of the uninsured in that labor force.<sup>75</sup> In Texas, 30 percent of the population, and 50 percent of the uninsured, are Hispanic. Nearly 48 percent of foreign-born, noncitizen workers were uninsured in California in 1998; in contrast, only 17 percent of U.S. native workers were uninsured.<sup>76</sup> Texas' situation is even worse. In 1999, 55 percent of noncitizens lacked health insurance, almost three times the rate for native U.S. citizens, and 20 percent of people in that category lacked health insurance.<sup>77</sup>

California is trying to correct its situation by expanding Medicaid and SCHIP programs to include more people, and by launching significant outreach campaigns to enroll those already eligible for these programs. California recently developed a four-page joint application for both Medicaid and SCHIP. California also grants 60 days of presumptive eligibility for pregnant women, but does not exercise the same option for children.<sup>78</sup>

Another important difference between the Medicaid programs in Texas and California is that California passed legislation in September 2000 providing 12 months of continuous eligibility to all children under 19 years of age.<sup>79</sup> Families are no longer required to report any income changes during the year. If this policy were implemented in Texas the state would have far greater success enrolling children and keeping them in the program, and recidivism, one of the biggest challenges facing Medicaid, would therefore no longer be a problem.

California also has taken advantage of a federal law change, an expansion of Medicaid, to allow the parents of children eligible for Medicaid also to be covered. This expansion ensures that a far greater number of people will be eligible for Medicaid. If this policy were adopted in Texas, its greatest impact would be among the Hispanic population.

While California's and Texas' Medicaid programs have a number of differences, most of the changes in California were made by recent legislation attempting to address the growing problem in the state. If Texas lawmakers were to follow California's lead and exercise the same changes during the current legislative session, many more people, most of them Hispanic, would become eligible and enroll in Medicaid, and the number of people without health insurance in the state likely would decrease.

## **Immigrants and Migrant Farmworkers**

Immigrants born in other countries make up 10 percent of the population in the United States. Approximately 2,443,000 immigrants live in Texas. Only three other states have larger immigrant populations.<sup>80</sup> The large majority of immigrants in Texas are Hispanic. Forty-three percent of Texas' immigrant population has less than a ninth-grade education. This percentage is much higher than the national average of 26.3 percent.<sup>81</sup> The rate in Texas is higher than the national rate because the vast majority of immigrants in Texas are Hispanic and from Mexico, and typically are less educated than other immigrant groups. Income levels for immigrants in Texas in 1990 were about \$10,500 per year, far lower than the national average of \$15,033 per year.<sup>82</sup> Fifty-six percent of immigrants in Texas are uninsured.<sup>83</sup> A 1996 study by the Immigration and Naturalization Service determined that approximately 700,000 of the noncitizens living in Texas at that time did not have legal permission to do so.<sup>84</sup> A research study at UCLA estimated that approximately 75 percent of undocumented citizens in the United States are without health insurance.<sup>85</sup> That would result in approximately 525,000 undocumented immigrants in Texas having no health insurance. Approximately 20 percent of the uninsured in Texas are noncitizens; that is, approximately 927,000 people. An additional 5 percent (210,000 Texans) of the uninsured in Texas are naturalized citizens.<sup>86</sup>

A large barrier to improving children's health insurance rates in Texas is the high percentage of mixed families comprised of both children who are U.S. citizens and one or more family members who are not. Eighteen percent of Texas children live in families where at least one parent is an immigrant. In the low-income population this increases to 27 percent of Texas children.<sup>87</sup> Immigrants face two major barriers in obtaining health insurance. One is that many work in low-paying jobs where they either are not offered health insurance or cannot afford the premiums when it is offered. The second is a side effect of the federal welfare reform act of 1996, which denies Medicaid or SCHIP to children and pregnant women who legally immigrated after August 22, 1996. As a result of that legislation, many immigrants who might in fact be eligible for public health insurance are reluctant to apply due to confusion and fear created by the new law. U.S. Census data showed that, in 1999, 32 percent of all uninsured low-income children in the country were members of low-income immigrant families.<sup>88</sup>

The new welfare laws denied Medicaid or SCHIP to children and pregnant women who legally immigrated after August 22, 1996, but legal immigrants who arrived before that date still may qualify for SCHIP. Those arriving after that date must be in the United States for five years before federal money can be used to support their health care coverage under SCHIP. In order to avoid imposing this waiting period on post-1996

immigrants, states can choose to use their own funds to finance the cost of including people in SCHIP until they are eligible for the federal match. Texas has done this for legal immigrant children, but has not extended similar benefits to legal immigrant pregnant women. In order to apply for SCHIP, parents are not required to provide a social security number for their children, but they must make a declaration of citizenship or provide the child's immigration status. They do not have to provide this information for family members not applying for SCHIP.<sup>89</sup> Unfortunately, this, too, has caused confusion and fear among potential SCHIP applicants, particularly those in families where not all members are legal immigrants. Ensuring enrollment of members of families, or of individuals, usually requires an extra outreach effort to clarify the enrollment/verification process.

There also has been confusion related to the INS' "public charge" label. The INS made it clear in 1999 that any legal noncitizen living in the United States and eligible for Medicaid or SCHIP could utilize that health insurance without it affecting their efforts to become U.S. citizens. Although this decision was announced in 1999, outreach efforts still need to be undertaken to convince immigrants that using that insurance will not cause them or their family members to be labeled public charges. The Texas Department of Health is addressing this issue. They have a new Medicaid application form that will be put into use in April 2001 that has a section clearly stating that the use of Medicaid will have no adverse effects on the legal status of immigrants.

Hispanic immigrants also include those coming to Texas for seasonal jobs on a continual basis, such as migrant farmworkers. Most migrant farmworkers are immigrants who are rarely offered insurance by employers, and, if it is offered, may be less able to afford it. They also face unique barriers to health care such as lacking continuous access to providers, increased exposure to environmental contaminants, a high rate of illiteracy, and cultural barriers.<sup>90</sup> Their health is jeopardized by unsanitary working and housing conditions, as well as by poverty and frequent transience. This population is more susceptible to infectious disease, nutritional health problems, dental disease, diabetes, hypertension, contact dermatitis, and pregnancy.<sup>91</sup> Young children of migrant farm workers who go to the fields with their parents may also be exposed to pesticides that can harm their health.

Although poverty rates among all farmworkers are extremely high, few participate in federal public assistance programs.<sup>92</sup> Even though most of their parents are foreign-born, many farmworkers' children are U.S. citizens.<sup>93</sup> For several reasons discussed in the previous sections, immigrants are less likely to enroll their children in programs such as Medicaid. The federal government has recognized this population's unique health care needs and funds 15 migrant health centers in Texas (primarily in South Texas and El Paso). When working outside the state of Texas, however, migrant workers often have no access to care.

It is estimated that approximately 35,000 children of migrant workers who live in Texas spend a good portion of each year "in stream" living in other states. During their time away from Texas health access is difficult to obtain, even if the children are covered by

Texas Medicaid. Many providers in other states do not feel it is worth the expense for them to register as Texas Medicaid providers, and they refuse to provide services to migrant patients. Pilot programs have been tried with other states to establish a sort of Medicaid portability. For example, Texas had an agreement with Wisconsin in which the state of Texas paid for Medicaid services that Texas-based migrants received in Wisconsin. Medicaid providers were registered under the Texas Medicaid program. Because Medicaid benefits and services vary by state, however, that program was unsuccessful and has been abandoned.

The Texas Association of Community Health Centers (TACHC) is working with Texas Medicaid and HCFA to file a 1915(b) waiver that would create a national PPO solely for migrant workers enrolled in Medicaid. A toll-free phone number would also be available to provide migrant workers with information and to direct them to the closest clinic where they could seek services.<sup>94</sup>

Mexican government officials are investigating ways to compensate health centers in Texas for care they provide to Mexicans working legally in the United States. The TACHC has been contacted about this possibility and is interested in pursuing this further.<sup>95</sup>

## **Case Studies**

The Kaiser Family Foundation released a series of accounts of people across the country who are without health insurance. One of these was the story of Rose Ann Cervantes. Rose Ann lives with her three children and parents in Corpus Christi, Texas. Like many others, she has been forced to go without health insurance. Until February 2000, she was able to afford the family's private health plan, but when the premiums rose 63 percent she could no longer do so. She constantly worries that something is going to happen. She also has about \$10,000 in medical bills that she has been unable to pay. These bills stem from various emergency room visits, as well as her son's hand injury that required surgery.

Rose Ann has tried to get her children enrolled in SCHIP. She mailed in an application, but received a letter back stating they were not eligible for SCHIP but might be eligible for Medicaid. The letter said that someone from the Department of Human Services would contact Rose Ann to discuss the status of the application. After two months had passed with no word from them, Rose Ann called the department. She was unable to get accurate information as to whether her children qualified for Medicaid and was told she would need to make an appointment. She is unable to take time off from work and thus has been unable to get her children enrolled in Medicaid.<sup>96</sup> Rose Ann's case is not out of the ordinary for Hispanics in Texas, but, rather, is quite common.

Some areas in Texas have clinics that offer some medical services to the uninsured, while in other areas of the state it is very difficult for the uninsured to access medical care. Travis County is one area of the state providing health care access for the uninsured.

The Seton Topfer Community Clinic in Austin, founded with a \$1 million dollar donation from Mort and Angela Topfer, provides medical and other services to the working uninsured, to SCHIP enrollees, to Medicaid enrollees, and to some Medicare enrollees. Patients and their families are eligible for services based on income at or below 200 percent of poverty (about \$34,000 per year for a family of four). The clinic receives funds from the Daughters of Charity, the Elizabeth Ann Seton Board (a local organization whose primary mission is to support financially the Seton clinics), and from the Seton Fund, which raises money for many of Seton's programs. The Seton Healthcare network also provides uncompensated, unfunded charity care that is written off as such. In sum, this clinic is able to serve uninsured individuals primarily through public monies (e.g., Medicaid and SCHIP reimbursements), the fundraising/donation efforts of private individuals, and the generous, committed doctors and staff who provide uncompensated care

Dr. Eduardo Sanchez, a physician at the clinic, gives examples of the numerous uninsured patients that visit the clinic in need of care:

There are many stories that can be told. Most, but not all, of our patients are Hispanic. Many are immigrants without legal resident status. The vast majority of those are working or have spouses or parents who are working. The jobs are mostly construction, house cleaning or other custodial work, restaurant work, and landscaping work.

I have seen a number of able-bodied working men with inguinal (groin) hernias who presented in various stages of progression in the size of their hernias. I am able to refer these gentleman to general surgeons in Austin who have agreed to care for our uninsured patients at no or low cost. The men have all had hernia repairs (an operation) and have been able to return to work.

One man, in particular, was a 32 year-old sheet rock-worker and father of three, who noticed a bulge in his left groin six months before seeing me. He continued to work, and the bulge continued to grow until it became very painful to work. When I saw him, he had a baseball-size hernia. He was operated on and he is back on the job.

I have seen a number of women who have been found by me, or others who referred them to our clinic, to have [follow-up on] abnormal pap smears. This sometimes requires a more specialized procedure called a colposcopy for a view of and biopsy of the cervix to better determine the degree of abnormality (worst case is invasive cancer) and the treatment options. I refer women needing colposcopy to the Seton McCarthy Community Clinic, where a nurse practitioner trained in colposcopy does colposcopies once a week. This can be a terrifying ordeal, but we are able to either rule out cancer outright, treat pre-cancerous lesions, or address cancer early and cure these women. It might be a challenge for a working person and/or a parent to work or parent optimally with something like this looming.

One gentleman came to see me last week. He is only 33 years old. He is a landscaper and is married with three children. He has been losing weight for the past six months. He has frequent urination, an insatiable appetite, and unquenchable thirst. He is not obese, but he has a family history of diabetes. He has normal blood pressure and no unusual physical findings on examination. He does, however, have a very high blood sugar. We talked about diabetes. I ordered some additional testing for him. He has appointments for nutritional counseling, diabetes education, and training on use of a blood glucose monitor set up in the next two weeks.

We are the health care provider for an ever-growing number of children. Sometimes I am convinced that half my practice is pediatrics. We provide well care, which includes vaccines, screening for tuberculosis, and screening for any developmental problems, in addition to the physical exams and teaching that we do. We also provide care for children with acute sicknesses like ear infections and other upper respiratory conditions. We are able to keep children who do not need to be there out of emergency rooms, and we are able to develop the kinds of relationships that allow for self-care of minor problems.

Our clinic has a medical social worker as part of our team. She and most of our staff are bilingual in English and Spanish. We can address mental health issues and behavioral health issues in a less harried manner. The 15-minute doctor's appointment is not usually optimal, so the access to a medical social worker improves our ability to address these issues. The medical social worker also serves as a resource and link to a whole host of other challenges that our patients and their families face that are not resolvable within the medical model, such as school or work-related problems.

I consider myself fortunate to work for an entity that provides access to the medically under- or uninsured. It is important to note that the experience of uninsured Hispanics living in Travis County is very different from the experience of those in Hays or Williamson County where there are very few resources, public or private, available to care for the uninsured.<sup>97</sup>

## **The Current Safety Net**

The current safety net strains society as a whole. Increasing the number of people with health insurance would benefit many. Counties and public hospitals have the responsibility under Texas state law to serve the medically indigent.<sup>98</sup> Disproportionate Share Hospital Programs add money to hospitals that provide a disproportionate amount of health care to the medically indigent and Medicaid-eligible populations. The program, which is part of Medicaid, provides some relief for uncompensated care, but does not cover all of the costs. Graduate Medical Education funding provides teaching hospitals with some supplemental funds to help with the costs of training students and supplements the many Medicaid and Medicare patients such hospitals receive.<sup>99</sup> The uninsured also receive care at private nonprofit hospitals and clinics, private for-profit hospitals, state

facilities, free clinics, local health departments, private doctors, rural health clinics, special facilities, and federally qualified community and migrant health centers.

At Texas Community Health Centers, average total Medicaid spending for each health center Medicaid patient is \$2,202. Texas community health centers had 358,743 patient encounters last year. Of those, 76,681 were Medicaid encounters; 22,969 migrant and seasonal farmworkers were treated at the centers last year as were 20,784 homeless. Of the total number served, 286,044 were minorities and 204,505 were uninsured. Seventy-two percent of the patients at community health centers in Texas were Hispanic.<sup>100</sup> Texas' health centers receive federal primary care grant funding.

All of these resources are strained by the number of uninsured in the state. Some of the benefits of reducing the uninsured rate are illustrated in Table 12.7.

**Table 12.7. Benefits to Reducing Uninsured Rate**

<b>Stakeholder</b>	<b>Benefits of Solving the Problem</b>
Uninsured	Access to preventive care and less financial strain if illness occurs
Health Care System	Reduced indigent care costs and budgetary shortfalls; less need for hospital districts to raise tax rates
Consumers/Public	Fewer premium and tax increases to cover unpaid care for the uninsured
Communities	Overall improved public health and money to focus on preventive and primary care; Reduced indigent care costs.
Health Care Providers	Fewer charity patients and cases caused by untreated conditions

Source: Texas Institute for Health Policy Research, "The Uninsured in Texas," Policy Brief, Health Policy Forum, Austin, Texas, September 29, 2000, p. 4.

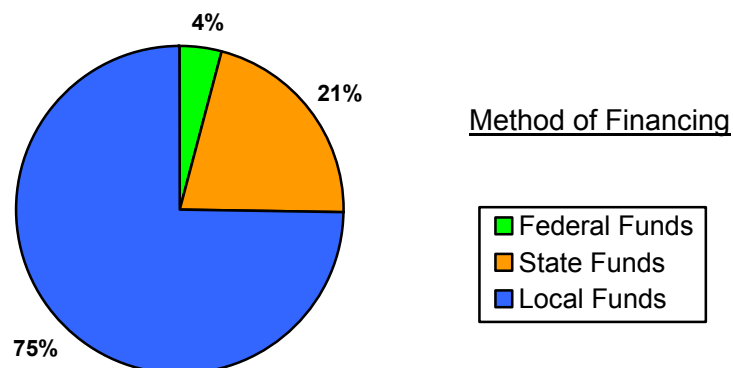
## **Importance and Options**

### **Why this Issue is Critical in Texas**

There are two reasons why this issue is pertinent and problematic for the state of Texas. One, obviously, is the monetary cost of health care for the uninsured. When an uninsured individual seeks medical attention, it is often through the emergency room. This is because it is difficult for the uninsured to receive access to care outside of the ER. It is also due to the fact that many uninsured individuals delay seeking medical attention until a problem becomes critical. The result is that emergency rooms become overcrowded and patients are forced to wait long periods of time for care. The estimated amount Texas spent on uncompensated care (not exclusively emergency room care) in FY 1998 was \$4,718,081,000.<sup>101</sup>

That amount is comprised of \$198 million of federal funding sources, \$989 million from state agencies, and \$3.5 billion from local sources (“local” includes spending by local governments, charity care by providers and others, and other sources of revenue to individual institutions). (See Figure 12.1.) Breaking these numbers down further shows us that, for example, Texas Department of Health hospitals’ and university teaching hospitals’ spending accounted for \$223 million of spending on the uninsured. Physicians’ charity accounted for \$914 million. Accounting for the largest percentage of the \$4.7 billion was \$1.6 billion (30 percent) spent by hospital districts and other local hospitals. Commenting on this large, local expenditure on the uninsured, José Camacho, Executive Director of the Texas Association of Community Health Centers said, “Basically, instead of paying for insurance with taxes we are already paying, we’re shifting the burden to the local property tax payer.”<sup>102</sup>

**Figure 12.1. Texas Spending on the Uninsured, FY 1998**



Adapted from: Texas Comptroller of Public Accounts, *Texas Estimated Health Care Spending on the Uninsured*. Online. Available: <http://www.window.state.tx.us/uninsure>. Accessed: November 28, 2000.

The second reason is that a large and growing part of the Texas workforce is Hispanic. In order to maintain a healthy economy, it is important to maintain a healthy and reliable workforce.

### **Policy Options**

There are three main subgroups within the Hispanic population in the state of Texas that need to be considered when weighing different policy options that would improve the overall rate of insurance coverage among Hispanics. These subgroups are immigrants,

children, and low-wage workers. If an effort is made to reduce the high rate of uninsurance in any of these categories, the overall rate of Hispanics in Texas with health insurance will improve significantly.

The following actions could improve health insurance among these groups and improve the rate among the Hispanic population and Texas' population as a whole:

- Simplify Medicaid so it is as easy to enroll and stay enrolled in the program as it is in SCHIP. This includes eliminating the assets test and face-to-face interview, and including continuous eligibility for a twelve-month period and presumptive eligibility for the time it takes to process the application. It also includes redoing the application, requiring less documentation, and allowing mail-in applications.
- Work with community-based organizations to improve outreach efforts for Medicaid. (The CBOs are currently only contracted to work with the SCHIP program.)
- Make legal immigrant pregnant women who entered the United States after August 22, 1996, eligible for SCHIP and Medicaid, as has already been done for children.
- Work with the INS to inform the Hispanic community that the use of SCHIP and Medicaid coverage will have no bearing on other family members' immigration status.
- Make all outreach materials and services available in Spanish.
- Focus on additional outreach efforts to address this particular population group.
- Utilize the Medicaid Expansion rule that allows parents of children on Medicaid to also receive Medicaid insurance.
- Provide public subsidies to help with the insurance premiums for employees and their dependents.
- Enforce laws that are currently in place that do not allow insurance carriers to deny coverage to small employers.
- Encourage the employers who offer health insurance to communicate more effectively with their employees about their options within the insurance plan (taking into special consideration employees with a language/cultural barrier).

## **Conclusions**

Hispanics in the United States are often of a lower socioeconomic class than most other racial/ethnic groups. Hispanics have a lower average level of education, and tend to end up in low-skilled, lower-paying jobs. As stated previously, 61 percent of Hispanics in Texas are poor or near poor. If the immigration of Mexicans and other Latin Americans to Texas continues at the same rate as in the past ten years, the overall socioeconomic

status of Hispanic Texans will not improve. This leads to Hispanics being more likely than other groups to be without health insurance.

Lack of health insurance is a problem for all populations in the state of Texas. However, it clearly affects Hispanics to a much greater extent than non-Hispanic whites or other minorities. While much of the problem has to do with low rates of employer-sponsored insurance, as well as very stringent eligibility requirements for Medicaid and other public insurance, it goes beyond that. In low-wage jobs, non-Hispanic whites still receive health insurance at a higher rate than Hispanics. Any attempt to reduce the number of people without health insurance in the state of Texas will need to focus much of its effort on the Hispanic population. There currently are 6.3 million Hispanics in Texas, a number that is projected to more than double by the year 2030. Though Hispanics are a significant part of the state's culture, workforce, and consumer population, they are disproportionate users of emergency rooms and community clinics. Increasing the level of health insurance among Hispanics would facilitate their access to care, reduce their high usage of emergency rooms for nonurgent care, reduce local taxes citizens pay for emergency room use, improve the overall health of Hispanics, and improve the productivity of the Texas workforce. In short, improving the rate of health insurance among Hispanics will have a positive effect on all of Texas.

*Note: Anna Schechter contributed to the initial research and writing of this report.*

## Notes

<sup>1</sup> Jennifer M. Haley and Stephen Zuckerman, "Health Insurance Access and Use: Tabulations from the 1997 National Survey of America's Families," *Assessing the New Federalism* (Washington, D.C.: The Urban Institute, July 2000), pp. 1-2. Online. Available: <http://newfederalism.urban.org/html/discussion00-14.html>. Accessed: May 8, 2001.

<sup>2</sup> Texas Health and Human Services Commission (HHSC), "Demographic Profile of the Texas Population Without Health Insurance in 1999," (Austin, Texas, October 2000), p. 1.

<sup>3</sup> Ibid.

<sup>4</sup> Kaiser Family Foundation, *Kaiser Public Opinion Update: The Uninsured*. Online. Available: <http://www.kff.org/content/2000/3013/PublicOpinion.PDF>. Accessed: January 4, 2001.

<sup>5</sup> Ibid.

<sup>6</sup> Texas Institute for Health Policy Research, *The Uninsured in Texas* (Austin, Texas, September 29, 2000), p. 2.

<sup>7</sup> Ibid., p. 3.

<sup>8</sup> Office of Public Insurance Counsel, *Health Insurance Coverage in Texas: Context and Demographics* (July 6, 1998). Online. Available: <http://www.opic.state.tx.us/Healthlykids.html>. Accessed: November 14, 2000.

<sup>9</sup> Elisabeth Simantov, et al., *Uninsured and At Risk: Coverage Profiles and Trends Among 10 States* (New York, N.Y.: The Commonwealth Fund, September 2000), p. 36.

<sup>10</sup> The Urban Institute, *Snapshot of America's Families II: Comparison of State Estimates to National Estimates, by Indicator and by Income* (Washington, D.C., October 2000), p. 1. Online. Available: <http://newfederalism.urban.org/nsaf/pdf/99state-v-us.pdf>. Accessed: November 28, 2000.

<sup>11</sup> The Urban Institute, *Snapshot of America's Families II: Data by State*, (Washington D.C., October 2000), p. 21. Online. Available: <http://newfederalism.urban.org/nsaf/pdf/statebystate.pdf>. Accessed: November 28, 2000.

<sup>12</sup> Ibid.

<sup>13</sup> HHSC, *Demographic Profile of the Texas Population Without Health Insurance from 1996-1998*. Online. Available: [http://www.hhsc.state.tx.us/cons\\_bud/dssi/BRT/BRT.htm](http://www.hhsc.state.tx.us/cons_bud/dssi/BRT/BRT.htm). Accessed: September 21, 2000.

<sup>14</sup> Texas State Data Center, *1990 Census Lookup, Texas State Level Data*. Online. Available: <http://txsdc.tamu.edu/txprof.html>. Accessed: December 4, 2000.

- <sup>15</sup> Steve H. Murdock, *Current and Future Patterns of Population Change in Texas: Implications for the Number of Uninsured in Texas* (College Station, Texas: Texas A&M University, January 2000), p. 10.
- <sup>16</sup> HHSC, *Demographic Profile of the Texas Population Without Health Insurance from 1996-1998*. Online. Available: [http://www.hhsc.state.tx.us/cons\\_bud/dssi/BRT/BRT.htm](http://www.hhsc.state.tx.us/cons_bud/dssi/BRT/BRT.htm). Accessed: September 21, 2000.
- <sup>17</sup> Ibid.
- <sup>18</sup> Texas State Data Center. *Social and Economic Characteristics of State of Texas* (College Station, Texas: Texas A&M University, 1990), p. 143.
- <sup>19</sup> E. Richard Brown, et al, *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles, Calif.: UCLA Center for Health Policy Research, August 2000), p. 88.
- <sup>20</sup> HHSC, "Demographic Profile of the Texas Population Without Health Insurance in 1999," p. 1.
- <sup>21</sup> The Urban Institute, *1997 National Survey of America's Families: Texas State Data* (Washington D.C., May 2000), table 4.
- <sup>22</sup> American College of Physicians, "Hispanics in Crisis Fact Sheet," distributed at Hispanics in Crisis Symposium, Austin, Texas, October 18, 2000, p. 1.
- <sup>23</sup> The Urban Institute, *1997 National Survey of America's Families: Texas State Data*, table 4.
- <sup>24</sup> Ibid.
- <sup>25</sup> HHSC, *Demographic Profile of the Texas Population Without Health Insurance from 1996-1998*. Online. Available: [http://www.hhsc.state.tx.us/cons\\_bud/dssi/BRT/BRT.htm](http://www.hhsc.state.tx.us/cons_bud/dssi/BRT/BRT.htm). Accessed: September 21, 2000.
- <sup>26</sup> Ibid.
- <sup>27</sup> Victoria Pulos, Families USA, *Deep in the Heart of Texas: Uninsured Children in the Lone Star State*. Online. Available: <http://www.familiesusa.org/kidtex.htm>. Accessed: January 4, 2001.
- <sup>28</sup> Email from Edli Colburg, Research Specialist, Texas Health and Human Services Commission, "Hispanic Data Request," to Anna Schecter, October 15, 2000.
- <sup>29</sup> Email from Randy Fritz, CHIP Operations Manager, Texas Health and Human Services Commission, "CHIP Data Request," to Anna Schecter, October 10, 2000.
- <sup>30</sup> HHSC, *Children's Health Insurance Program Web Page*. Online. Available: <http://www.hhsc.state.tx.us/chip/index.html>. Accessed: April 10, 2001.

- <sup>31</sup> Fritz email.
- <sup>32</sup> Ibid.
- <sup>33</sup> TexCare Partnership, “TexCare Partnership Application Assistance Training Program,” training program held in Austin, Texas, September 27, 2000.
- <sup>34</sup> Ibid.
- <sup>35</sup> Center for Public Policy Priorities and Orchard Communications, Inc. *Every Child Equal: What Texas Parents Want from Children’s Medicaid* (report to The Texas CHIP Coalition, September 2000). Online. Available: <http://www.cppp.org/products/reports/ece.pdf>. Accessed: February 13, 2001
- <sup>36</sup> The Urban Institute, *1997 National Survey of America’s Families: Texas State Data*, table 4.
- <sup>37</sup> Kevin Quinn, *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (New York, N.Y.: The Commonwealth Fund, February 2000), p. 7.
- <sup>38</sup> Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Total Medicaid Enrollment in 50 States* (Menlo Park, Calif.: Kaiser Commission on Medicaid and the Uninsured, October 2000), p. 6.
- <sup>39</sup> Center for Public Policy Priorities, *Medicaid Caseloads Decline*. Online. Available.: <http://www.cppp.org>. Accessed: January 5, 2001.
- <sup>40</sup> Center for Public Policy Priorities and Orchard Communications, Inc. *Every Child Equal: What Texas Parents Want from Children’s Medicaid* (report to The Texas CHIP Coalition, September 2000). Online. Available: <http://www.cppp.org/products/reports/ece.pdf>. Accessed: February 13, 2001.
- <sup>41</sup> Ibid.
- <sup>42</sup> Texas Health and Human Services Commission, *Cumulative DHS CHIP Status Report as of 02-09-01*. Online. Available: <http://www.hhsc.state.tx.us/chip/DHSrpt.htm>. Accessed: February 21, 2001.
- <sup>43</sup> Texas Department of Health, “TexCare Partnership Statewide Outreach Initiatives,” unpublished data, no date, received from Lynn Denton on February 7, 2001.
- <sup>44</sup> Texas Department of Health, “TexCare Partnership Community-Based Organization Outreach List of Contractors,” unpublished data, no date, received from Lynn Denton on February 7, 2001.
- <sup>45</sup> Lynn Denton, Texas Department of Health, “Outreach Initiatives in South Texas,” personal email to Jeff Hamilton, February 8, 2001.
- <sup>46</sup> Texas Department of Health, “Outreach Documentation,” unpublished data, no date, received from Lynn Denton on February 7, 2001.

- <sup>47</sup> Quinn, *Working Without Benefits*, p. 7.
- <sup>48</sup> Paul Fronstin and Ruth Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, Issue Brief 226 and Special Report 35 (Washington, D.C.: Employee Benefit Research Institute, October 2000), p. 4.
- <sup>49</sup> This number indicates those without health insurance for the entire year 1998-1999. U.S Census Bureau, *1999 U.S. Census*. Online. Available: <http://www.census.gov/prod/2000pubs/p60-211.pdf>. Accessed: April 10, 2001.
- <sup>50</sup> Simantov, et al., *Uninsured and At Risk: Coverage Profiles and Trends Among 10 States*, p. 36.
- <sup>51</sup> The Urban Institute, *Snapshot of America's Families II: Data by State*, p. 21.
- <sup>52</sup> Simantov, et al., *Uninsured and At Risk: Coverage Profiles and Trends Among 10 States*, p. 36.
- <sup>53</sup> Ibid.
- <sup>54</sup> Quinn, *Working Without Benefits*, p. 7.
- <sup>55</sup> Fronstin and Helman, *Small Employers and Health Benefits*, p. 15.
- <sup>56</sup> Ibid.
- <sup>57</sup> American College of Physicians, American Society of Internal Medicine, "No Health Insurance? It's Enough to Make You Sick; Latino Community at Great Risk," White Paper (Philadelphia, PA, 2000), p. 13.
- <sup>58</sup> The Agency for Health Care Research and Quality, *Research Findings No. 11: Health Insurance Status of the Civilian Noninstitutionalized Population: 1998*. Online. Available: [http://meps.ahrq.gov/papers/rf11\\_00-0023/rf11.htm](http://meps.ahrq.gov/papers/rf11_00-0023/rf11.htm). Accessed: October 30, 2000.
- <sup>59</sup> Urban Institute, *Snapshots of America's Families I: Texas State Data* (Washington, D.C.: May 2000), table 4.
- <sup>60</sup> Quinn, *Working Without Benefits*, p. 7.
- <sup>61</sup> Ibid.
- <sup>62</sup> Ibid.
- <sup>63</sup> Paul Fronstin, *Health Insurance Coverage and the Job Market in California*, Special Report 36 (Washington, D.C.: Employment Benefit Research Institute, September 2000), p. 9. Online. Available at: <http://www.ebri.org/sr36/index.htm>. Accessed: January 4, 2001.

<sup>64</sup> Quinn, *Working Without Benefits*, p. 7.

<sup>65</sup> Olga Oralia Garcia, "Increasing Health Insurance Coverage to Hispanics in Texas: Public and Private Solutions" (Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 1999), p. 12.

<sup>66</sup> Ibid.

<sup>67</sup> Department of Labor, Office of the Assistant Secretary for Policy, Office of Program Economics, *Findings from the National Agricultural Workers Survey (NAWS) 1997-1998, A Demographic and Employment Profile of United States Farmworkers*, Research Report No. 8 (Washington D.C., March 2000). Online. Available: [http://www.dol.gov/dol/asp/public/programs/agworker/report\\_8.pdf](http://www.dol.gov/dol/asp/public/programs/agworker/report_8.pdf). Accessed: January 4, 2001.

<sup>68</sup> Fronstin, *Health Insurance Coverage and the Job Market in California*, p. 6.

<sup>69</sup> Quinn, *Working Without Benefits*, p. 7.

<sup>70</sup> Fronstin and Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, p. 15.

<sup>71</sup> Fronstin and Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, p. 15.

<sup>72</sup> Michael J. Perry, Christopher G. Marshall, and Neil J. Robertson, *Business Attitudes Toward Health Insurance Coverage of Employees and their Dependent Children* (Washington, D.C.: Economic and Social Research Institute, August 1999), p. 9.

<sup>73</sup> Fronstin and Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, p. 15.

<sup>74</sup> Ibid.

<sup>75</sup> Fronstin, *Health Insurance Coverage and the Job Market in California*, p. 18.

<sup>76</sup> Ibid.

<sup>77</sup> HHSC, "Demographic Profile of the Texas Population Without Health Insurance in 1999," p.2.

<sup>78</sup> Kaiser Commission on Medicaid and the Uninsured, *Comparison of Medi-Cal and Healthy Families Programs for Children in California* (Washington D.C., October 2000). Online. Available: <http://www.kff.org/content/2000/2209/2209.pdf>. Accessed: January 6, 2001.

<sup>79</sup> Ibid.

- <sup>80</sup> Steven A. Camarota, *Immigrants in the United States—2000: A Snapshot of America’s Foreign-Born Population* (Washington, D.C.: Center for Immigration Studies, January 2001). Online. Available: <http://www.cis.org/articles/2001/back101.html>. Accessed: January 19, 2001.
- <sup>81</sup> Immigration and Naturalization Service, *The Triennial Comprehensive Report on Immigration, State Impacts*, p. 196, Online. Available: <http://www.ins.gov/graphics/aboutins/repstudies/part5.pdf>. Accessed: January 12, 2001.
- <sup>82</sup> Ibid.
- <sup>83</sup> HHSC, “Demographic Profile of the Texas Population Without Health Insurance in 1999,” p. 2.
- <sup>84</sup> Immigration and Naturalization Service, *Illegal Alien Resident Population*. Online. Available: <http://www.ins.gov/graphics/aboutins/statistics/illegalalien/index.htm> Accessed: January 5, 2001.
- <sup>85</sup> Brown, *Racial and Ethnic Disparities in Access to Health Insurance and Health Care*, pp. 20-21.
- <sup>86</sup> HHSC, “Demographic Profile of the Texas Population Without Health Insurance in 1999,” p. 2.
- <sup>87</sup> Center for Public Policy Priorities and Orchard Communications, Inc. *Every Child Equal: What Texas Parents Want from Children’s Medicaid* (report to The Texas CHIP Coalition, September 2000). Online. Available: <http://www.cppp.org/products/reports/ece.pdf>. Accessed: February 13, 2001.
- <sup>88</sup> Shannon Blaney and Leighton Ku, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage* (Washington D.C.: Center on Budget and Policy Priorities, October 2000). Online. Available: <http://www.cbpp.org/10-4-00health.htm>. Accessed: January 5, 2001.
- <sup>89</sup> Center for Public Policy Priorities and Orchard Communications, Inc. *Every Child Equal: What Texas Parents Want from Children’s Medicaid* (report to The Texas CHIP Coalition, September 2000). Online. Available: <http://www.cppp.org/products/reports/ece.pdf>. Accessed: February 13, 2001.
- <sup>90</sup> Anna Fay Williams and Russell D. Jones, “Health Problems of Migrant Farm Workers,” *Texas Medicine*, vol. 92, no. 10 (October 1996), p. 25.
- <sup>91</sup> Ibid.
- <sup>92</sup> Alexis M. Herman, Department of Labor, *Report on the Youth Labor Force* (Washington, D.C., 2000). Online. Available: [http://www.dol.gov/dol/asp/public/programs/agworker/report\\_8.pdf](http://www.dol.gov/dol/asp/public/programs/agworker/report_8.pdf). Accessed: October 2, 2000.
- <sup>93</sup> Ibid.

<sup>94</sup> Interview by Jeff Hamilton with Jana Blasi, Deputy Director, Texas Association of Community of Health Centers, Austin, Texas, February 13, 2001.

<sup>95</sup> Ibid.

<sup>96</sup> Kaiser Commission on Medicaid and the Uninsured, *In Their Own Words: The Cervantes and Zamora Family* (Washington D.C., October 2000). Online. Available: <http://www.kff.org/content/2000/2207/cervanteszamora.pdf>. Accessed: January 5, 2001.

<sup>97</sup> Email from Eduardo Sanchez, Physician, Seton Topfer Clinic, Austin, Texas, "Re: Hispanics and Private Health Insurance," to Sarah Lovering, January 19, 2001.

<sup>98</sup> Caton Fenz, *Providing Health Care to the Uninsured in Texas: A Guide for County Officials* (Austin, Texas, August 9, 2000), p. 1.

<sup>99</sup> Ibid.

<sup>100</sup> National Association of Community Health Centers, *Texas Community Health Centers*. Online. Available: [http://www.nachc.com/state\\_affairs/frame/state\\_data.htm](http://www.nachc.com/state_affairs/frame/state_data.htm). Accessed: October 21, 2000.

<sup>101</sup> Texas Comptroller of Public Accounts, *Texas Health Care Spending on the Uninsured*. Online. Available: <http://www.window.state.tx.us/uninsure>. Accessed: January 16, 2001.

<sup>102</sup> Carlos Guerra, "How we are Penny Wise, Pound Foolish," *The San Antonio Express-News* (February 4, 2001), p. 1B.

