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What Stands Between Texans and the Health Care They Need?

Many Texans Lack Health Coverage. U.S. Census estimates for 1991 show that 25.3% of Texans under age 65 - 3.8 million Texans - went without health coverage **all year**; less than 1% of those over 65 were uninsured. Only the District of Columbia had a higher percentage uninsured (30.3%), and the lowest rate of uninsured was about one-third of Texas' rate (Connecticut at 8.8%). Though **all** Texans run a slightly higher-than-national-average risk of being uninsured, the greatest burden falls on children, young adults, and poor and low-income working Texans, who are all **substantially** more likely to be uninsured than their U.S. counterparts in general. Roughly three-quarters of Texas' uninsured have family incomes at or under 200% of the federal poverty line - $28,700 for a family of four. The vast majority of uninsured Texans **are** either workers or their dependents; less than 15% live in households headed by a non-worker.

Why Texas? Why are Texans so much more likely to be uninsured? First, Texas has a workplace culture - characterized by a relatively low presence of organized labor and collective bargaining - that has traditionally not stressed the provision of health benefits. Second, even with expanded coverage of **maternity care** and of young children, Texas still has one of the most restrictive Medicaid eligibility policies in the U.S. Third, Texas has high employment rates in services and retail trade, two industries with high levels of uninsured workers, and these industries are expected to provide the great majority of new jobs in the coming decades. Along with this, Texas also has a slightly higher concentration of employment in small firms, where levels of coverage are low. Finally, Texas has higher-than-average proportions of persons "at risk" of being uninsured, namely, low-income workers and children.

ABOUT THIS ISSUE

The Texas Health Policy Task Force, created in November 1991, released its final report in January 1993. League research analyst Anne Dunkelberg provided research assistance to the Task Force at the request of the lieutenant governor.

Assistance was provided both through direct presentations to the Task Force and its subcommittees, and in briefing papers provided to Task Force staff. In addition, Dunkelberg served as consulting faculty for a policy research project, *Health Care for Texans*, of the LBJ School of Public Affairs, whose graduate students also provided research to the Task Force. This issue of *Analysis* is updated from a briefing provided to the Task Force on the "big picture" of Texans' access to health care at an opening meeting of that body in December 1991.

MANY OTHERS ARE "UNDERINSURED"

Uninsured Texans are not the only ones facing barriers to health care. Experts say that another 1.2 to 1.8 million Texans were probably **underinsured** in 1990 - at high risk of having to spend more than 10% of income on out-of-pocket health costs because of limits in their health coverage. Added to these are a **new** generation of potentially underinsured Texans: those who are at risk of high costs due to loss of coverage, pre-existing condition waiting periods and exclusions, or high premium increases. The nearly 1.4 million Texas workers in private firms with 25 or fewer workers, their dependents, plus Texans who purchase individual (non-group) health coverage, **all** can be considered at risk of losing coverage. It is important to notice that, while low income is strongly linked to being uninsured, the risk of being **underinsured** cuts across all incomes but the very wealthiest.

Three Ways To Be Uninsured. There are three major causes of being uninsured, any or all of which may overlap: economic barriers, lack of access to the insurance market, and history of illness. Researchers have found that working families who make less than roughly 250% of the federal poverty line ($35,875 for a family of four in 1993) simply do not have enough disposable income available to pay even a one-third share of an economical health policy. (Employees paid an average share of 25-30% of premiums for family coverage in 1991.) But Texans of moderate income and above - who could afford insurance if it were available to them at the rates paid by large employers - also may be uninsured because they work in a small or a high-risk business, because they are "medically uninsurable," or both. Texans are affected by two trends, rapid inflation in health costs and deterioration of the health insurance market. Though linked, the two trends can have distinct effects.

Runaway Health Costs. Over the last 30 years, the combination of open-ended tax incentives for employer-provided health insurance and (until recently) an open-ended Medicare program added up to a blank check for financing health care. This fertile ground promoted the development of much valuable medical technology, but it also created for many years a nearly unlimited potential for the growth of profit-oriented health service providers. As a result, health care costs have inflated much faster than any other part of the Consumer Price Index: the medical care CPI grew 630% from 1960-1990, compared to a 342% increase in prices overall. In the period from 1980 to 1991 alone, the share of personal consumption expenditures in the U.S. that goes to medical care grew from 8.7% to 14.8%.

The problem of paying for health care for poor and very low-income Texans is one that has never gone away, but the explosion in health care costs over the last 30 years has made the problem worse. As the slice of the family budget that goes to health costs gets fatter and fatter, more and more working people who before could just barely afford health care find themselves newly in the position of being unable to afford basic care.

The Health Insurance Market: A Whole New Game. Twenty years ago, most Texans' employer-provided health coverage came from commercial insurers or Blue Cross & Blue Shield, and the premiums paid were largely based on community rates - that is, the same rates were paid by all members of a group, regardless of age or health status. In 1992, most Texans who work for big employers are probably covered by a self-insured health plan, though the benefits may be **administered** by a commercial insurer. For Texans who remain in the commercial market, community rating is but a memory.

For employer groups of 50 or fewer, premium rates may vary according to the age and gender of the workforce, the industry, the location, and the claims experience or health status of the workers and their families. Businesses thought to be hazardous, to have high turnover (e.g., restaurants), to be especially litigious (law firms), or especially prone to use health

care (doctor's offices, psychotherapists) may be unable to purchase coverage at all. Clearly, it is **not** necessary to be poor to be at risk of being uninsurable in the small group market.

The smallest groups often see their rates multiply, and/or payment for certain conditions capped or excluded completely when their policies come up for renewal. Sometimes a carrier no longer may be willing to cover a sick employee or dependent at **any** price. Small employers always have been at a disadvantage when buying health coverage, because the overhead costs of their health plans (administration, commissions, premium taxes, marketing) can make up 40% of the premium for the smallest group, compared to as little as 5.5% for the largest employers. Because they were **already** paying higher prices, the health cost explosion and the movement to health-experience-based insurance rates have hit small groups hard. Between the possibility of rate hikes that may exceed a company's capacity to pay and the risk of exclusion or cancellation, no Texan in a small group health plan today can be confident of still having coverage in the future.

FINANCING IS NOT THE ONLY BARRIER

Unfortunately, even if every Texan had some kind of health insurance tomorrow, many still would be unable to get the care they need. Like the factors that contribute to being uninsured, non-financial barriers to health care often overlap, making access to care even more difficult and unlikely.

Health Professional Supply and Distribution. In some areas of Texas, even a well-insured person can have trouble getting health care. In 1991, only 13 of the 205 non-metropolitan Texas counties were **not** officially designated as either Medically Underserved, as a Health Professional Shortage Area or Population, or both. Some of these areas have **no** doctors, while others lack an adequate number of primary care doctors - the doctors who provide "first-line" health services involved in maintaining good health and treating simple illness or injury. Less than half of the doctors who **do** practice in Texas' underserved counties are graduates of Texas medical schools. Access to physician care isn't strictly a rural problem, either; low-income neighborhoods in Texas' cities are notably lacking in doctors' offices. Health professional distribution problems are not unique to doctors; nurse practitioners and physician assistants, like physicians, are concentrated in urban areas of the state in greater numbers than the general population.

Medicaid. Medicaid-eligible Texans are **not** counted as being uninsured, but their access to health providers is far from comparable to what privately insured Texans expect. In the first quarter of 1992, 27% of Texas' primary care doctors saw no Medicaid patients. Of those who **did** see Medicaid patients, 60% saw a low volume (less than 10 per month) of Medicaid recipients, and 43% took no **new** Medicaid patients. Rural doctors' participation in Medicaid is much more extensive than their urban colleagues. For many urban Medicaid recipients, eligibility fails to increase their choice of providers significantly; instead, it means that the same (chiefly public) providers who treat the uninsured will treat them, but will get paid for doing so.

Hospitals and Trauma Care. Texas led the nation in hospital closures over the last decade with 116 hospitals that closed, and **stayed** closed. Over half of these were rural hospitals. In 57 Texas counties, there is no hospital at all. In counties and communities without hospitals, emergency care can be a hit-or-miss proposition. Even where hospitals **do** exist, there may be no reliable arrangement for transporting critically ill or injured persons to a higher-level hospital; in fact, there may be no higher-level hospital that can be relied on to accept the transfer! The need for full development of a true trauma system is reflected in Texas' automobile accident-related death rates, which are 10% higher if the accident occurs in a rural county.

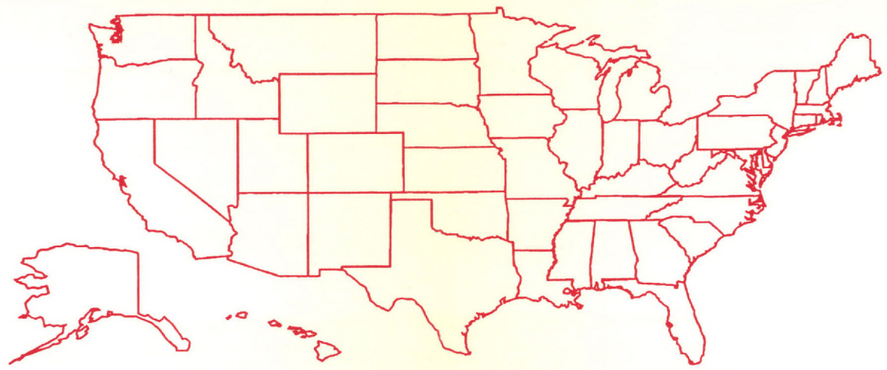
Maternity Care. Poor access to prenatal care and delivery services may result from a lack of health professionals, facilities (i.e., hospitals or birthing

Imperfect Competition: The U. S. Health Care Market

Failing the Test

The notion persists in contemporary political rhetoric that certain simple changes could bring the U.S. health care market into a state of near-perfect competition that would, in turn, bring health care costs under control. Economists who specialize in health care markets, however, caution that this attractive concept may be ill-founded, for reasons that are easily explained. Simply put, almost all of the conditions that an introductory economics course says are required for a perfectly competitive market are **absent** in the health care market. First, there is a lack of perfect information: information on prices of health services is neither routinely collected nor readily available. Even if such data **were** available, Americans lack the medical expertise to evaluate their options among either providers or various courses of medical treatment. Indeed, medicine is now so complex and specialized that **physicians** are often not well qualified to make such judgements outside of their particular area of expertise. Second, entry to and exit from the market are not unrestricted. For example, U.S. physicians have long exercised their considerable political influence to limit the degree to which health practitioners with other academic credentials may participate in the market -- and numerous other illustrations exist.

The highly differentiated nature of health care services creates a third departure from the competitive ideal. Attempts to make comparisons among doctors, or treatments, or hospitals, or health insurance plans are often apple-to-orange propositions. A fourth element that cannot be assumed to exist is rational behavior by consumers. A "rational" consumer would make market choices that yield an optimal value or return on investment. Given the lack of perfect information and the extreme differentiation of health care services, consumers are hard-pressed to make such determinations; moreover, the assignment of values to improved health, extension of life, avoidance of pain, etcetera, is highly individualized and not based on clear-cut objective standards.



Perfectly competitive markets also are assumed to consist of large numbers of buyers and sellers; this is the area in which the health care market comes closest to the competitive criteria (except in rural areas where "sellers" are scarce). However, it is not always clear who the buyer **is** in the U.S. health care market. Is it the employee, who pays out-of-pocket cost plus a share of insurance premiums, or the employer, who picks up the biggest share of the insurance premium and chooses the carrier? How do health insurers and HMOs, who can limit which health services are covered, fit into the buyer-seller relationship? Once a consumer picks a doctor and consents to treatment of a condition, specific decisions as to what tests, procedures, and hospitalizations should be consumed are, more often than not, made by the physician. Hospital care accounts for about 40% of health care spending (physicians' bills another 20%), but patients usually do not pick hospitals, they pick **doctors**, and then are hospitalized wherever their doctor has practice privileges. Thus, some of the most costly health care consumption decisions are often not made by the ultimate consumer.

More Sellers and Higher Prices

A final illustration of the health care market's failure to conform to competitive market behavior is shown in the paradoxical behavior of incomes for health care professionals. The usual expectation in a competitive market is that growing health professional-to-population ratios -- what would normally be characterized as increased competition -- would result in shrinking average incomes for those professionals. The number of practicing doctors per 1,000 Texans grew from 1.06 per thousand in 1970 to 1.53 in 1990 (national trends were quite similar), while ratios of nurses and other health professionals also surged ahead. However, instead of competitors having to settle for smaller pieces of the pie, the pie just got bigger; incomes of doctors, nurses, and other health professionals grew substantially faster than average incomes in the 1980s.

Increased Consumer Spending Not the Cure

The theory that U.S. health care costs could be controlled if consumers had to spend more of their own money is widespread among politicians. However, a look at the facts about Texans' and Americans' out-of-pocket spending on health care calls such notions into question. Americans currently spend **more out-of-pocket** than citizens of any other industrialized nation. Despite this fact, total per capita health spending is much greater in the U.S. (40% higher than in Canada, the next highest spender) than in any of those countries; higher out-of-pocket spending clearly does **not** necessarily lower health costs. A 1991 study found that Texas tied with Massachusetts for the distinction of having the highest out-of-pocket spending per family in the nation. And a 1992 report found that in real (inflation-adjusted) dollars, Americans over age 65 spend over twice as much -- this means twice as many real dollars -- out-of-pocket as they did just prior to the creation of Medicare!

The lack of evidence of a reasonably competitive health care market suggests that health reform approaches that purport to correct market distortions should be subject to careful scrutiny. In all probability, "fixing" America's health care economy will be a somewhat painful process of trial and error.

centers), or both. In the 57 Texas counties with no hospital at all, unless a birthing center was present, **all** pregnant residents had to leave the county to deliver - a potentially dangerous situation for women with high-risk pregnancies and for their babies. One eight-county region in West Texas (8,772 square miles) has no public prenatal care services available; only two counties out of the eight have a hospital that offers OB services, yet over 2,000 babies were born to residents of the eight counties in 1989. There are 57 counties with no public provider of prenatal care, and 119 counties lack either OB or newborn care in a hospital.

Texans will want to know that their tax dollars are not going to undue profits, waste, unnecessary care, duplicative administrative costs. . .

The impact of these barriers to access is illustrated by the fact that nearly one-third of Texas women delivering babies in 1990 did not get prenatal care in the first three months of pregnancy; the numbers are far worse for teenagers (over 56% had no first trimester care), African-Americans (41%), and Hispanics (43%). Close to one in five African-American and Hispanic women, and over one-quarter of teen mothers actually got no care until the **last** three months of pregnancy. Improving Texas' prenatal care track record is particularly important because prenatal care has been solidly demonstrated to be one of the most cost-effective kinds of preventive care; each prenatal care dollar spent translates into a three dollar reduction in newborn intensive care costs alone.

Transportation Deficits. One-third of Texas' 254 counties have **no** scheduled public transportation services. There are 30 Texas counties containing **no** public transportation services of any kind, and many other counties are served only by transit systems for the elderly and handicapped, which are not routinely available to the able-bodied poor, including children. Texas has 39 federal Section 18 Rural Public Transportation providers serving small cities (50,000 or less) and/or rural areas, but there is enormous variation in the number of vehicles operated by the providers and in the frequency with which trips are available. Though Medicaid recipients are entitled to necessary transportation for health care, in rural areas a round-trip for medical care may involve a pre-dawn pick-up and a return trip home 12 hours (or more) later. City dwellers may have to cover many miles and make multiple bus transfers to reach health providers, which can take several hours. Both urban and rural Texans - young, poor, aged and disabled alike - face problems of matching transit systems' schedules with health providers' hours, problems of child care and other expenses while taking a sick child to the doctor, not to mention the problem of getting time off from work to deal with all of the above.

Emergency medical transportation is a special problem in rural areas. Rural EMS services often struggle to achieve adequate funding for training, equipment, and personnel. Contributing to their financial woes are Medicaid payments for rural emergency medical services that the federal government reports fail to cover the actual costs of service delivery in many states, and the fact that public and private insurers alike usually do not pay EMS services for care provided on site, when the patient is not transported to a hospital.

Texans with Disabilities and Other Special Needs. Persons with disabilities and chronic health conditions face special barriers to care, since typical insurance policies often fail to cover all their special needs. This group includes Texans with diabetes, HIV, hepatitis, cancer, tuberculosis, and Alzheimer's; the mentally ill; the chemically dependent; infants born addicted or with fetal alcohol syndrome; and the developmentally disabled; to name just a few. Their needs are as

varied as their disabilities, but some of the most commonly **unmet** needs include services that allow Texans to remain at home or in independent living settings, rehabilitation and therapy services, and medical, communication, and mobility devices that allow a maximum level of independence.

TEXAS TODAY. THE CLIMATE FOR CHANGE

How Big is the Pie? Determining the total amount of health care spending in the Texas economy is not a simple calculation; 1988 is the most recent year for which detailed numbers are available. In that year, about $33.6 billion was spent on public and private health care; about $4.2 billion of that was state government spending. Rough estimates of total spending for 1990 range from $40-42 billion. In 1988, the percent of Texas' economy devoted to health care was slightly lower than the national average, but because the health sector in Texas was growing at a rate **much** faster than the national average, it is expected that the gap has probably closed by now. Health spending **per Texan** in 1990 was less than the national average (Texas was 33rd overall), mostly due to lower-than-average public expenditures. On the other hand, Texans spend more out-of-pocket on health care than the average American.

A Throng of Interests. Making changes in the way we finance, deliver, or pay providers for health care in Texas is a challenge because the health care sector, which affects all consumers, is also directly related to the livelihood of so many. About 7.4% of Texans are **directly** employed in health services, and this does not include government-employed health care workers or the thousands of Texans involved in the marketing and administration of health insurance, the manufacture of health-related products, etc. About 30% of the new jobs created in Texas in the last year were in the direct health services sector.

Hospitals, doctors, other health professionals, nursing homes, health product manufacturers, insurers, employers, and even attorneys all have financial stakes in how health care is delivered and paid for. Slowing the growth in health care costs in any significant way will, over time, cause shifts in employment and profitability. Consumers, too, will be faced with changes in how they access care. All will want to have a voice in health reforms, and all sectors can be expected to resist the changes most painful to their interests. Movement toward universal health coverage in Texas will raise similar concerns.

Texas' high employment in small firms and uniquely high number of health insurers (many of them also small) will play a role in how health financing can be reformed at the state level. Small businesses in Texas, which employ almost 24% of Texas' workers (national average is 20%), will have serious concerns about any requirements for employers to provide health benefits. The number of insurers selling health policies in Texas is not precisely known, but is **at least** 600; in contrast, New York state has just 152 companies **licensed** to sell health insurance. New York regulators review about 7,000 policies per year, compared to the Texas Department of Insurance's workload of over 30,000 forms per year.

Finally, the average Texan's stand on reform is unpredictable. A 1992 Texas Poll found that only 23% of Texans favored maintaining the current system of private insurance, Medicare, and Medicaid. A "pay-or-play" employer mandate was the most popular choice at 36%, but just barely: 34% favored a national health care plan run by government and financed by the taxpayers that would cover all Americans. However, these simple responses leave a great deal to be fleshed out, not the least of which is the **costs** of such changes. One national poll found that 66% of respondents were willing to pay **some** additional taxes (49% said less than $200), while 31% were unwilling to pay any new taxes. The willingness of Texans, who have the **lowest** state and local per capita tax burden of the 10 most populous states (and 35th nationally), to fund

any additional health coverage is unclear. Texans will want to know that their tax dollars are not going to undue profits, waste, unnecessary care, duplicative administrative costs, or avoidable legal costs in exchange for their financial commitment to health reforms that make basic health care available to every Texan.

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