

Texas Borderlands: "Ground Zero of Health Care in America"®

Border residents face the most dramatic health disparities in America today. Sharing an international boundary ensures that disease and other chronic illnesses travel freely across this frontier and create crises due to lack of physical infrastructure, inadequate access to resources, and a poor health care infrastructure. The health issues analyzed in this chapter - poor access to care, a shortage of health professionals and dental care, a lack of health insurance, obesity, infectious diseases, mental health, hunger, Medicaid and Children's Health Insurance Program (CHIP) capitation rate disparities, incompetent operation of public health benefits by privatized vendors, and recent budget cuts - are just some of the challenges that Texans on the Border confront.

Many of these issues are interrelated. Health disparities exist because the Border has higher incidences of many health problems than the rest of the State, and, unfairly, fewer resources to deal with prevention and treatment. In so many health-related issues, the Texas Borderlands are "Ground Zero of Health Care in America."[®]

The Texas Borderlands: Ground Zero of the Uninsured

The Uninsured in Texas

U.S. Census Bureau data shows that Texas leads the nation in the number of citizens without health insurance. In 2004, almost 25 percent of all Texans reported that they had no health insurance of any kind.¹ This alarming statistic results from many factors, perhaps the most important of which is the fact that in large areas of Texas, the jobs available to low-income workers do not offer full family health insurance coverage.² Another contributing factor is that for those who are employed, union membership is low, limiting workers' ability to organize and demand insurance coverage.

In addition, Texas' large Mexican-origin population has the lowest rates of health insurance coverage in the nation.³ For this population, a lack of proficiency in English, lack of familiarity with insurance principles, a fear of governmental bureaucracies, and low educational levels add to general labor market and social service difficulties.⁴ This combination means that the uninsured population of Texas faces multiple barriers to coverage that present state lawmakers, employers, and policy makers with major challenges in addressing their insurance needs.⁵

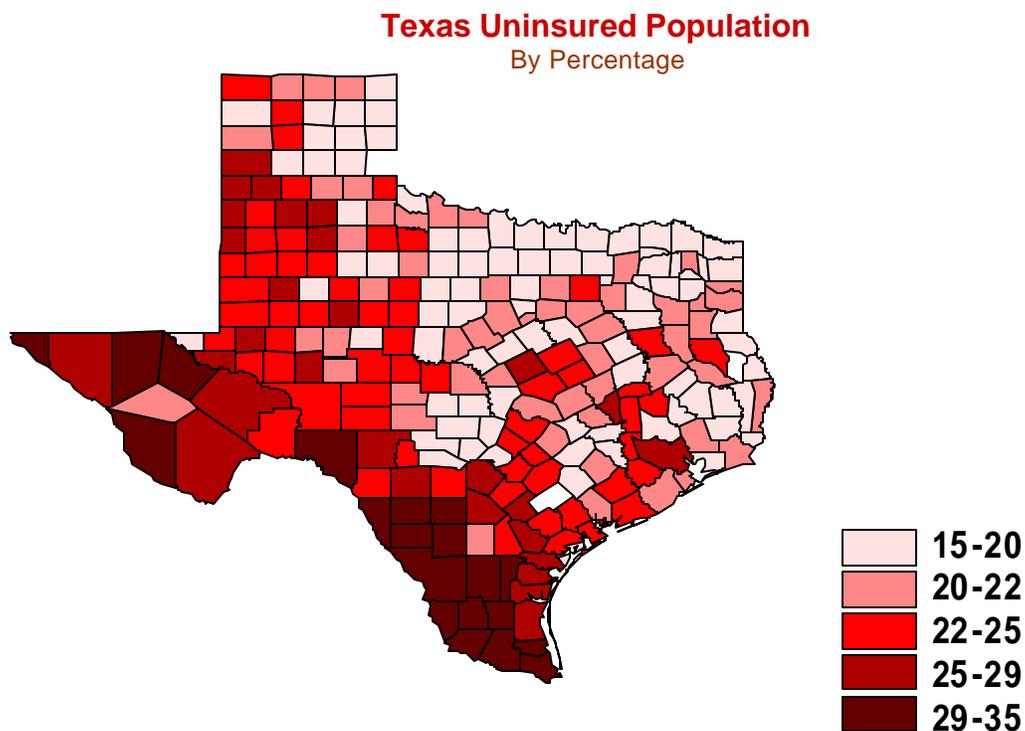
In the United States, unlike most of the rest of the developed world, health insurance is often tied to employment.⁶ Employment problems, then, translate directly into health insurance problems. Low wage jobs in the restaurant, hotel, cleaning, and other service industries often do not offer health insurance, and if they do, the premiums an employee must pay for family coverage make it an unrealistic luxury. The Mexican-origin population is overrepresented among those who cook our food, clean our offices and homes, and care for our children. In providing these services they buoy the high standard

of living for middle class Americans, but they themselves receive minimum pay and no benefits.⁷

Many Texas families face both financial and non-financial barriers to obtaining health insurance. These include factors that limit access to private or employer-based insurance, including high costs, family structure, and employment in jobs that do not offer health insurance or only do so at a prohibitive cost to the employee. Texas workers are less likely to have employment-based health insurance coverage than those in other states. In 2003, Texas ranked 48th in the nation, with only 52.4 percent of Texans having employment-based health insurance coverage.⁸ Even if a company does want to offer health insurance to its employees, it is often prohibitively expensive, especially for small businesses. In Texas, the average insurance premium for each employee in a business with fewer than 10 employees was almost \$3,877 in 2002, but only \$3,195 for companies with 50 or more employees, a difference of \$682 per year per employee.⁹

Other barriers include factors that limit access to public insurance, including complicated application and renewal procedures, asset tests, inadequate outreach efforts by agencies charged with administering health-related programs, and coverage for only the poorest of the poor. For example, in 2006, a working parent of two has to make less than \$3,696 per year, or 22.3 percent of the Federal Poverty Level, in order to qualify for Medicaid in Texas.¹⁰ In California, and in New York, ...

The chart *Texas Uninsured Population* shows that the bulk of uninsured residents live on the Border.



Source: Community Scholars, El Paso, Texas. www.communityscholars.org

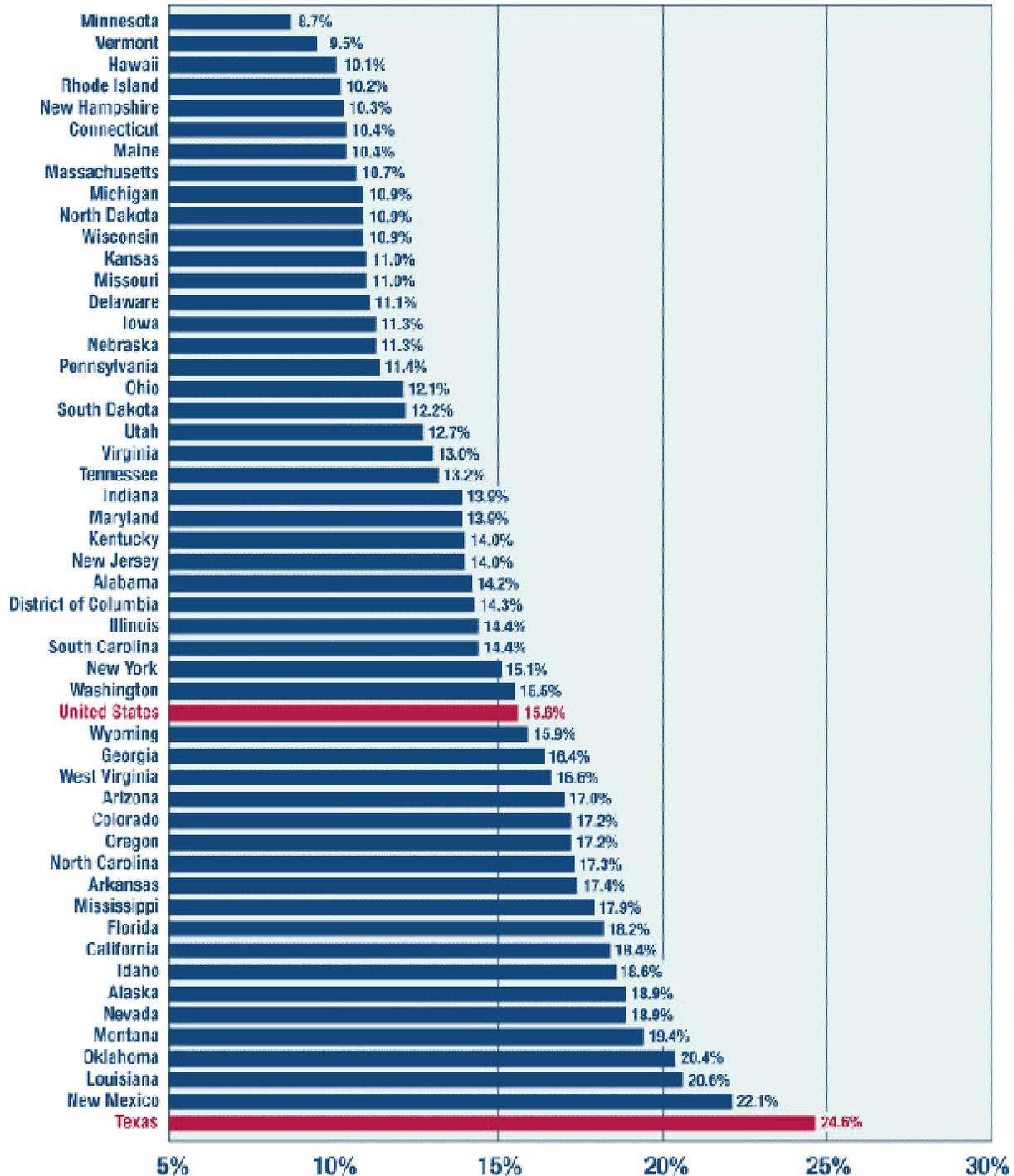
Why is it so important that Texas make health coverage a top priority? The lack of health insurance coverage places adequate medical care out of reach for many poor families in the United States.¹¹ Families close to the poverty threshold, who are for the most part the working poor, are at particularly high risk of lacking coverage.¹² Children in families that do not have employer-sponsored health insurance and are not enrolled in Children's Medicaid or the Children's Health Insurance Program (CHIP) are less likely to have a usual source of care than children in families that are covered.¹³ Uninsured children are also more likely than those with health coverage to be hospitalized for preventable illnesses and their resulting consequences.¹⁴ On average, uninsured children see the doctor less often for acute illnesses, and they are less likely to use prescription drugs than are children with insurance coverage.¹⁵ Although inequities in access to medical care between the rich and poor have decreased due to Medicaid and CHIP, poor children are still far less likely to receive dental care than children in more affluent families.¹⁶ Uninsured children are also less likely to be treated for conditions such as asthma and ear infections that can lead to more serious health problems.¹⁷

Because they are less likely to have a regular source of care, uninsured children are more likely than insured children to receive care in emergency rooms, community and migrant health centers, and other publicly-funded health facilities.¹⁸ Often, these publicly-funded facilities, especially in Border counties, are funded on the nation's lowest per capita property tax base, severely limiting their ability to care for these children. As a result, routine care received in emergency rooms is excessively expensive and may be of lower quality than that received from a personal physician familiar with a child's overall health.¹⁹ The lack of a stable, consistent source of care places these children at a high risk of illness.²⁰

Demographic Profile of the Uninsured

Texas has the highest percent of uninsured population compared to any other state, averaging 25.2 percent between 2002 and 2003.²¹ During the same time period, however, only 15.4 percent of the entire United States was uninsured.²² Indeed, Texas was by far the most uninsured state in the nation, as the chart *Percent Uninsured in Each State, 2003* shows. Note that the chart below shows the percent of uninsured for the year 2003 only.

Percent Uninsured in Each State, 2003



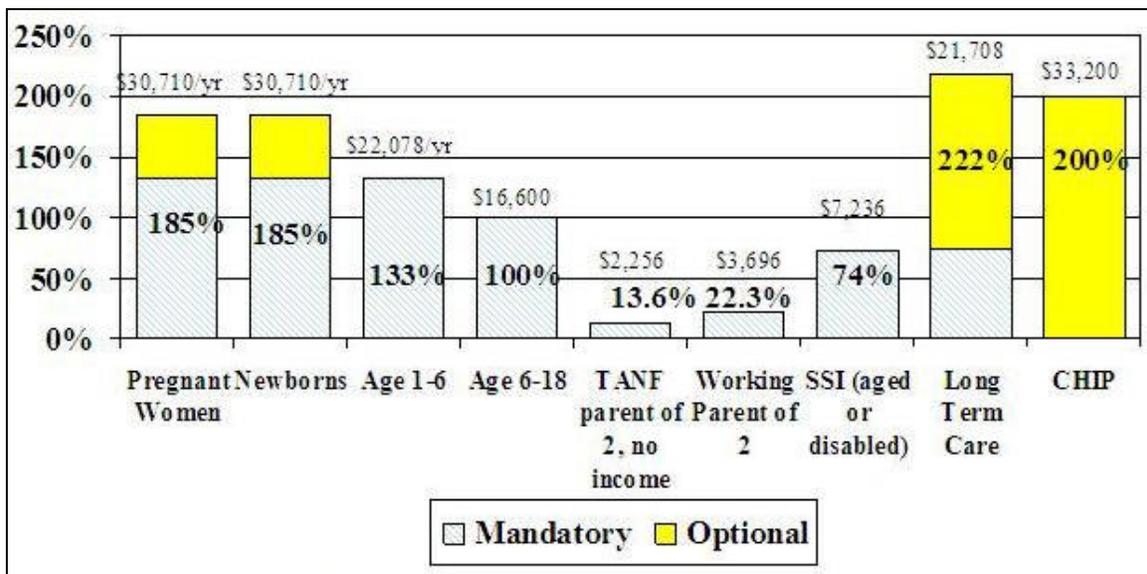
Source: Carole Keeton Strayhorn, Texas Comptroller of Public Accounts; U.S. Census Bureau Annual Demographic Survey, March 2004.

Age

Among the total population of Texans, adults 18 - 24 years old were less likely than other age groups to have health insurance coverage, with 57.5 percent covered for some or all of 2002. Because of Medicare almost all Texans 65 and over had health insurance in 2002. Slightly over 25 percent of children had no health insurance. For children under age 19 years, health insurance coverage ranged from 19.65 percent for those 6 years and younger and 24 percent for those age 7 - 17 years.

The number and percentage of children without insurance increased from 2001 to 2002. Those under 100 percent Federal Poverty Level increased from 472,593 to 482,271. The poorest Texas families have access to Medicaid and CHIP. The chart *Income Caps for Medicaid and CHIP in Texas, 2006* details the maximum amount of money a family of three can make and still be eligible for Medicaid and CHIP.

Income Caps for Medicaid and CHIP in Texas, 2006



* *Income limit as percentage of Federal Poverty Level; Annual income is for a family of 3, except individual incomes shown for SSI and Long Term Care*

Source: Bryan Sperry, PowerPoint presentation, 2006 Texas Health Care Access Conference, Feb. 2, 2006.

Online: http://www.tachc.org/Community_Resources/Outreach/Materials/Pres06/Bryan%20Sperry.ppt.

Accessed: June 18, 2006.

Race and Hispanic Origin

Historically underrepresented minorities accounted for 68 percent of the uninsured population in 2000. Among all age groups in the United States, Mexican Americans are the least likely to be insured.²³ One-fifth of African Americans and more than one-third of Hispanics were uninsured compared with only 12 percent for non-Hispanic white Texans.

Mexican-origin adults, especially immigrants, are over-represented in the service sector, in which either they are usually not offered employer-sponsored health insurance or the premiums required for individual or family coverage make such coverage out of reach. The chart *Uninsured Texan Population by Race or Ethnicity: 2000* shows that Hispanics are disproportionately uninsured compared to other minorities.

Uninsured Texan Population by Race or Ethnicity: 2000

Race/Ethnicity	Number Insured	Number Uninsured	Percent Uninsured within Race/Ethnicity Category	Percent of Total Uninsured
Anglo/Other	10,261,933	1,420,140	12.2	31.6
African American	1,809,689	487,617	21.2	10.8
Hispanic	4,474,763	2,592,896	36.7	57.6
Total	16,546,384	4,500,653	21.4	100.0

Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001 CPS. Research and Forecasting Department, Texas Health and Human Services Commission

Hispanic workers are less likely to get health benefits on the job, even if they are doing the same work as blacks or whites, especially if they earn \$15 an hour or less, or work at small companies with fewer than 25 employees.²⁴ Due to rising health care costs, these small businesses, including retail stores, restaurants, and construction firms, are unable to compete in the market when they offer health insurance to their employees.

Karen Davis of The Commonwealth Fund notes that the “[l]ack of health insurance and gaps in coverage can have serious health consequences. Hispanics are at high risk of failing to receive medical care that can prevent lifelong or even life-threatening health problems.”²⁵ They are also less likely than other minorities to have a regular doctor and to seek medical care for chronic diseases such as diabetes or be screened for cancer.

This problem becomes everyone’s concern when doctors and hospitals pass the cost of uncompensated care of the uninsured to paying patients and local taxpayers, which has the effect of increasing the cost of health insurance. The report also found that Hispanics are less likely than other ethnic groups to get health benefits from welfare programs. Salvador Gomez, the board chairman of the Colorado Hispanic Chamber of Commerce explained this data by suggesting, “[i]t’s a pride thing. These are people who will get in the back of a truck and drive thousands of miles just to get a job. They aren’t looking for a handout. They’re looking for a job.”²⁶

Immigration Status

In 2000, over a million Texas immigrants lacked health insurance. The percentage of the foreign-born population without health insurance, 52 percent, was more than double that of the native population. Additionally, 24 percent of the uninsured are non-citizens.²⁷ Nationally, foreign-born residents are three times more likely to be uninsured, and non-citizens are twice as likely.²⁸

Income Level

There is a direct relationship between income level and health insurance coverage. Two-thirds of the nation's uninsured have income levels below 200 percent of the Federal Poverty Level, or an annual income of \$33,200 for a family of three.²⁹ Further, 56 percent of Americans below the Federal Poverty Level (\$16,600 per year for a family of three) were uninsured during some part of 2001 or 2002, compared with 16 percent of those at 400 percent of the Federal Poverty Level (\$66,400 per year for a family of three).³⁰

Employment

The likelihood of being insured is linked to employment status. Nationally, for every 100 people who become unemployed, 85 people, including family members, lose their health insurance coverage.³¹ But having a job, even a well-paying one, does not guarantee health insurance coverage. Indeed, nationally, 25 percent of working individuals and their families with incomes from 300 to 400 percent of the Federal Poverty Level (\$49,800 to \$66,400 per year for a family of three) were still uninsured.³² Plus, in Texas, 79 percent of the uninsured worked either full- or part-time during 2001-02.³³ Many jobs simply do not offer health insurance or only offer it at a level where the employee's contribution proves too expensive.

Texas is a state which relies heavily on small businesses, as businesses with less than 50 employees constitute 73 percent of all businesses in Texas. However, only 37 percent of small businesses offer health insurance to employees. Compare this with the national average of 47 percent, and once again Texas lags behind the rest of the nation in terms of health insurance coverage.³⁴

Uninsured Hot Spots - County Differences

In Texas, 35 of the state's 254 counties account for 80 percent of the state's uninsured.³⁵ The table *Texas Counties with the Ten Largest Uninsured Populations* shows that half the ten counties with the highest number of uninsured are on the Border. In the half that are not on the Border, the largest population of uninsured are Hispanic.

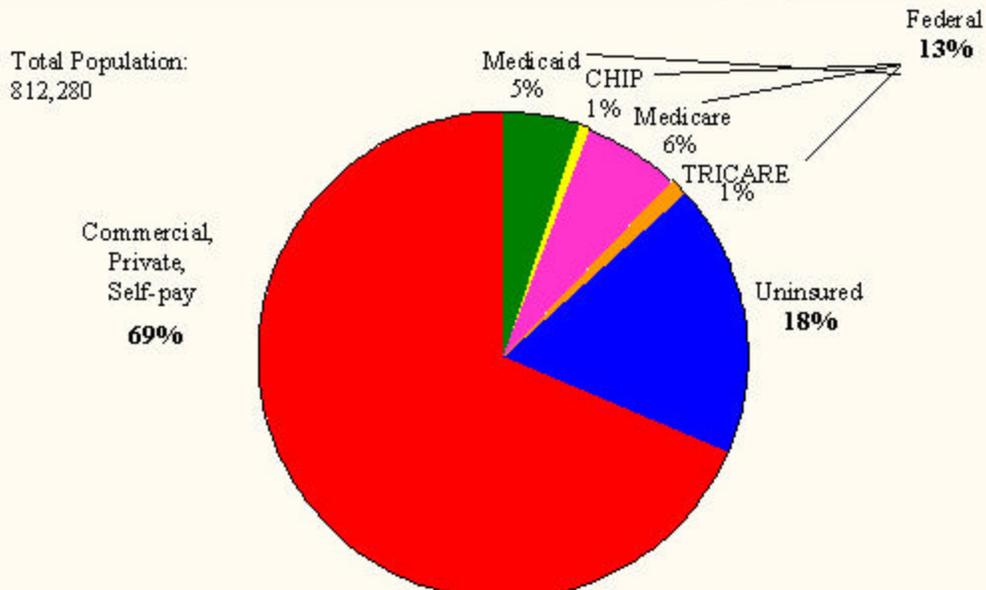
Texas Counties with the Ten Largest Uninsured Populations

County Name	Uninsured Population	% of Statewide Total
Harris	812,628	17.2
Dallas	499,970	10.6
Bexar	349,043	7.4
Tarrant	325,556	6.9
El Paso	231,534	4.9
Hidalgo	173,769	3.7
Travis	147,461	3.1
Cameron	103,474	2.2
Denton	81,413	1.7
Nueces	79,930	1.7
All Other	1,907,434	40.5

Source: Texas Department of Insurance, Working Together for a Healthy Texas, 2003.

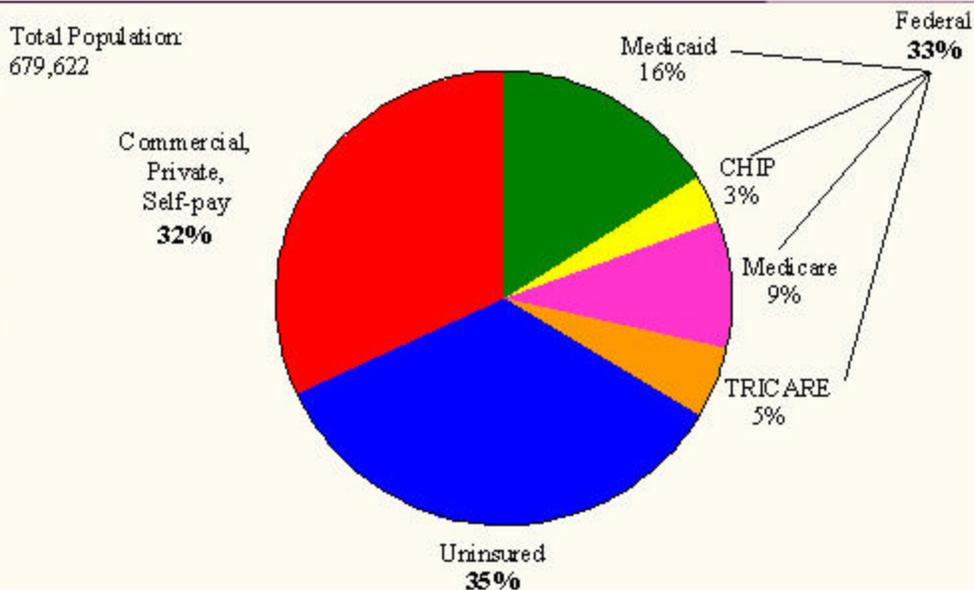
An example of this county-level disparity can be seen when you compare Travis to El Paso County. The charts *Estimated 2000 Insurance Mix for Travis and El Paso Counties* show that Travis County had a manageable rate of uninsured at 18 percent, but El Paso's was a devastating 35 percent. El Paso has the dubious distinction of being the "[g]round zero of the uninsured; the most uninsured city in America."³⁶

Estimated 2000 Insurance Mix for Travis County



Source: Community Scholars, El Paso, Texas. www.communityscholars.org

Estimated 2000 Insurance Mix for El Paso County



Source: Community Scholars, El Paso, Texas. www.communityscholars.org

Barriers to Health Insurance for Families in the United States

One of the major reasons for the large number of uninsured children in Texas is the fact that many children in low income families are not enrolled in public programs for which they are eligible. Data from the *Three City Study* indicate that differences in state eligibility criteria, as well as local administration of the program, are of major importance in determining who enrolls.³⁷ In Boston, 82 percent of families with incomes below 100 percent of poverty include a child who receives Medicaid, a figure similar to that for Chicago. In San Antonio, on the other hand, only 64 percent of families with household incomes below 100 percent of poverty receive Medicaid.

Since Hispanics in San Antonio are primarily of Mexican origin, one might ask if the lower rates of coverage among Mexican American children generally reflect the fact that this group is heavily concentrated in Texas. Rather dramatic results are observed when other factors are controlled for. Namely, Mexican-origin children are only 29 percent as likely to be covered by any form of health insurance and 43 percent as likely to be covered by Medicaid as non-Mexican Hispanics.³⁸

Texas' dubious distinction of leading the nation in uninsured children and adults results from a number of barriers to coverage that present the state with serious challenges. The large number of uninsured Texans along the Border presents the state with unique problems. This population is concentrated in some of the poorest counties in the state in which their demographic and labor supply problems are compounded by restricted labor markets and high unemployment. Increasing the insurability of the population through employment would be the most appealing solution; however, it is clear that reducing the number of uninsured and vulnerable Texans will require new and imaginative initiatives.

Three-Share Plan

An innovative program in Galveston County may offer part of the solution to helping reduce the number of uninsured residents in Texas. Called the "Three-Share Plan," the program will help offer low-cost health insurance to the working uninsured who would otherwise not be able to afford coverage. Under the plan, the cost of health insurance would be split three ways between the employer, the employee, and government funds.³⁹ The plan is currently awaiting approval by the Centers for Medicare and Medicaid Services.⁴⁰

Santa Clara Family Health Plan

In order to solve the problem of Texas' high rates of uninsured, state leaders often have to look to other states. In California, the Santa Clara County Children's Health Initiative is an example of such a pioneering program. The Initiative has two parts. First, an insurance product called Healthy Kids covers children in households with income up to 300 percent of the Federal Poverty Level who are ineligible for the two major state

insurance programs, Medi-Cal and Healthy Families.⁴¹ Second, the Initiative has an outreach program aimed at locating uninsured children and enrolling them in coverage.⁴² In order to help reduce the number of uninsured children, ambitious and comprehensive programs such as the Children's Health Initiative must be attempted throughout the state.

Medicaid and CHIP Capitation Rate Disparities

Compounding the problem of the uninsured, the State spends significantly less per capita for Medicaid acute care services delivered on the Border than in other geographic regions of Texas. Payments to health care providers are inadequate, perpetuating a provider shortage and, consequently, a lack of general access to health care services.

The reason the State has historically spent less per capita for Medicaid on the Border than in the rest of the state is because rates are based on historic utilization of health care services in a county. The Border has low utilization due primarily to the lack of health care providers and infrastructure. It is common knowledge that El Paso ranks near the bottom in comparison to the rest of the state in terms of number of physicians, dentists, and every other type of provider. Infrastructure is so poor that the number of hospital beds per capita in itself is a crisis. For every 317 people in Texas, on average, there is one hospital bed; in El Paso County, there is one bed for every 339 people.⁴³

The Medicaid rates paid to physicians and dentists are woefully inadequate, particularly for a community like El Paso, where Medicaid is a major payer for health care services. This problem is not limited to just the traditional Medicaid fee-for-service program. Under the Medicaid managed care program, the capitation rates paid to participating Health Maintenance Organizations (HMO) are set with the assumption that physicians will be paid the Medicaid fee-schedule. The chart *Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006* shows the wide variation in rates in cities throughout the state.

Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006

Organized by HMOs in Selected Care Service Areas

	Bexar Superior	Dallas Parkland	Harris Amerigroup	Lubbock Firstcare	Tarrant Amerigroup	Travis Amerigroup	El Paso Superior
TANF Children (> 1 year)	\$81.18	\$86.51	\$75.28	\$77.51	\$74.73	\$73.69	\$83.04
TANF Adults	213.41	191.29	227.92	203.50	238.18	193.85	206.16
Pregnant Women	358.30	310.37	320.04	501.47	318.23	322.44	345.09
Newborns	563.36	622.35	678.97	340.97	465.19	520.87	495.48
Expansion Children (> 1 year)	80.14	101.25	77.68	87.19	69.77	85.50	89.97
Federal Mandate Children	67.63	73.67	70.18	72.44	78.20	61.79	70.24
CHIP (ages 15-18)	87.15	119.94	83.64	94.53	101.71	n/a	96.06

Source: Texas Health and Human Services Commission

Capitation rates, or the fee per child, paid to managed care organizations participating in Medicaid are based on historic expenditures per capita. Cities like El Paso that have always had disproportionately low Medicaid expenditures per capita find themselves in a difficult situation. In order to achieve higher capitation rates, they must be spending more per capita. But because the capitation rates are so low, it is impossible to spend more per capita. The disproportionately low per-capita expenditures, the low managed care capitation rates, and the wholly inadequate Medicaid fee schedules have forced health care providers to significantly limit their participation in Medicaid or leave the program altogether. This negatively impacts Medicaid recipients' access to services.

Adding to the Health Crisis: The Budget Cuts of the 78th Legislature

Despite the health crisis and health disparities on the Border, and the fact that Texas trails other states in allocation of health care resources, lawmakers still made inhumane health and human service budget cuts during the 78th Legislature. Texas short-changed its citizens with accounting gimmicks that actually added up to huge reductions in services and benefits for our populace. These budget cuts were cleverly disguised to make it appear as if funding for health and human services is being "maximized," but sadly, quite the opposite has occurred. Funding for such state-supported health programs as Medicaid and CHIP, nursing home and hospice care, community care, university teaching hospitals, state and local district employee insurance coverage, and adult and youth inmates, has been reduced by:

- reducing income guidelines and eliminating participation;
- making it more difficult for people to become eligible (or remain eligible) for services;
- eliminating benefits that were previously available; and
- reducing payments to health care providers who are serving those who are eligible.⁴⁴

Some health care programs actually received an increase in their funding compared to 2002-2003, based strictly on the dollar amount being appropriated to them. However, this is highly misleading, because while some of these programs may show a slight increase in their overall General Revenue funding, this increase does **not** keep up with rapidly increasing health care costs, which are rising at a rate of more than 10 percent annually.⁴⁵

H.B. 2292 was passed during the 78th Legislative Session to cut twelve health and human service agencies down to five, and to centralize powers under the Health and Human Services Commission (HHSC). HHSC now coordinates administrative functions across the system, provides eligibility determination for health and human services

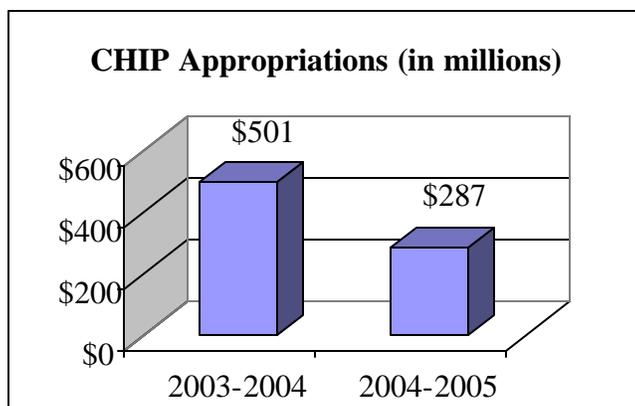
programs, and administers Medicaid and the Children's Health Insurance Program. Additionally, it conducts oversight of the other four programs:

- **The Department of Family and Protective Services** includes the programs previously administered by the Department of Protective and Regulatory Services. DFPS began services Feb. 1, 2004.
- **The Department of Assistive and Rehabilitative Services** combines the programs of the Texas Rehabilitation Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing and Interagency Council on Early Childhood Intervention. DARS began services March 1, 2004.
- **The Department of Aging and Disability Services** consolidates mental retardation and state school programs of the Department of Mental Health and Mental Retardation, community care and nursing home services programs of the Department of Human Services, and aging services programs of the Texas Department of Aging. DADS is scheduled to begin services Sept. 1, 2004.
- **The Department of State Health Services** includes the programs provided by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse and the Health Care Information Council, plus mental-health community services and state hospital programs operated by the Department of Mental Health and Mental Retardation. DSHS is scheduled to begin services Sept. 1, 2004.

Under the past system, most people applied for public benefits at one of 381 local eligibility offices administered and staffed by the Texas Department of Human Services (DHS). H.B. 2292, however, mandated the use of call centers to determine eligibility for the major health and human services programs, including Medicaid, CHIP, Food Stamps, and Temporary Assistance for Needy Families (TANF). The resulting debacle that has occurred since HHSC has attempted to privatize this responsibility and transfer it to a contractor will be discussed shortly.

Cuts to CHIP

The chart *CHIP Appropriations (in millions)* shows that CHIP was appropriated \$287 million for the 2004-2005 biennium, representing a 43 percent reduction from what the program spent during the previous year (\$501 million). The program also now carries stricter eligibility policies and offers fewer benefits. Furthermore, CHIP has higher co-pays and premiums, and makes beneficiaries wait 90 days before the policy takes effect.⁴⁶ These inhumane cuts were made when Texas was already ranked 50th in the percentage of children who have health insurance.⁴⁷



Cuts to Medicaid

Medicaid also took a severe hit during the 78th Legislative Session. Funding for the 2004-2005 biennium rose a meager 3.8 percent, and new eligibility standards and enrollment procedures will have far-reaching ramifications that will leave many citizens out in the proverbial cold, with no benefits.⁴⁸ For 2003, approximately 2.5 million Texans, including 1.6 million children, received Medicaid acute care services on a monthly basis. As a result of these cuts, this number was expected to shrink by 4,000 in 2005.⁴⁹ Had the eligibility policies been left untouched, 350,000 additional Texas children and adults could have potentially been covered by Medicaid.⁵⁰

These cuts also severely affect low-income pregnant women. Medicaid can be used for prenatal care, delivery, and postpartum care for 60 days after delivery. The budget reductions mean that almost 13,000 women will no longer be covered, representing a loss of approximately \$110 million in reimbursement for Texas health care providers over a two-year budget cycle.⁵¹

Furthermore, Texas lost \$41.2 million in state and federal funds from the 2004 mental health budget, and Medicaid coverage for adults who need counselors and psychologists was wiped out completely. Approximately 200,000 adults had to make do without these services, resulting in health crises for families, at the local level, and in emergency rooms.⁵²

Cuts in Texas Assistance for Needy Families

Other estimable programs also were reduced through stricter eligibility requirements. Temporary Assistance for Needy Families (TANF) provides cash assistance on a monthly basis for poor Texas families with children under the age of 18. A family of three (mother and two children) may qualify for TANF assistance if their gross income is below \$784 a month and their assets are valued at less than \$1,000. On September 1, 2003, more than 19,000 adults and 41,000 children in Texas lost **all** of their cash assistance benefits because of the new full-family sanction policy, and most of the adults receiving

TANF assistance also lost their Medicaid benefits. State projections are that 75 percent of TANF recipients who will lose their assistance will be children.⁵³

The new legislation that was enacted wiped out coverage for such basic necessities as eyeglasses and hearing aids for adults on Medicaid.⁵⁴ It also eliminated coverage for elderly, disabled and adult TANF recipients seeking help in such high-demand areas as social work, marriage and family therapy, podiatric and chiropractic care, psychological counseling, and licensed professional counselors.⁵⁵ Further, the state chose not to maximize its federal matching dollars requested by the Health and Human Services Commission, leaving approximately \$1.6 billion in federal Medicaid and the Children's Health Insurance Program funding "on the table" - \$1.6 billion that could have gone toward providing health care to Texans.⁵⁶

These budget cuts and reductions cost the state and local jurisdictions millions of dollars in unnecessary emergency care that could have been prevented. Balancing the budget on the backs of kids and people who need them the most contradicts government's mission. Medicaid and CHIP are social insurance programs designed to protect our most vulnerable citizens. By continuing to chip away at these services, we are forcing more and more Texans to fend for themselves and exposing them to a greater risk of chronic or debilitating illness or even premature death. Further, costs passed on to local taxpayers will increase taxes. That is not the recipe for a healthy populace or economy. Steps to redress these problems must be taken immediately, so Texas leaders can begin to repair the damage that was created through these draconian budget cuts.

Partial Restoration of Budget Cuts in the 79th Legislature

The 79th Regular Session restored some of the cuts from the disastrous 78th Regular Session, but many of the major cuts remain unrepaired. Despite the increased funding, Texans who rely on public health programs such as CHIP and Medicaid will still suffer the effects of an underfunded system.

Some CHIP Cuts Restored

Fortunately, the state budget restored vision care, dental care, and mental health coverage to 2003 levels, thus undoing the cuts from the 78th Legislature. Dental services were delayed numerous times before they were finally included in CHIP beginning in April 2006.

Many of the cuts from the previous session remain, however. In fact, none of the bills filed that would have restored CHIP coverage back to 2003 levels ever received a public hearing. Thus, any changes that were made to the CHIP program were instituted through the budget bill.⁵⁷ The cuts that were not restored include:

- Children are only covered for six month periods, not a full year;
- Upon initial enrollment for the first time, children are not covered for 90 days;

- Elimination of the income deductions that allowed families to deduct child care or child support payments from the income level that determines eligibility;
- An asset limit added for families who are above 150 percent of the Federal Poverty Level (\$24,900 annual income for a family of three);
- A 2.5 percent reimbursement rate cut for CHIP medical providers; and
- A reduction in outreach and marketing funding.⁵⁸

Those intent on reducing the number of children who can benefit from CHIP coverage also employed a different tactic. The budget assumes a lower CHIP caseload and cost-per-client than what HHSC had initially projected. As a result of these assumptions, the CHIP allocation of general revenue was reduced by \$60.6 million.⁵⁹

Some Medicaid Cuts Restored

In addition to CHIP, some of the cuts made in the 78th Legislature to the Medicaid budget were repaired. The budget restored eyeglasses, hearing aids, mental health professional services, chiropractic, and podiatry benefits for all 863,000 adult Medicaid clients, 78 percent of whom are aged or disabled.⁶⁰ Total Medicaid funding was increased \$1.8 billion over the 2006-07 biennium with the addition of programs such as the Medicaid buy-in program for workers with disabilities and enhanced family violence funding.

Similar to CHIP, though, the budget assumed a lower Medicaid caseload growth and cost-per-client than what HHSC had originally projected, thus lowering the Medicaid budget by \$929.7 million in general revenue.⁶¹ Further, Medicaid provider rates were not increased back to 2003 levels.⁶²

Further Cuts in the Future?

Unfortunately, it seems extremely likely that Texas' most vulnerable citizens may once again be forced to bear the brunt of enormous budget cuts. The recent Special Legislative Session conducted during April and May 2006 passed tax legislation to comply with a Texas Supreme Court ruling.

The Perry Tax Plan passed this special session will create an enormous budget deficit, and its effects will be felt throughout the state for the foreseeable future. H.B. 1, the bill designed to cut property taxes, creates a huge hole in the state budget that has to be made up somewhere. H.B. 3, 4, and 5 are intended to fill that hole by raising revenue through a new business tax, a used cars tax, and a \$1 cigarette tax increase. Simply put, these bills don't raise enough money.

The net effect of the Perry Tax Plan is a legislatively-designed deficit scheduled for 2009. Financial experts have reported to the legislature that the business tax will grow from a base of roughly \$3.5 billion to replace the property tax cut base of \$6.5 billion. Estimates based on calculations from data provided by the Legislative Budget Board show that Perry's Tax Plan is already \$2.31 billion short for 2007 and \$2.62 billion short for 2008.⁶³ And, since the constitution requires Texas to balance the books, tax cuts from this session will mean budget cuts in the next. This will force a 16 percent spending cut in the 2008-09 budget.⁶⁴

Watch for major cuts to health and education programs rivaling the massive cuts of 2003 and a full penny increase in the state sales tax rate during the 2007 Legislative Session that will increase the most regressive of Texas taxes to 9.25 percent - nearly the highest sales tax rate in the U.S. What we defeated in 2003 will come back in 2007. Remember, Texas already ranks 50th in general per capita spending.⁶⁵

To get an idea of the size of the deficit compared with the amount of tax revenue coming in, see the chart below, *Fiscal Impact of HB 1, 3, 4, & 5*:

FISCAL IMPACT OF HB 1, 3, 4 & 5					
	HB 1	HB 3	HB 4	HB 5	Net Shortfall
		business tax	used cars tax	cigarette tax	
2007	(\$3.92 B)	(\$2 M)	\$31 M	\$432 M	(\$3.53 B)
2008	(\$8.69 B)	\$3.38 B	\$42 M	\$691 M	(\$4.57 B)
2009	(\$10.13 B)	\$3.45 B	\$43 M	\$731 M	(\$5.90 B)
2010	(\$9.85 B)	\$3.72 B	\$43 M	\$635 M	(\$5.45 B)
2011	(\$10.35 B)	\$3.97 B	\$43 M	\$675 M	(\$5.67 B)
5-year total	(\$43.02 B)	\$14.51 B	\$202 M	\$3.16 B	(\$25.12 B)

Source: fiscal impact numbers are based on the Legislative Budget Board's fiscal notes for HB 1, HB 3, HB 4 and HB 5. Last Updated May 15, 2006.

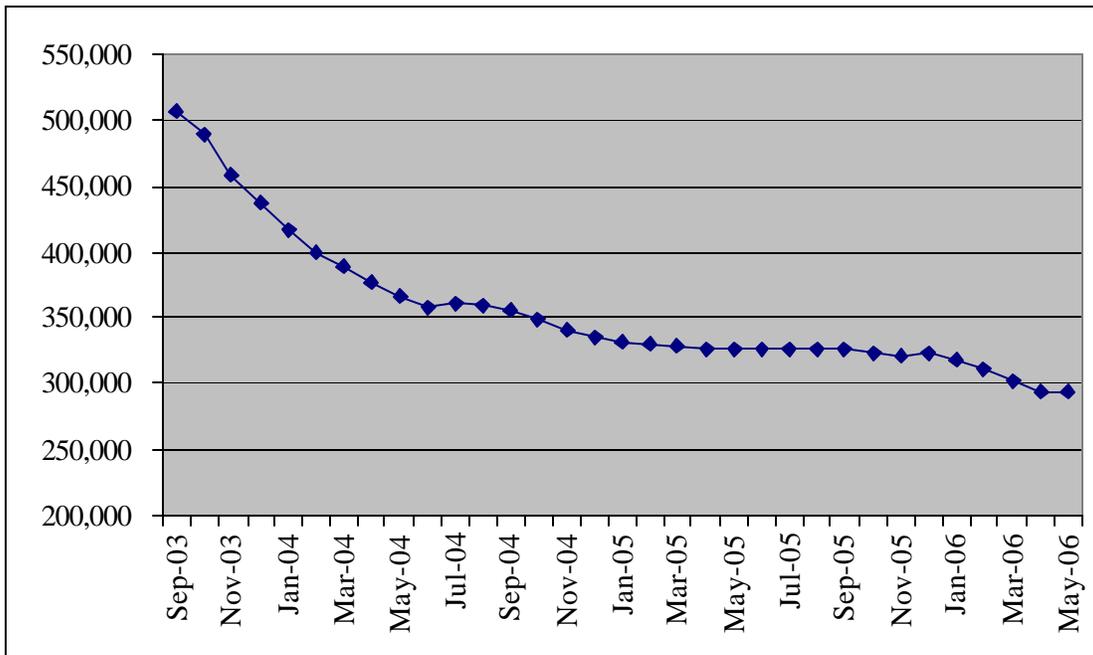
Privatization of Enrollment and Eligibility Services: The Health Equivalent of Katrina

H.B. 2292, which was passed in the 78th Legislative Session, required the privatization and use of call centers to determine applicants' eligibility for the major health and human services programs, including Medicaid, CHIP, Food Stamps, and Temporary Assistance for Needy Families (TANF).⁶⁶

In November 2005, Texas Access Alliance (TAA), a consortium of companies led by the Bermuda-based Accenture LLP, began processing statewide applications for CHIP and Children's Medicaid. In January, TAA began processing local applications in Travis and Hays Counties for other key programs such as food stamps and TANF. These dates correspond with the beginning of significant decreases in both CHIP and Children's Medicaid enrollment and huge backlogs of applications for food stamps and TANF in Travis and Hays Counties.⁶⁷

Since November, almost 30,000 children have been dropped from the CHIP rolls. In April, enrollment dropped by nearly 10,000 children, bringing the total enrollment to 292,681 - the lowest point in five years. Astoundingly, the preliminary enrollment numbers for May 2006 indicated over a 28,000 client decline in that month alone. HHSC responded to this alarming drop by granting a reprieve to the more than 28,000 children that would have lost coverage in May.⁶⁸ This is a temporary solution to what seems to be a permanent problem. In the chart *CHIP Enrollment, September 2003 to May 2006*, one can see the dramatic decline in enrollment:

CHIP Enrollment, September 2003 to May 2006



Source: Texas Health and Human Services Commission

In El Paso, almost 2,000 children have been disenrolled from CHIP since November. Further, more than 2,700 additional CHIP accounts in El Paso would have been disenrolled as of April 30, 2006 had HHSC not intervened.⁶⁹ In El Paso, which is the most uninsured large city in the nation, this is especially intolerable.⁷⁰

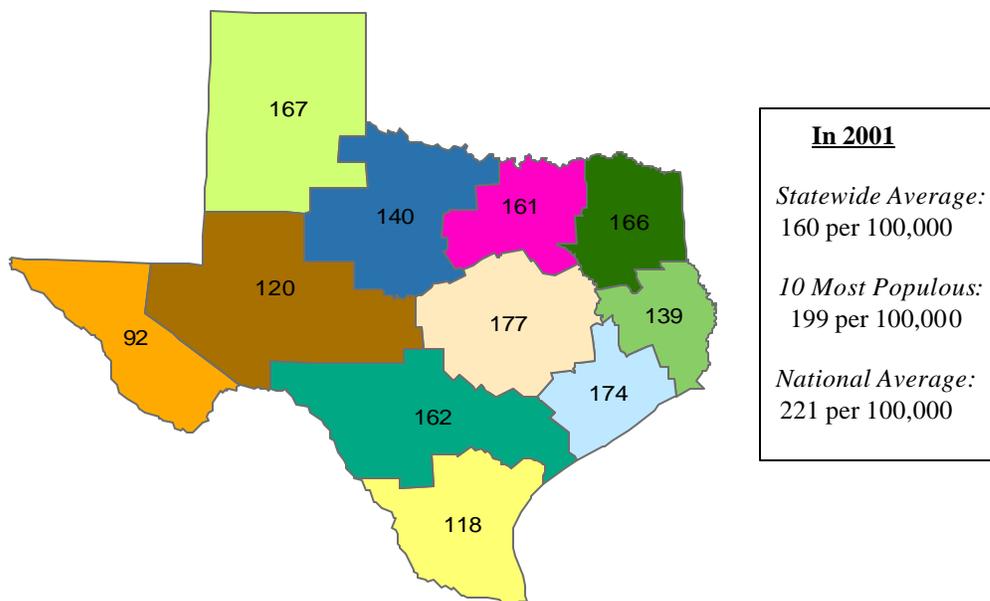
The Commissioner of HHSC, Albert Hawkins, announced in April 2005 that HHSC was going to temporarily stop the roll-out of the new privatized system, citing the need for technical and operational improvements.⁷¹ Accenture, the call center vendor, thus returned more than 12,000 applications to local field offices across the state for processing. As a result, state eligibility offices had to work Accenture's backlog as well as their own caseload despite being extremely short staffed.⁷²

Limited Number of Health Care Providers

There is a strong need for physicians in the state of Texas as a whole. As shown in the chart *Physicians per 100,000 Population in Texas Regions in 2001* on the following page, Texas has fewer physicians, 160 per 100,000 people, than the national average of 221. Further, Texas has fewer physicians than the ten most populous states, which average 199 physicians per 100,000 people.

The chart highlights the fact that physicians are not evenly distributed among the regions of Texas. Far West Texas had only 92 per 100,000 in 2001, and the Rio Grande Valley had 118 per 100,000.

Physicians per 100,000 Population in Texas Regions, 2001



SOURCE: Texas State Data Center, Texas Department of Health, & Texas State Board of Medical Examiners; Bureau of Health Professions, Website: www.bhpr.hrsa.gov; 2001 data

The shortage of health professionals extends to many other disciplines. While Texas has 35.7 dentists per 100,000 population, El Paso only has 16.1 per 100,000 population.⁷³ The Border is also considered a medically underserved area because of the lack of pharmacists, nurses, and physician's assistants.

The Texas population has grown from 14.7 million in 1981 to over 22.6 million in 2005.⁷⁴ It is expected that the population in Texas will be over 26 million by 2015.⁷⁵ With the population continuing to increase, Texas will need to graduate more medical school students in the future. In 2000, 44 percent of physicians in Texas graduated from a Texas medical school, with 35 percent coming from other states, and 21 percent coming from other countries.⁷⁶

Health Issues of Particular Importance in the Border Region

The Texas Borderlands are faced with numerous health-related challenges that, while prevalent throughout the rest of the nation, do not negatively impact residents to the extent one can see in the Border Region. These challenges included obesity, mental health, infectious diseases, hunger, and oral health, each of which will be examined in turn.

The Obesity Epidemic on the Border

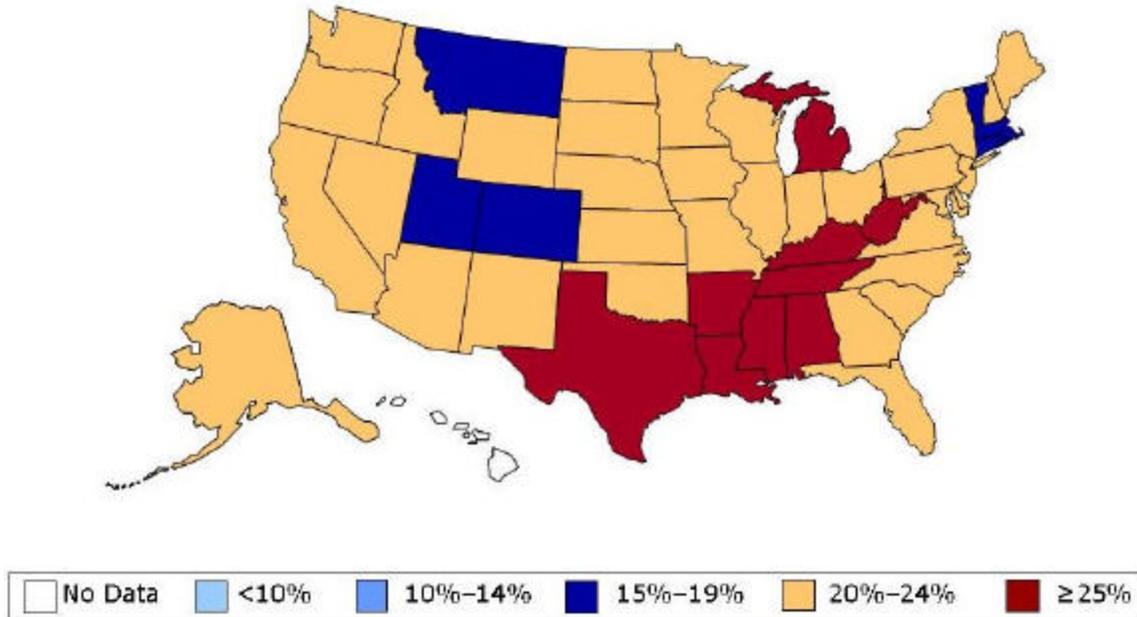
The prevalence of obesity is developing into a nationwide health crisis. According to the national Centers for Disease Control and Prevention (CDC), obesity is only second to tobacco use as the leading cause of preventable death in the United States.⁷⁷

The CDC estimates that as many as 112,000 Americans die each year due to an obesity-related cause.⁷⁸ The tragic loss of life due to obesity is accompanied by staggering costs to the health care system. CDC officials estimate the social costs of obesity amount to \$117 billion annually.⁷⁹

The obesity problem is particularly serious in Texas. In 1991, 43 percent of Texans were overweight or obese, but by 2002, the percentage had increased to 63 percent.⁸⁰ The rate of obesity in Texas increased 88 percent during the 1990s, faster than three-quarters of the nation.⁸¹ State health officials estimate that the direct and indirect costs of obesity in Texas exceed \$10 billion annually.⁸² The Department of State Health Services believes the problem will continue to accelerate rapidly if not addressed, and warns Texans that the costs to the state could potentially escalate to \$40 billion per year if no action is taken.⁸³ The chart *Obesity Trends Among U.S. Adults*, on the next page, shows that Texas has one of the highest rates of obesity in the country.

Obesity Trends* Among U.S. Adults BRFSS, 2004

(*BMI ≥ 30 , or ~ 30 lbs overweight for 5' 4" person)



Source: Centers for Disease Control and Prevention

Generally, the Border has higher rates of obesity compared to the rest of the state. The predominantly Mexican-American Border population is one of the most likely to suffer from obesity and obesity-related medical conditions in the U.S. According to the CDC, 73 percent of Mexican-Americans are overweight, compared to 62 percent of non-Hispanic Whites.⁸⁴ Research shows that Mexican-Americans are two to three times more likely to suffer from diabetes than non-Hispanic Whites⁸⁵ and are also more likely to suffer from other obesity-related diseases such as cancer and heart disease.⁸⁶

Results from a survey coordinated by the Paso del Norte Health Foundation showed that, in El Paso, 49.5 percent of males were overweight and 26 percent were obese. For El Paso females, 32 percent were overweight and 24 percent were obese.⁸⁷

What is Obesity?

According to health agencies like the National Institutes of Health (NIH), obesity is a complex chronic disease caused by genetic, environmental, and behavioral factors.⁸⁸ Health officials measure obesity using a formula called Body Mass Index (BMI) that compares weight to height. People with a BMI score over 30 are considered obese, and those with a BMI score between 25 and 30 are considered overweight.⁸⁹

People with obesity are significantly more likely to suffer from conditions such as Type 2 diabetes, heart disease, high blood pressure, and osteoarthritis.⁹⁰ The effects of child obesity are also very serious. Children with obesity are at greater risk of suffering

from asthma, Type 2 diabetes, and high blood pressure.⁹¹ The chart *Increased Risk of Obesity Related Diseases with Higher BMI* illustrates the serious consequences of obesity.

<i>Increased Risk of Obesity Related Diseases with Higher BMI</i>				
Disease	BMI of 25 or less	BMI between 25 and 30	BMI between 30 and 35	BMI of 35 or more
Arthritis	1.00	1.56	1.87	2.39
Heart Disease	1.00	1.39	1.86	1.67
Diabetes (Type 2)	1.00	2.42	3.35	6.16
Gallstones	1.00	1.97	3.30	5.48
Hypertension	1.00	1.92	2.82	3.77
Stroke	1.00	1.53	1.59	1.75

Source: Centers for Disease Control. Third National Health and Nutrition Examination Survey. Analysis by The Lewin Group, 1999.

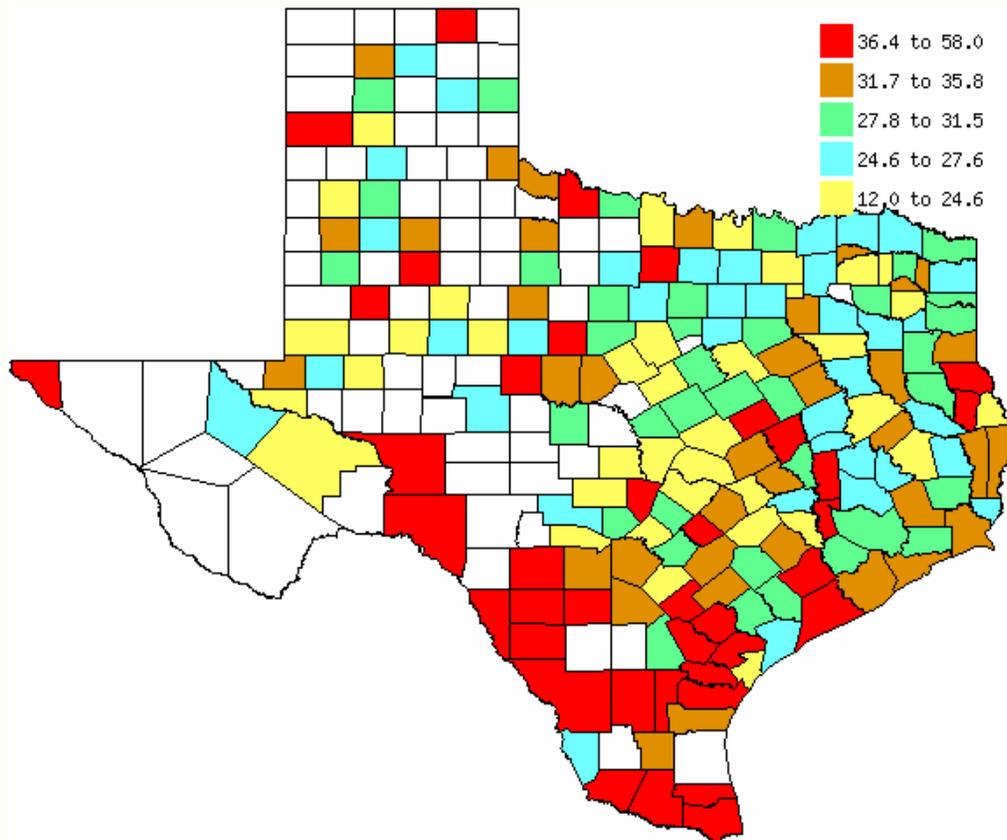
Obesity in our School Children

A particularly serious problem is the increase in obesity among children. About 28 percent of U.S. children are overweight or at risk of becoming overweight.⁹² In Texas, the number of students who are overweight or at risk is about 29 percent.⁹³ According to the CDC, 38 percent of students in Texas do not regularly engage in vigorous physical activity.⁹⁴ In addition, 40.5 percent of Texas students watch three or more hours of television daily.⁹⁵

Obesity and Diabetes

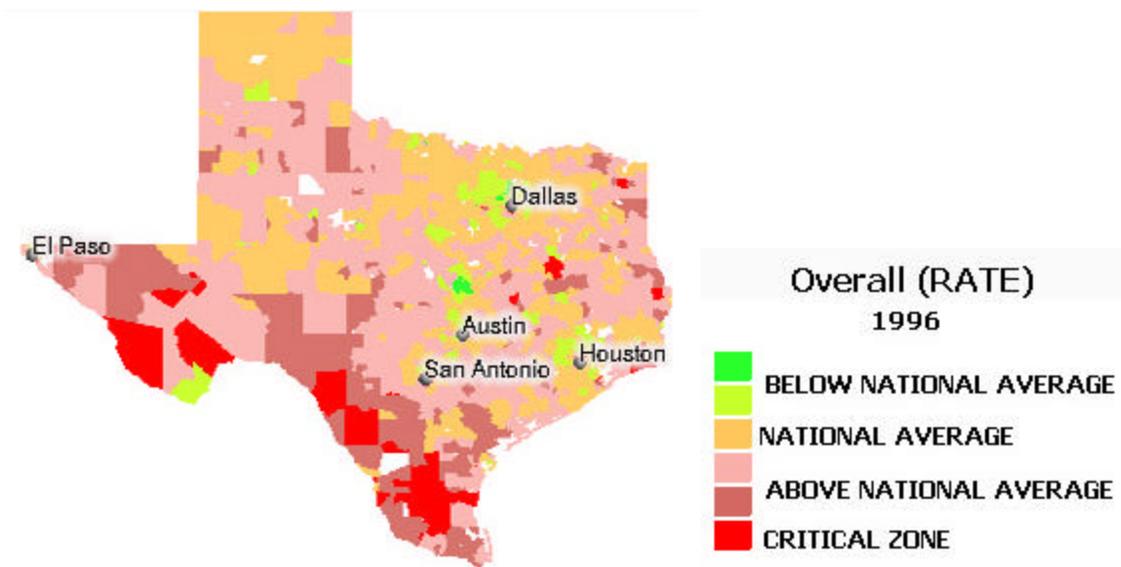
Diabetes is a disease where the body does not produce or properly use insulin, a hormone used to convert sugar and other food materials into energy.⁹⁶ According to the American Diabetes Association, diabetes is the fifth deadliest disease in the United States, contributing to over 224,000 deaths in 2002.⁹⁷ People with diabetes are twice as likely to suffer heart disease and two to four times more likely to have a stroke and a reoccurrence of a stroke.⁹⁸ The chart *Texas Deaths: Diabetes Rates per 100,000, 1990-1998* shows that, generally, the Border has higher death rates due to diabetes than the rest of the state.

Texas Deaths: Diabetes Rates per 100,000, 1990-1998



Source: Texas Department of State Health Services

Texas Diabetes Prevalence, 1996



Source: National Minority Health Month Foundation

Increases in Type 2 diabetes, where the body does not properly use insulin, may be one of the first consequences of the epidemic of obesity among young people. Approximately 20.8 million Americans suffer from diabetes, of which 176,000 are under 20 years old.⁹⁹ Approximately one in every 400 to 600 children and adolescents have Type 1 diabetes, where the body cannot produce insulin.¹⁰⁰ Clinic-based reports and regional studies indicate that Type 2 diabetes is becoming more common among children and adolescents, particularly in American Indians, African Americans, and Hispanics/Latinos. The prevalence of Type 2 diabetes is 1.5 times higher in Hispanics than non-Hispanic whites.¹⁰¹

The incidence of diabetes is particularly high in the Border Region. While the rate is ten percent in Texas, it is 16 percent in El Paso.¹⁰² Type 2 diabetes accounts for 95 percent of all diabetes cases in El Paso.¹⁰³

Current Initiatives

State agencies recognize the growing problems that obesity presents, and have developed some initiatives. In 2003, a statewide taskforce produced a plan for combating obesity in Texas. The plan calls for increasing general awareness of the problem of obesity and mobilizing schools, parents, and communities to address the issue. It also calls for encouraging policies that promote healthy eating and physical activity, and establishing procedures for data collection.¹⁰⁴ In the 77th Legislative Session, the Texas Legislature established the *Texas Pediatric Diabetes Research Advisory Committee* to develop a plan for researching pediatric diabetes and medical conditions associated with diabetes in Texas. The *Texas Diabetes Council*, established in 1983 and housed in the Department of State Health Services, produces a biannual state plan dedicated to reducing the prevalence of diabetes and increasing public and professional education regarding the disease.¹⁰⁵

Other recent policies have attempted to improve nutrition and physical activity in schools. After state officials moved administration of the school lunch and school breakfast programs from the Texas Education Agency to the Texas Department of Agriculture (TDA) in 2003, TDA issued a policy that limits the amount of food of minimal nutritional value (FMNV) in public schools. FMNVs include food items such as carbonated beverages and most candies. Sale of FMNVs are now restricted during the entire school day in elementary schools and half the school day in middle and high schools.¹⁰⁶

Other current policy initiatives include reforming the vending machines in schools and requiring elementary school students to engage in thirty minutes of physical activity daily. Still, the state struggles with how to integrate nutritional meals into school lunches without losing valuable revenue from competing vending machines and fast food vendors. Recently, however, the country's top-three soda companies agreed that, beginning in the fall of 2006, they will start removing sodas from school cafeterias.¹⁰⁷

An initiative that has been successful on the Border is the Coordinated Approach to Child Health (CATCH), which integrates nutrition, fitness, faculty, and parental involvement in the prevention of obesity. They try to increase awareness of nutrition in the classroom, increase the amount of physical activity during physical education, serve healthier foods at lunch, and promote health awareness among the students' families.¹⁰⁸ The state has mandated that this type of program be integrated into all elementary schools by 2007.

While steps such as these are important, there is no guarantee that current initiatives will dramatically slow the rise in obesity and related health problems. With the increasing prevalence of obesity in Texas and the Border Region, it is important that citizens, policy makers, and health officials act quickly to address this issue. State leaders must act boldly to develop strategies aimed at the Border and Hispanics and work to build effective programs, a sound health care infrastructure, and adequate resources to fight the growth of obesity in the Region.

Mental Health Issues and Inadequate Resources

In the Borderlands Region, there is a great strain on families and communities due to the inability of the public mental health care system to serve those at risk. Exacerbating the gap between need and availability of mental health care are the growing societal pressures stemming from the economic downturn, unemployment, and threats to homeland security.

Thanks to advances in medical research, many serious mental illnesses can now be treated with enormous success. Many biological brain disorders and illnesses respond to proper treatment, and new medications are being released that are immensely effective. However, Texas has not had the capacity to provide mental health care and medications to all those who need them. Due to budget constraints, there has been insufficient funding for the state agency charged with helping low income Texans with mental illness, the Texas Department of State Health Services (TDSHS). For example, during the 78th Legislative Session, the public mental health system experienced enormous funding cuts, and policy changes were implemented that will make it even more difficult to access mental health services.

Poor Access to Mental Health Care

A recent study released by the Mental Health Association in Texas reveals that Texas has not even come close to being able to care for the majority of those who are eligible for mental health care and are at extreme risk of serious impairment due to a mental disorder.¹⁰⁹

This problem is even greater in the Borderlands. For example, El Paso is currently experiencing a crisis in mental health care. Before September 2005, the budget allocation from TDSHS to El Paso Mental Health & Mental Retardation (EPMHMR) and the El Paso

Psychiatric Center provided for 64 beds.¹¹⁰ However, TDSHS reduced the budget allocation by eight beds. Since that date, the EPMHMR crisis assessment facility and the Psychiatric Center often turn away and refuse to assess mental health patients due to this lack of funding.¹¹¹ EPMHMR is the mental health authority responsible for immediately screening and assessing El Pasoans in a mental health crisis. If necessary, they are then referred to and admitted into the Psychiatric Center. This system, however, is broken.¹¹²

El Pasoans who need emergency psychiatric services are instead being forced upon area hospitals, who are ill-equipped to provide inpatient psychiatric treatment. Further, these patients are being forced to wait in the emergency room for many hours until a bed can be found for them at the Psychiatric Center.¹¹³

This crisis became so severe that the El Paso County Attorney filed a lawsuit against TDSHS stemming from the repeated failure by EPMHMR and the Psychiatric Center to adequately treat El Paso's mentally ill.¹¹⁴ The lawsuit is currently pending in El Paso District Court.

The entire Borderlands experiences this lack of mental health care. The table *Estimated at Risk, Eligible, and Served by the TDMHMR in 2002* shows the numbers of people served for certain Border counties.

Estimated At Risk, Eligible, and Served by TDMHMR in 2002

	Adults			Children		
	Estimated Adults At Risk and Eligible for MHMR Services	Adults served	Percent of Adults Who Were Served	Estimated Total Children At Risk and Eligible for MHMR Services	Children served	Percent of Children Who Were Served
Brewster	180	144	80%	49	27	55%
Cameron	5,979	2,199	37%	2,965	417	14%
Culberson	55	27	49%	23	*	*
Dimmit	180	76	42%	85	20	24%
El Paso	12,343	5,705	46%	5,577	1,322	24%
Hidalgo	10,033	1,993	20%	5,331	613	11%
Hudspeth	59	14	24%	28	*	*
Jeff Davis	44	21	47%	12	6	48%
Kinney	65	10	15%	21	*	*

Maverick	797	315	40%	451	129	29%
Presidio	130	86	66%	61	11	18%
Starr	902	212	24%	526	201	38%
Terrell	21	*	*	7	*	*
Val Verde	804	259	32%	373	96	26%
Webb	3,371	1,250	37%	1,861	535	29%
Zapata	216	96	44%	103	69	67%
BORDERLANDS	35,182	12,407	35%	17,473	3,446	20%
TEXAS	397,166	150,241	38%	151,464	39,591	26%

Source: Texas Department of Mental Health and Mental Retardation

Estimated At risk and eligible for services was defined using the proportions in the 2003 Strategic Plan for TDMHMR

Lack of adequate coverage for mental health treatment leads to desperate choices. Without proper intervention, children's mental health issues often lead to far worse problems later, including involvement in the juvenile justice system.

Prisons: De Facto Mental Health Care

There is a nation-wide trend to send mentally ill individuals to prison, contributing to the rising prison population. Furthermore, there is also a lack of available resources in the community, often leading to incarceration.

Once mentally ill prisoners are booked, how do they receive treatment? Screening mechanisms are often inadequate, due to the significant differences across prison systems.¹¹⁵ Therefore, we do not have accurate numbers on the mental health population in Texas prisons. As of February 2004, 17 percent of Texas inmates were reported to have mental health problems.¹¹⁶ Typically, prisons have a clinic staffed with a medical nurse and a psychiatrist, but inmates do not get adequate treatment and there is not sufficient follow-up.¹¹⁷

A needs assessment indicated the demand for an intensive mental health facility in a Travis County prison, which opened in December 2001. These inmates incur higher costs, but "the special unit reduces the need to outsource, the number of suicides, and bridges gaps within the community," according to the Travis County Sheriff's Department.¹¹⁸

Unique Challenges of the Borderlands

The Mental Health Association in Texas recently visited a number of towns along the Texas Border to learn more about the unique challenges of the region. Through community forums, residents and service providers outlined the following challenges for those seeking mental health care and those providing that care.¹¹⁹

- The U.S. Border with Mexico is somewhat artificial. People can cross back and forth and move about freely within ten miles of either side of the Border.
- The number of people living in poverty along the Border is very high.
- There is a prevalence of people with substance abuse and co-occurring mental health issues.
- Housing for people with mental illness and substance abuse problems on the Border is a particular challenge.
- Since drug costs are so high, and prescription drugs are cheaper in Mexico, many people go across the Border to have prescriptions filled even though this is against Texas state law.
- Transportation is a significant challenge; there are insufficient resources to hospitalize people with a mental health crisis, and transportation to the closest facility is a huge problem.
- Borderlands residents need more integrated services and funding streams.
- The stigma of mental illness in the Borderlands is hard to overcome and there is a great need for more community support.

Recommendations From Forum Participants :

- An anti-stigma campaign to provide the public with accurate information about mental illness and the treatments that are available.
- Increased collaboration between schools, universities, and other stakeholders.
- Implement a Family to Family Education Program with Mexico. This is a peer mentoring program that pairs families with a newly diagnosed member with families who have experience living with mental illness.
- Education of younger generation.
- More Patient Assistance Programs, which provides financial assistance for medication.

- Review the research and educational materials produced in Mexico to see if Texas can learn from them.
- Make mental health a key priority of the *United States - Mexico Border Health Commission*.¹²⁰

Infectious Diseases in the Border Region

Infectious diseases that are unique to the Border cause serious health risks to residents. Multiple factors, including inadequate water and wastewater infrastructure, migration from Mexico, the movement of disease vectors across the Border, genetic predispositions, and inadequate disease surveillance contribute to higher rates of some infectious and chronic diseases in Border communities.

Since infectious diseases are not bound by borders, their transmission can occur through a variety of channels beyond person-to-person infection, including livestock, insects, and birds. Border residents deal with outbreaks of mosquito-borne Dengue Fever and West Nile Virus, tuberculosis, and hepatitis A and C, among others.¹²¹ The costly treatment of these unique diseases coupled with high rates of infection pose a double threat to the Border Region. The table, *Infectious Diseases Along the U.S.-Mexico Border*, shows those diseases that are known or suspected to have increased prevalence in the region. Border colonias, in particular, suffer from basic infrastructure inadequacies, leaving residents without proper sanitation, a crucial factor in maintaining health standards. In addition, these areas often serve as a hub for frequent travel, increasing the likelihood of outbreaks in crowded living situations.¹²²

Infectious Diseases Along the U.S.-Mexico Border

Known	Suspected
Tuberculosis (TB)	Taeniasis
Drug-resistant TB	Histoplasmosis
HIV/AIDS	Trichinosis
Hepatitis A	Giardiasis
Hepatitis C	Cryptosporidiosis
Cysticercosis	Pathogenic <i>E. coli</i> infection
Brucellosis	<i>H. pylori</i> infection
Dengue fever	Chagas' disease
Salmonellosis	Leishmaniasis
Shigellosis	
Rabies	
Amoebic encephalitis	
Rickettsial diseases	

Source: Doyle, TJ and RT Bryan, "Infectious disease morbidity in the U.S. region bordering Mexico, 1990-1998," *The Journal of Infectious Diseases*, November 2000, 1503-10.

Tuberculosis

Tuberculosis (TB) is spread through the air from one person to another, making transmission likely between individuals in close proximity to one another.¹²³ There is a common misconception that TB has long since been eradicated from the United States, but certain areas within our borders remain susceptible to this disease. Several risk factors, such as being foreign-born, alcohol abuse, diabetes, and HIV/AIDS make individuals prone to Tuberculosis.¹²⁴ The connection of these health factors should be recognized and addressed accordingly. Early detection is a key preventative measure in minimizing TB incidence rates in the state. Commissioner Sanchez of the Texas Department of State Health Services stated, "One person with untreated active TB will infect on average as many as 15 people every year."¹²⁵

Dengue Fever

Dengue fever is a tropical disease transmitted easily via mosquito vectors. Those inflicted initially experience flu-like symptoms, but complications can lead to fatal hemorrhagic fever. With four possible serotypes, individuals do not obtain cross-protective immunity and can be susceptible to four dengue infections during their lifetime.¹²⁶

West Nile Fever

West Nile Fever was first documented in the U.S. in 1999, when several cases were reported. Like Dengue fever, this disease is transmitted through infected mosquitoes and can lead to severe conditions such as encephalitis, meningitis, or meningoencephalitis.¹²⁷ In 2003, West Nile was reported in 12 of the 43 Border counties, with an incidence rate of 4.75 percent for a population of 100,000.¹²⁸

Hepatitis A and C

Hepatitis A (HAV) is a viral infection spread primarily by contaminated food and water, which can be prevented with improved sanitation and widespread vaccinations.¹²⁹ Due to the state's efforts in the Border Region since 1998, the number of reported cases has declined in recent years.¹³⁰ The Hepatitis C virus (HCV), on the other hand, has no vaccine, and is transmitted through contaminated needles, sexual contact, or from mother to child.¹³¹ Because of this, HCV poses a more complicated problem for the Border Region; Efforts to educate the public on the nature of this disease is the primary prevention strategy. The table, *Preliminary 2003 Infectious Diseases in the 43 Texas-Mexico Border Counties*, shows the number and rate of the diseases listed above.

Preliminary 2003 Infectious Diseases in the 43 Texas-Mexico Border Counties

	Hepatitis A	Hepatitis C (Acute)	West Nile Encephalitis	Tuberculosis	AIDS
Number of Cases Reported	128	33	82	376	424
Incidence Rate (Per 100,000)	3	0.8	1.9	8.67	9.77

Source: Texas Department of Health, 2004

Addressing the Problem

Due to the unique nature of infectious diseases combined with easy transmission through multiple avenues, the Border Region is faced with the challenge of combating these startling statistics and decreasing the impact these diseases have on public health. A major obstacle in achieving healthy communities is the weak public health infrastructure in the Border Region. Even if individuals recognize symptoms and seek medical attention, many areas do not have primary health care professionals necessary to deal with these patients. Furthermore, these diseases are very costly for Borderland hospitals to treat, and if left unaddressed, they will continue to travel north and impact other parts of the state.

Furthermore, with health care costs rising every year, individuals who may already deal with unemployment or low wages must face the added burden of paying for medical treatment they cannot afford. Increasing the monitoring of these morbid conditions and engaging in active efforts to provide adequate education and training to health care professionals is essential.

Hunger in the Border Region

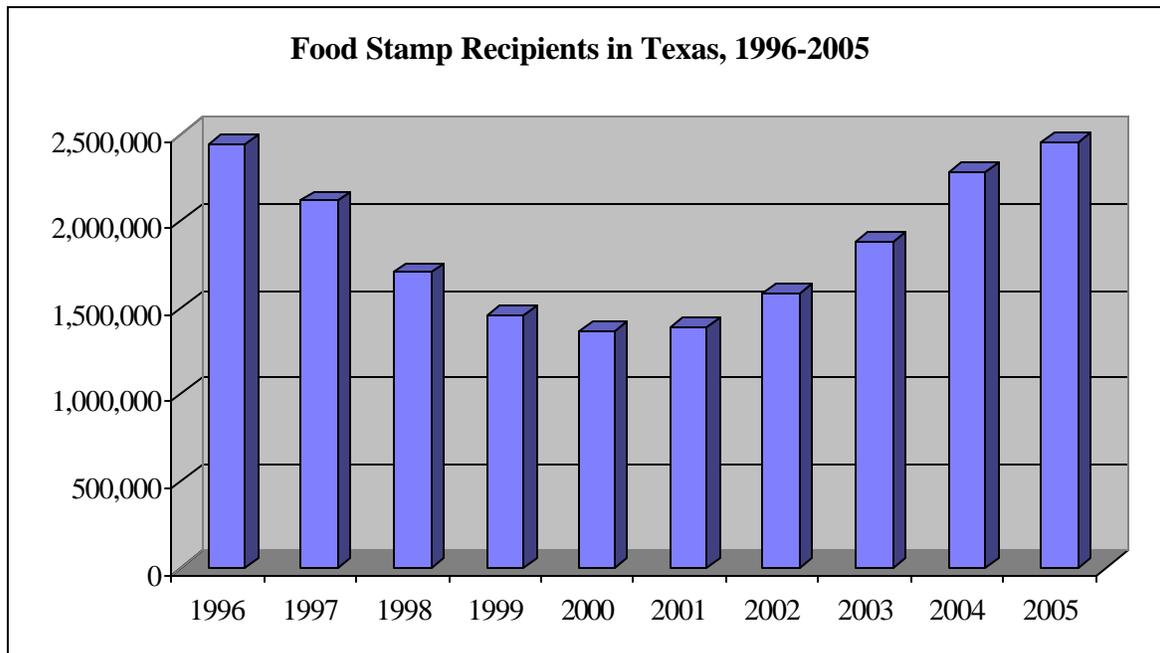
Texas ranks second in the nation in the percentage of the population that is food insecure and fifth in the percentage that is food insecure with hunger.¹³² Food insecurity is the lack of access to enough food to fully meet basic needs at all times due to a lack of financial resources.¹³³ Despite this great need, Texas ranks 47th in the nation in the amount of welfare and food stamp benefits paid. The national average benefit per person is only \$78 per month.¹³⁴

Still, the Food Stamp Program (FSP) is one of the key weapons in fighting hunger in our state. The FSP is run by the U.S. Department of Agriculture and administered statewide by the Texas Health and Human Services Commission. About 1.9 million Texans received Food Stamps benefits in 2003, and El Paso had an average participation of 163,034 recipients per month.¹³⁵

Problems With the Food Stamp Program

After 1996, Food Stamp enrollment was on the decline. Welfare reform in 1996 changed the way Food Stamps were administered. There has been an enrollment increase in recent years due to the lagging economy and an increase in the number of Texans who

are below the poverty level, as shown in the chart, *Food Stamp Recipients in Texas, 1996-2005*.



Source: Texas Health and Human Services Commission

Not all of those eligible for the FSP are receiving benefits. In El Paso, only 41 percent of eligible persons are receiving benefits, compared with an average 67 percent participation rate statewide. That number literally means 89,000 El Pasoans are not receiving assistance for which they are eligible.¹³⁶ As a result of its low participation rate, Texas has lost out on \$4.5 billion in federal grant money.¹³⁷

There are several reasons for low participation. First, the eligibility rules are confusing. Because the rules have changed several times over the past ten years, with the same people floating in and out of eligibility, many people who are eligible do not realize that they are. The rules regarding legal immigrants with citizen children can also be confusing and result in many people not receiving their benefits. Community outreach programs are currently putting a great deal of effort into education so that all eligible persons are aware of the program and their access to it.

One of the major changes that greatly affects the Border community is the loss of benefits by legal immigrants. Cuts like these damage the local economy since \$1.84 of state economic activity is generated for every food stamp dollar spent.¹³⁸ In El Paso alone, legal immigrants lost 21.5 percent of their purchasing power due to cuts in the FSP.¹³⁹

The FSP also has low participation due to the stigma associated with receiving government assistance.¹⁴⁰ The use of fingerprinting adds to this stigma.¹⁴¹ This practice was put in place to cut down on Food Stamp fraud. While there has been no evidence that

fingerprinting deters fraud, the practice has been a deterrent for people to apply, thus decreasing the number of participants.

Participation is not the only problem facing the FSP. Cuts in benefits have decreased the program's effectiveness. On average, Food Stamp benefits last 2.3 weeks out of every month.¹⁴² Benefits average out to only \$0.70 per meal, which does not come close to feeding a person for an entire month.¹⁴³

Issues like these, as well as accessibility, should be considered in restructuring the FSP. The state should not make it difficult for those who need assistance to receive it.

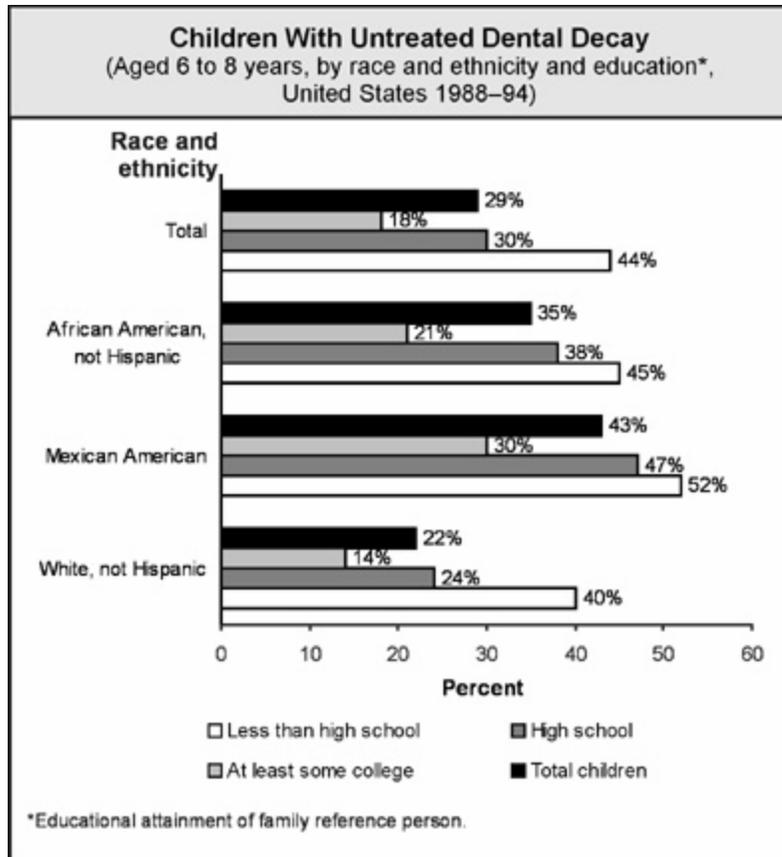
Oral Health Care on the Border

Oral health is a key component of overall health. As former U.S. Surgeon General David Satcher observed in *Oral Health In America*, “the mouth is a mirror,” which reflects an individual’s overall health.¹⁴⁴ Recent epidemiological studies have established a link between severe oral infections - especially periodontal (gum) disease - and a host of other health problems, including arteriosclerosis, heart attack, stroke, heart disease, and premature birth.¹⁴⁵ Periodontal organisms can enter the bloodstream and cause inflammation in certain organs, including the liver, major blood vessels, and the placenta.¹⁴⁶

Along with serious illness, oral diseases can cause debilitation, significant pain, interference with eating, poor self-image, over use of emergency rooms, and valuable time lost from school. School-age children are particularly vulnerable to dental problems. The Surgeon General has noted that tooth decay is America’s most common chronic childhood disease,¹⁴⁷ and the Texas Department of State Health Services (TDSHS) reports that dental caries, or cavities, is the leading cause of school absenteeism in Texas.¹⁴⁸ Even when they are in class, children with untreated dental problems have trouble concentrating on their schoolwork, hampering their ability to learn.

The Texas-Mexico Border region reflects many national health trends that threaten to overwhelm the current health care delivery system, including dental care. The combination of disproportionately large segments of the population in the lower socioeconomic strata, lower overall education levels, and ethnic groups with genetic predispositions to chronic diseases make the Border region even more susceptible to oral disease. Multiple challenges to Border health care require innovative solutions.

Two segments of the population, the young and elderly, are particularly vulnerable to disease. According to *Oral Health In America*, preschool Latino children experience higher dental carie rates than any other race or ethnic group.¹⁴⁹ Latino children of all ages are less likely to get dental care than their non-Latino counterparts. The chart *Children With Untreated Dental Decay* illustrates the high rate of dental decay amongst Mexican American children.

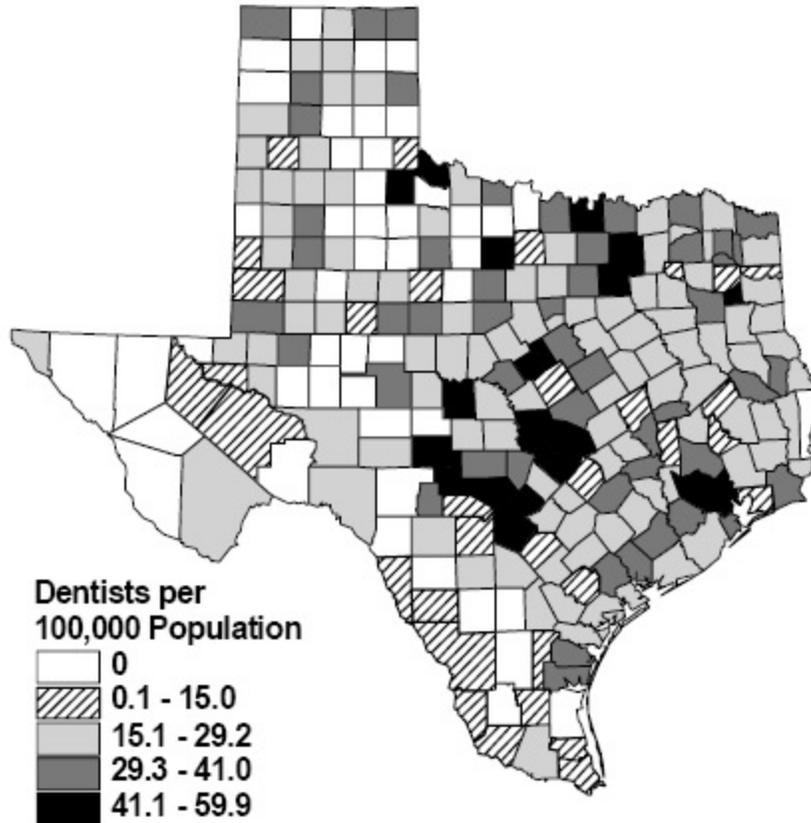


Source: CDC, NCHS. National Health and Nutrition Examination Survey (NHANES), 1988–94.

Expenditures for dental services alone made up 4.7 percent of the nation's health expenditures in 1998 - \$53.8 billion out of \$1.1 trillion. In 2000, nationwide expenditures for dental services are expected to exceed \$60 billion.¹⁵⁰ Working adults lose more than 164 million hours of work each year due to oral health problems or dental visits.¹⁵¹

The chart *Dentists per 100,000 Population by County of Residence* shows that the Border region faces an extreme shortage of dentists, falling far short of the state average of 35.7 dentists per 100,000 population.¹⁵² In Border metropolitan areas, there are 27.5 dentists per 100,000 population, but non-Border metropolitan areas have 40.2 dentists. Even worse, Border non-metropolitan areas have only 17.3 dentists per 100,000 population, but non-Border non-metropolitan areas have 25.1 dentists.¹⁵³

**Dentists per 100,000 Population
by County of Residence
Texas 2004**



Source: Texas Department of State Health Services

Oral Health Statistics in the 43-County Border Region

- 29 of the 43 counties in the Border region are currently designated “Dental Health Professional Shortage Areas” (27 whole counties; 2 partial counties);¹⁵⁴ and
- 13 counties in the Border region have no dentists, and 18 counties have no dental hygienists.¹⁵⁵

Sources of Dental Care in the Border Region

Oral health care consists of education, preventive care, and restorative care. Ideally, all Texans should receive regular preventive care (an annual exam and twice-yearly “prophylaxis” or cleanings) and restorative care (fillings, crowns, dental prosthetics, etc.), as needed.¹⁵⁶

Like other Texans, most residents of the Border region receive care from dentists in private practice. Many obtain care on a fee-for-service basis, paying the cost out of pocket, although some individuals have coverage from private or employer-provided dental insurance. Children in Texas from low-income families are eligible for two state programs that provide dental care coverage: Medicaid and the Children's Health Insurance Program (CHIP). Except for certain residents of long-term care facilities or individuals with disabilities, the State of Texas does not provide health or dental coverage for adults in Texas.

To the extent that they obtain care at all, adults who are unable to pay for dental care - or children who are not enrolled or do not qualify for Medicaid or CHIP - obtain care in hospital emergency rooms; from non-profit, charitable, or public health dental clinics; or from individual dentists who donate their services. A brief description of major sources of dental care in the Border region follows.

Medicaid Dental Program

Medicaid, the state's largest health care program, provides dental care through the Texas Health Steps Program. In addition to individuals with disabilities and certain residents of long-term care facilities, Medicaid covers children under age 1 to 6 in families with annual incomes up to 133 percent of poverty level and children age 6 to 18 in families with annual incomes up to 100 percent of the poverty level.¹⁵⁷ The dental program covers a wide array of services and usually pays for as much care as an eligible patient requires.¹⁵⁸ Dentists must enroll in the Medicaid program in order to receive reimbursement. Reimbursement is based on a statewide fee schedule, and most fees are less than dentists' overhead costs.

CHIP Dental Program

The Children's Health Insurance program, established in 1997, is intended to provide coverage for children in working families that earn too much to qualify for Medicaid but not enough to afford private insurance. Since the program's inception, CHIP dental benefits have been capped. Currently, preventative care is capped at \$175 for a 12-month period.¹⁵⁹ Therapeutic services are capped based on a three-tier program. The higher the tier level, the higher the maximum allowable amount for therapeutic services. The child's tier levels depends on factors including timely renewal, the amount of time a child as been enrolled in CHIP, and recent gaps in coverage. Tier levels for therapeutic services are:

- **Tier I:** Pays up to \$175 of preventative services and up to \$200 of therapeutic services.
- **Tier II:** Pays up to \$175 of preventative services and up to \$300 of therapeutic services.

- **Tier III:** Pays up to \$175 of preventative services and up to \$400 of therapeutic services.¹⁶⁰

The caps limit the therapeutic dental care (fillings, caps, root canals and extractions) and preventive dental care (annual oral evaluation, x-rays, prophylaxis and sealants) that children enrolled in CHIP can access.¹⁶¹

Division of Oral Health - Texas Department of Health

The Oral Health Group of the Texas Department of State Health Services (TDSHS) plays a key role in efforts to improve the oral health of residents of the Border region, which includes parts of four TDSHS regions. The Group provides a variety of services from its headquarters in Austin and through regional offices in Uvalde (Region 8), El Paso (Region 9/10), and Harlingen (Region 11).¹⁶²

In addition to helping oversee dental services provided through Medicaid and CHIP, the Group helps individual communities around the state optimize the fluoride content of public water supplies by providing financial and technical assistance with the installation and management of their fluoridation systems. Studies have established that fluoridation of public water supplies is the most cost effective means of combating dental disease for people of all ages.¹⁶³

School-based Clinics

Some school districts in the Border region employ full or part-time nurses to provide a range of health care services, which can include visual screenings for oral health problems. According to TDSHS, school-based oral health clinics facilitate collection of data about the oral health of school-aged children. School-based clinics also serve as sites for the TDSHS Sealant Program, which furnishes sealants for children to prevent the development of dental decay on the chewing surfaces, where 80 percent of all cavities occur.¹⁶⁴ In TDSHS Region 8, approximately 1,200 eligible children receive preventive dental sealants each year.¹⁶⁵

Charitable Care

Local dental societies and other organizations operate a variety of ongoing and one-day programs to provide dental care to indigent residents of the Border region. In El Paso, the El Paso District Dental Society has been active in initiating several programs for the city's indigent. These include the El Paso Coalition for the Homeless, where over 35 El Paso dentists volunteer to provide comprehensive dental care for needy patients.¹⁶⁶

Dentists Who Care, a charitable program organized in 1996 by the Rio Grande Valley Dental Society, operates a mobile dental van to provide dental examinations. The program provides access to dental care for hundreds of children who fall in the gap between Medicaid and private insurance in South Texas. By 2004, the program had served over 12,200 children and provided \$1.3 million in charitable care.¹⁶⁷ Each November,

reservists from the Texas National Guard and other military units provide free care to indigent residents of remote communities on both sides of the Texas-Mexico border between Del Rio and Presidio. Individual dentists in private practice also provide substantial amounts of care for disadvantaged individuals at no charge or at reduced fees.¹⁶⁸

Access to Dental Care Issues

Like Medicaid programs in most other states, the Texas Medicaid program has a hard time attracting and retaining dentists, resulting in a shortage of providers in some communities. Longstanding problems include low reimbursement rates, with fees often below a dentist's overhead costs, as well as administrative issues, including the burden of dealing with complicated rules and regulations, delays in processing claims or reimbursements, unwarranted or redundant requests for additional documentation, and lost dentist or staff time. Despite these problems, dentists in many communities in the Border region are more likely to participate in the Medicaid program than their counterparts in other parts of the state because of the large number of low-income residents along the Border. While this fact is encouraging, additional Medicaid dentists are still needed in virtually all parts of the Border region.

Legislators and state health and human service officials are well aware of the barriers to greater dentist participation in the Medicaid program and have been working with Medicaid, the Texas Dental Association, and other dental organizations to address those barriers. Remedial efforts to date include simplification of the dental provider enrollment application (reducing it from almost 50 pages to less than 5), increases in reimbursements for dental services, and periodic meetings between state health and human service officials, the Medicaid office, and participating dentists.¹⁶⁹

The Role of Dental Hygienists and Access to Care Along the Border

Dental hygienists are uniquely positioned to help close the gap in dental coverage by providing low cost preventive care and educating this population about the need for prevention. Several innovative projects have already been initiated with great success in the Lower Rio Grande Valley by the dental hygiene program at Texas State Technical College (TSTC) in Harlingen and the Texas Department of Health (TDH). Over the past five years, dental hygiene volunteers, dentists, and students have been providing free dental exams, radiographs, prophylaxes, fluoride, and pit and fissure sealants through the Sealants Across Texas program and the dental hygiene clinic at Texas State Technical College. Over 800 children have received free preventive dental care and have been referred to dentists for restorative dental treatment.¹⁷⁰

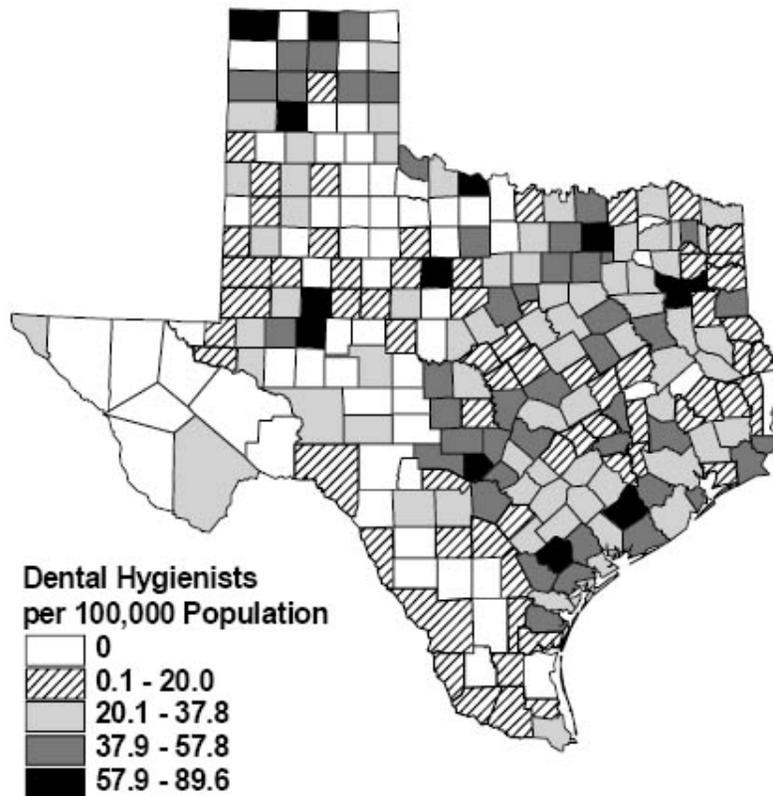
Access to Dental Hygiene Services

Dental hygiene educators have worked hard to meet the growing oral health needs of the citizens of Texas, and those of the Border region in particular. Twenty dental hygiene programs exist in the state, and all continue to take the maximum number of

students their capacity allows. Two dental hygiene programs in the Border region, El Paso Community College and TSTC in Harlingen have graduated dental hygienists at their maximum capacity. From 1992 to 2000, the number of graduates of Texas dental hygiene programs has risen from 250 to 380. In comparison, Texas dental graduates have dropped from 248 in 1992 to 230 in 2000.¹⁷¹

The chart *Dental Hygienists per 100,000 Population* exhibits the ratio of dental hygienists per 100,000 population. The table illustrates that most of the Borderlands counties have low than average numbers of dental hygienists when compared to the state average of 36.6 providers per 100,000 population. Border metro = 28.6, non-Border = 40.8; Border non-metro = 13.7, non-Border = 28.0.¹⁷²

**Dental Hygienists per 100,000 Population
by County of Residence
Texas 2004**



Source: Texas Department of State Health Services

It is surprising that given these statistics, recent graduates of many of the dental hygiene programs are unable to find full-time employment. Regulations that require dental supervision, when a documented shortage of dentists exists, limit the ability of dental hygienists to treat those who need it most. The medical community has been very proactive in utilizing registered nurses to provide low-cost care to a large number of patients. However, many believe that registered dental hygienists are currently underutilized in

addressing the disparities in oral health care in the Border region, and could play a much more active role in improving Border health if regulations were reviewed and potentially lifted.

Texas Borderlands: "Ground Zero of Health Care in America"®

The Texas Borderlands clearly face numerous health-related challenges, many of which are exacerbated by the area's poor access to health care, lack of resources, and dismal health infrastructure. In order to address these problems and ensure a brighter future for the citizens of the Border Region, Texas' state leaders must stop placing the Region behind the rest of the state.

Texas' Health Care: a 50 State Comparison

Measurement	Texas Ranking 50th = lowest, 1st = highest
Percentage of population with health insurance	50th
Percentage of children with health insurance	50th
Percentage of poor covered by Medicaid	44th
Percentage of adults with employer-based health insurance	47th
Number of diabetes deaths per 100,000 population	6th
Teen birth rate per 1,000 population	1st
Percentage of children who are immunized	48th
Obesity rate	3rd
Mental health expenditure per capita	46th
Percentage who visited dentist/dental clinic within past year	47th

Source: The Henry J. Kaiser Family Foundation, Kaiser statehealthfacts.org, Online: www.statehealthfacts.org

This chapter was written in conjunction with Dr. Jacqueline Angel, University of Texas, the Mental Health Association in Texas, the Center for Public Policy Priorities, the Texas Dental Association, Barbara Bennett, C.D.A., R.D.H., M.S., and the El Paso Diabetes Association.

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