Texas Borderlands 2009

Ground Zero of Health Care in America®

Texas Senator Eliot Shapleigh
District 29
El Paso, Texas
February 2008

Table of Contents

Introduction

Residents of the Borderland region face the most dramatic health disparities in America today. The consequences of an international boundary combined with a lack of physical infrastructure, inadequate access to resources, and a poor health care infrastructure have created a health care crisis for the Border region. The health issues analyzed in this chapter—poor access to care, a severe 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 confront Texans living on the Border.

Today, the Texas counties on the U.S.-Mexico border represent the most challenged health care system in the United States. Herein below are key disparities along the U.S.-Mexico Border:

- Of the Texas counties with the ten largest uninsured populations, half of the counties are on the Border (Bexar, El Paso, Hidalgo, Cameron and Nueces counties).

- Of the 43 Border counties, all but one are federally designated medically underserved areas.

- In 2007, metro Border areas had an average of 145.2 direct care physicians per 100,000 residents and non-metro Border areas had an average of 70.7 per 100,000. *Compare these averages with those of non-Border areas: 170.7 physicians per 100,000 in metro areas and 88.7 physicians per 100,000 in non-metro areas.*

- An extreme shortage of dentists exists in the Border region. In 2007, Border metro areas had 15.7 dentists per 100,000 (*versus 41.1 dentists per 100,000 in non-Border metro areas*); Border non-metro areas had 11.8 dentists per 100,000 (*versus 25.2 dentists per 100,000 in non-Border, non-metro areas*).

- Of the Texas counties with highest diabetes prevalence rates (defined as 7.7% or above), all 16 counties are Border counties.

- Adults and children living on the Border who are at risk for mental illness and eligible for mental health care receive significantly less treatment as compared to those in non-Border areas.

- Between 2003 and 2005, seven of the ten counties that had tuberculosis incidence rates at least two times higher than the state average were located in the Border region.

Furthermore, the sharing of an international boundary allows for disease and other chronic illnesses to travel freely across this frontier. Infectious disease rates for several communicable diseases are much higher along the Border than in the rest of the state. Significant threats to Texas health through dengue fever and tuberculosis are getting worse, not better. After several decades of no cases of dengue and hemorrhagic fever, this disease is

increasingly affecting U.S. individuals, particularly on the Texas-Mexico border. Texas has the fourth highest tuberculosis infection rate, with 7.4 infections per 100,000 residents. The Border region has a rate of 9.0, and if it were the "51st state", it would have the highest rate in the country. Finally, hepatitis A is also more prevalent; Texas has 2.8 infections per 100,000 residents, while the Border has 3.5.

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 many health-related issues, the Texas Borderlands are the "Ground Zero of Health Care in America."®

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

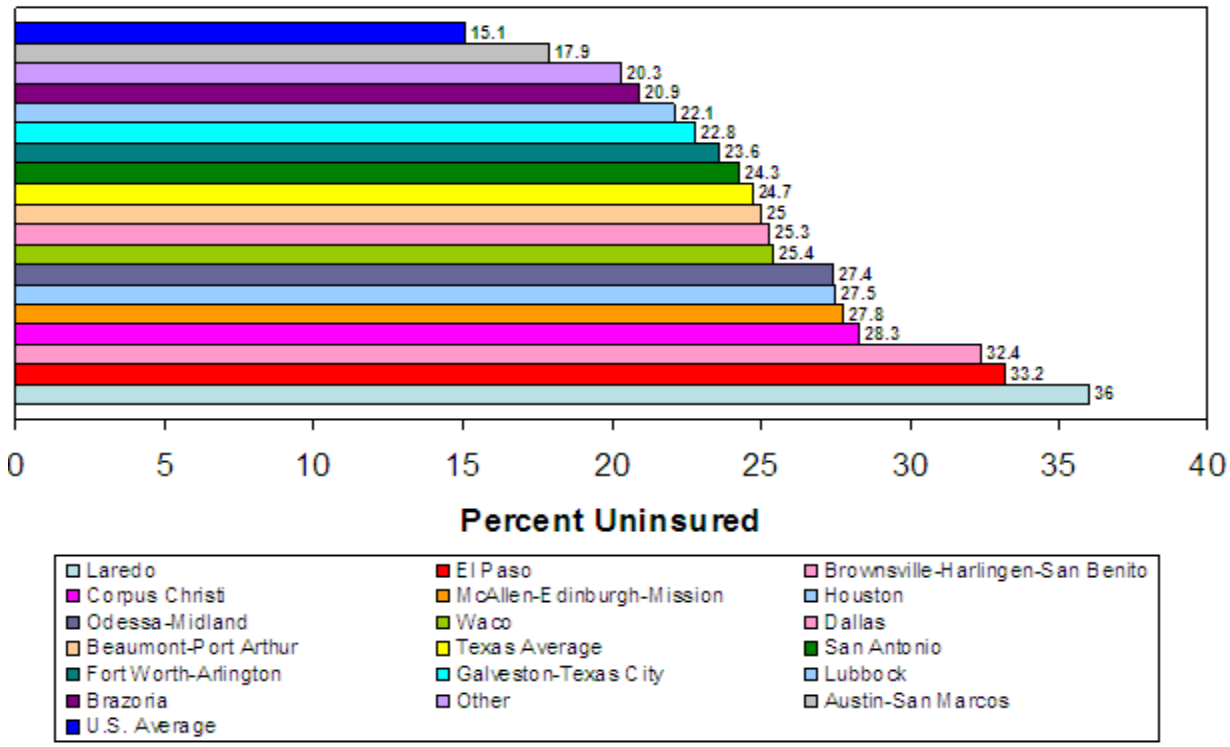
Source: The Henry J. Kaiser Family Foundation, Kaiser statehealthfacts.org Available at: www.statehealthfacts.org

The Texas Borderlands: Ground Zero of the Uninsured

The Uninsured in Texas

U.S. Census Bureau data show that Texas leads the nation in the number of citizens without health insurance. In 2006, one out of every four Texans was uninsured.[1] In fact, no Texas city—not Dallas, Houston or even Austin—reaches the national average for people with health insurance. As the chart below shows, the most uninsured Texas cities are all in the Border region with rates of 36% in Laredo, 33.2% in El Paso, 32.4% in Brownsville/Harlingen/San Benito, 28.3% in Corpus Christi, and 27.8% in McAllen/Edinburgh/Mission.

No Texas City Reaches National Average



Source: The Uninsured, Texas State Comptroller's Office, April 2005.

Many factors contribute to this alarming statistic, perhaps the most important of which is the fact that in large areas of Texas, the jobs available to low-wage workers do not offer full family health insurance coverage.[2-3] Another contributing factor is that for those who are employed, union membership is low. Back in 1993, right-to-work labor laws were enacted to favor owners over workers. So unlike workers in California and many states in the Midwest and East, Texas workers do not have union protections on health contracts and have limited ability to organize and demand such coverage.

Unlike most of the developed world, the majority of U.S. citizens depend on job-related health insurance.[4] Employment problems, then, translate directly into health insurance problems. Low wage jobs in the restaurant, hotel, janitorial, and other service industries often do not offer health insurance. Even when employers offer coverage, the premiums an employee must pay to cover themselves and their family make insurance an unrealistic luxury. The Hispanic 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 often receive minimum pay and no benefits.[5]

Although Americans pay more for health care, we do not receive better or more health services.[6] Recent studies have shown that Americans pay more for health care primarily because of higher charges for health care services including hospital stays, doctor's visits and

pharmaceuticals.[7] Another reason that U.S. health care costs have increased at a staggering rate is the proportion of health care dollars spent on administrative costs. In 2005, the U.S. spent $98 billion on administrative costs. Of the $84 billion associated with private payers, 64% was attributable to administrative costs of underwriting risks, sales and marketing. Notably, this number does not include the administrative costs associated with denial management. Public programs, however, do not incur these administrative costs. In fact, administrative costs only account for 3-5% of the Medicaid budget and 3% of the Medicare budget.[8]

Although the Texas Border is one of the poorest areas in the nation, Border hospitals charge some of the highest rates for services. Of the top 100 most expensive hospitals in the U.S., three operate in the Border region. In fiscal year 2003-2004, Brownsville Medical Center (Brownsville, TX) was #8 on the list, Sierra Medical Center (El Paso, TX) was #37, and Providence Memorial Hospital (El Paso, TX) was #46. These hospitals' total charges as a percent of total costs were 813.57%, 698%, and 675%. The national average total charge to cost ratio for the 4,292 hospitals studied is 205.84%.[9]

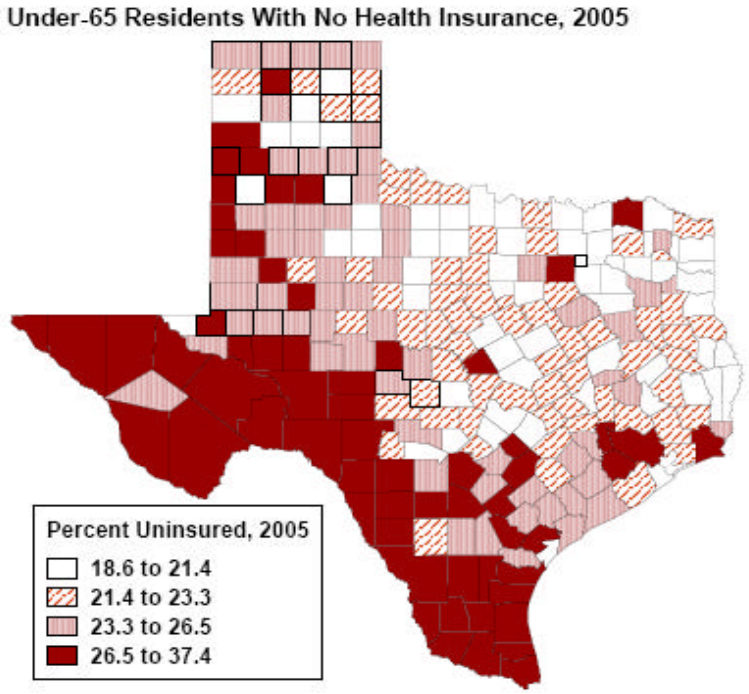
Texas families face both financial and non-financial barriers to obtaining health insurance. Due to the rising costs of health care, the number of employers who offer health care coverage is dwindling. There are several additional factors that limit access to private or employer-sponsored insurance, including high costs, pre-existing conditions, lack of job tenure, a part-time schedule, and employment in jobs that do not offer health insurance or only do so at a prohibitive cost to the employee.[10] Fewer Texans receive insurance through their employer than in other parts of the nation. Nationally, about 60 percent of citizens have insurance through employers. In Texas, 52.2 percent of residents have employer-sponsored insurance coverage. In 2006, only four states (Arkansas, Louisiana, Mississippi, and New Mexico) had lower rates than Texas.[11] Even when Texans are offered employer-sponsored health insurance, the average premium an employee must pay to cover their family is higher than the national average.[12] Premiums are even higher for workers employed by small businesses. The average premium was $4,608 for an employee in a firm with fewer than 10 employees in 2005, and $4,065 for firms with more than 50 employees, a difference of $543 per year per employee.[13]

In addition to high premiums and high hospital charges for services, providers in the Border region receive lower reimbursement rates for services. All of these factors place extraordinary stress on the economic foundation of health care, thereby creating a vicious cycle. When payments to providers are reduced, providers start raising their gross charges. In response, insurance companies raise their premiums, and inevitably, the health care costs of providing insurance increase. This, in turn, allows fewer and fewer individuals to be able to afford health care coverage.

Another contributing factor is that Texas' large Hispanic population has one of the lowest rates of insurance coverage in the country.[14] 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.[15] This unique combination of factors 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.

Other barriers include factors that limit access to public insurance, such as complicated application and renewal procedures, assets tests, inadequate outreach efforts by agencies charged with administering health-related programs, and coverage for only the poorest of the poor. For example, in 2007, a working parent of two had to make less than $3,696 per year [22.3 percent of the federal poverty level (FPL)] to qualify for Medicaid in Texas.[16]

The chart *Under-65 Residents with No Health Insurance, 2005* shows that the bulk of uninsured residents live on the Border.



Source: Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

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 Texas. In 2004, one in five Texans admitted that in the past year they needed to see a doctor but did not because of the high cost.[17] Individuals close to the poverty threshold, who are for the most part the working poor, are at particularly high risk of lacking coverage. In Texas, 35 percent of people with an annual income between $10,000 and $15,000 are uninsured—a much higher rate than any other income range in the state.[18] Almost half the children in Texas are covered by employment-based insurance through a family member. Another quarter are covered through public programs such as Medicaid and the Children's Health Insurance Program (CHIP). The remaining quarter of the population of Texas children are uninsured.[19]

These children living without coverage are less likely to receive needed medical care including preventative care, vaccinations, dental screenings, and access to mental health services.[20] Uninsured children are at risk for missed diagnoses of serious illnesses and hospitalizations for preventable conditions.[21] They are more likely to be hospitalized for asthma

attacks and ear infections.[22] These conditions, if left untreated, can lead to serious health problems and even death.[23] Although some inequalities 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. Only half of children living below the FPL visited a dentist in the past year compared to almost three-fourths of children above the FPL.[24]

Because they are less likely to have a regular source of care, uninsured individuals are more likely to use the emergency rooms, community and migrant health centers, and other publicly-funded health facilities as their primary source of health care. One in every five uninsured individuals uses the emergency room regularly, compared to 3 percent of insured individuals.[25] 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.[26] The lack of a stable, consistent source of care places uninsured individuals at a high risk of being diagnosed in later stages of disease, which leads to a higher mortality rate than that of insured individuals.[27]

Uninsured Along the Border

In Texas, 35 of the state's 254 counties account for 80 percent of the state's uninsured.[28] The table *Texas Counties with the Ten Largest Uninsured Populations* shows that half of the ten counties with the highest number of uninsured are on the Border. In the half of the counties that are not on the Border, the largest population of uninsured is Hispanic.

Texas Counties with the Ten Largest Uninsured Populations

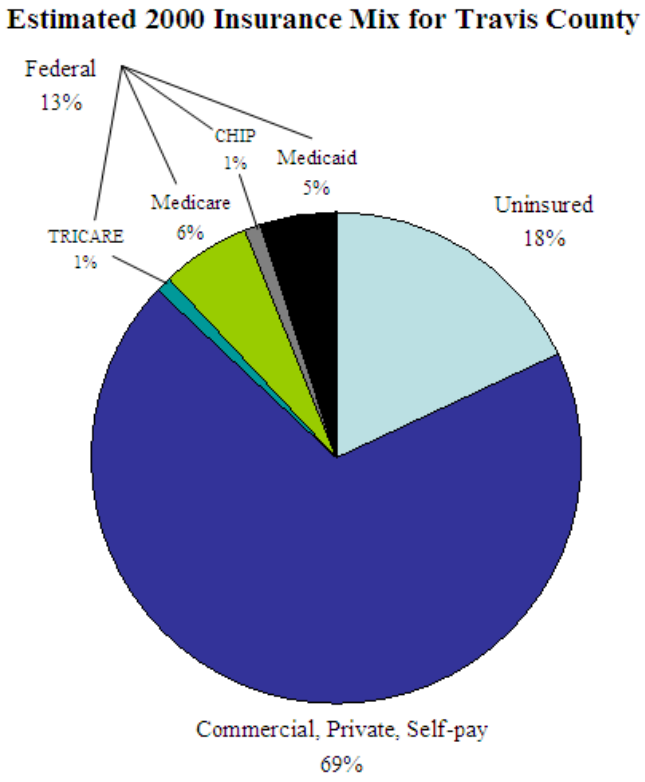
County Name	Uninsured Population	% of Statewide Total
Harris	812,628	17.2
Dallas	499,970	10.6
***Bexar**	349,043	7.4
Tarrant	325,556	6.9
***El Paso**	231,534	4.9
***Hidalgo**	173,769	3.7
Travis	147,461	3.1
***Cameron**	103,474	2.2
Denton	81,413	1.7
***Nueces**	79,930	1.7
All Other	1,907,434	40.5

*Counties in the Border Region

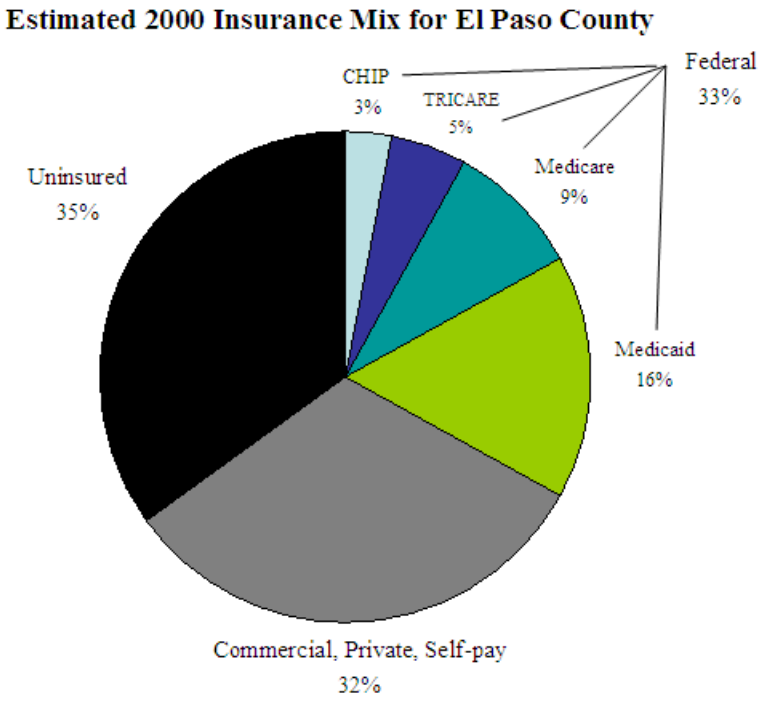
Source: Task Force on Access to Health Care in Texas, Code Red: The Critical Condition of Health in Texas, 2006, Online: http://www.coderedtexas.org/files/Report_Chapter02.pdf

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."[29]



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

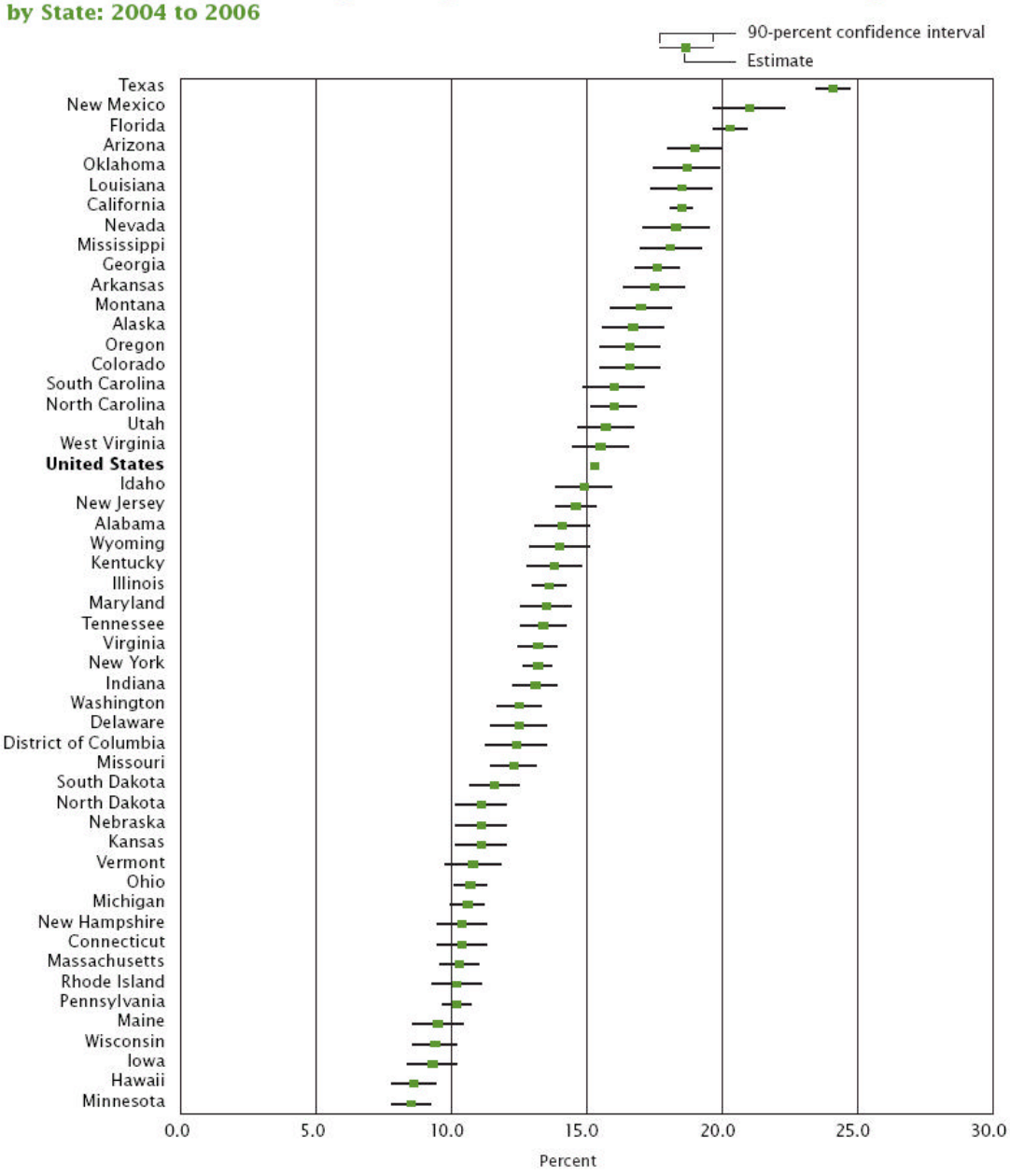


Source: Community Scholars, El Paso, Texas www.communityscholars.org

Demographic Profile of the Uninsured

Texas has more uninsured residents than any other state, averaging 24.1 percent between 2004 and 2006.[30] During the same time period, however, only 15.3 percent of the entire United States was uninsured.[31] Indeed, as the chart *Three-Year Average Percentage of People Without Health Insurance Coverage by State: 2004 to 2006* shows, Texas had the highest percentage of uninsured residents.

Three-Year Average Percentage of People Without Health Insurance Coverage by State: 2004 to 2006

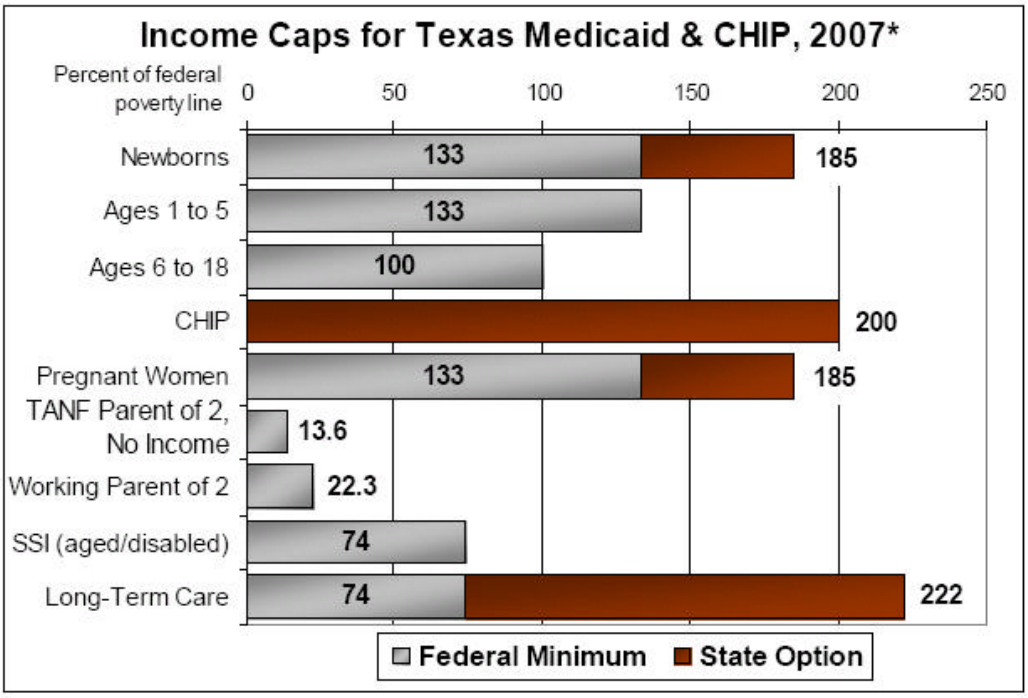


Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

Age

Among the total population of Texans, adults 18-24 years old were less likely to have health insurance than other age groups; only 59.2 percent of adults in this age bracket had health insurance for all or part of 2006.[32] Because of Medicare, almost all Texas residents over 65 had health insurance—97 percent had coverage of some kind.[33] Over 20 percent of Texas children do not have any health insurance. Children from birth to 5 years are slightly less likely to have coverage than children who are between 6 and 17 years old.[34]

More children are living without health insurance in Texas now than in previous years. In fact, there are 62,000 more uninsured children living in the state today than there were in 2002.[35] Over the same time period, the number of children living below the FPL increased from 1,318,889 to 1,435,607.[36] The poorest Texas families can qualify for government insurance programs such as Medicaid and CHIP. However, a gap exists between the income cap for program eligibility and minimum income necessary to obtain private insurance.[37] The chart *Income Caps for Texas Medicaid & CHIP, 2007* details the maximum amount of money a family of three can make and still be eligible for Medicaid and CHIP. For reference, in 2006, the FPL for a family of three was set at $17,170.



*Annual income limit is for a family of three for child and parent categories. For SSI and Long-Term Care, income cap is for one person.
Source: Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007,* Center for Public Policy Priorities, November 2007.

Race

Underrepresented minorities are more likely to live without health insurance than other groups. Within the United States, Hispanic people have much higher rates of being uninsured than non-Hispanics. 34.1 percent of Hispanics are uninsured while 12.6 percent of non-Hispanics are uninsured. The difference between these groups is larger when just looking at Texans. Almost 40 percent of Hispanic Texans do not have health insurance. For non-Hispanics, the rate was only slightly higher than the national average with 15.9 percent of non-Hispanic Texans living without insurance in 2006.[38] Hispanic adults, especially immigrants, are over-represented in the service sector. They are usually not offered employer-sponsored health insurance or the costs of premiums required for individual or family coverage place such

coverage out of reach. The chart *Uninsured Texas Population by Race or Ethnicity: 2006* shows that Hispanics are disproportionately uninsured compared to other minorities.

Uninsured Texas Population by Race or Ethnicity: 2006

Race/ Ethnicity	Number Insured	Number Uninsured	Percent Uninsured within Race/ Ethnicity Category	Percent of Total Uninsured
Anglo/Other	10,302,329	1,690,183	15.3	31
African American	1,986,365	622,560	23.9	11
Hispanic	5,194,378	3,172,434	37.9	58
Total	17,483,072	5,485,177	23.9	100

Source: Texas: Distribution of Non-elderly Uninsured by Race/Ethnicity (2006), Kaiser Family Foundation, available at Statehealthfacts.org.

Hispanic workers are less likely to get health benefits through their job, even though their employment rates are similar to those of whites. Hispanics are much more likely to have jobs in companies that do not offer employment-based coverage.[39] Often these are small companies with fewer than 25 employees, including retail stores, restaurants, and construction firms. Because of the rising costs of health care, small companies are unable to compete in the market when they offer health insurance to their employees. Gaps in health coverage or a complete lack of health insurance can have devastating health consequences.

Hispanics are less likely than other racial or ethnic groups to have a regular doctor, regardless of whether they have insurance. Without a regular doctor, an individual is less likely to have preventative care such as blood pressure and cholesterol screenings. Those without a regular doctor are less confident in their ability to manage chronic conditions.[40] One report found that Hispanics utilize ten different preventative services less than other ethnic groups. These services included colorectal cancer screening, assistance from a health professional to quit smoking, and being vaccinated against pneumococcal disease.[41]

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. Employment-based health insurance premiums could be 15 percent lower if there were no uncompensated costs for uninsured Texans' health care.[42] In 2005, $10.2 billion was spent on uncompensated care in Texas. Due to the high cost of providing uncompensated care, the normal health care premium is $805 more than the national average.[43]

Contrary to popular belief, Hispanics are less likely than other ethnic groups to get health insurance through a welfare program. Only 15 percent of Hispanics were insured through a public program compared to 21 percent of white citizens and 32 percent of African Americans.[44] Salvador Gomez, the Board Chairman of the Colorado Hispanic Chamber of Commerce explained these 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."[45]

Immigration Status

In 2006, almost two million Texas immigrants lacked health insurance. The proportion of the foreign-born population without health insurance—53.1 percent—was more than double the rate of the native population. Additionally, 26 percent of the uninsured are non-citizens, which include legal and undocumented residents.[46] Nationally, foreign-born residents are twice as likely to be uninsured and non-citizens are three times as likely.[47]

Income Level

A direct relationship exists between income level and health insurance coverage. Individuals with income levels below 200 percent of the FPL, or an annual income of $34,340 for a family of three, are almost three times more likely to be uninsured than individuals making more than 200 percent of the FPL.[48] Further, 31.6 percent of Americans below the FPL ($17,170 per year for a family of three) were uninsured during some part of 2006, compared with 6.7 percent of those at 400 percent of the FPL ($68,680 per year for a family of three).[49]

Employment

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.[50] But having a job, even a well-paying one, does not guarantee health insurance coverage. In fact, nationally, 20 percent of individuals working full-time with incomes from 200 to 400 percent of the FPL ($34,340 to $68,680 per year for a family of three) were still uninsured.[51] In Texas, 74 percent of the uninsured either worked full- or part-time during 2006 or were not of working age (under 15 years old).[52] Many jobs simply do not offer health insurance or only offer it at a level where the employee's contribution proves too expensive.

The Texas economy relies heavily on small businesses; 73 percent of all businesses in the state have fewer than 50 employees. However, only 37 percent of these small businesses offer health insurance. In contrast, nationally, about 61 percent of employees working for small businesses were at companies that offered health insurance in 2003—almost twice the state rate.[53] In addition, only 65 percent of employees working in small businesses offering coverage enrolled in the employer-sponsored program.[54]

Barriers to Health Insurance for Families in the United States

One of the major reasons for the large number of uninsured children is the fact that many children in low income families are not enrolled in public programs for which they are eligible. The Congressional Budget Office has stated that between 5 and 6 million children in the country who are eligible for either Medicaid or SCHIP (the federal version of Texas' CHIP) are not enrolled.[55] There are several factors that contribute to the high number of eligible, but unenrolled children. One of the major barriers preventing enrollment in public programs is a lack of accurate information about Medicaid and SCHIP. Another factor is a long and complicated application process. Studies have indicated that children in Hispanic families must

deal with additional barriers when enrolling in public insurance programs.[56] This combined with the large Hispanic population in Texas could be a reason for the high rates of uninsured children in the state.

Texas' dubious distinction of leading the nation in uninsured children and adults results from a number of barriers to coverage that presents the state with serious challenges. Further, 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 restricted labor markets and high rates of unemployment further compound demographic and labor supply problems. 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.[57] In December 2005, a waiver was submitted to the U.S. Health and Human Services Center for Medicare and Medicaid Services for approval to use federal funds for the program. In May 2007, the Galveston Three-Share waiver was modified into a statewide waiver. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) declined the waiver on January 31, 2008. CMS denied the waiver because it would have used CHIP monies to partially fund the program; CMS wants all CHIP monies directed towards insuring lower income children. However, HHSC will incorporate three-share programs into the Texas Medicaid Reform waiver, which uses a different federal funding stream.

State Universal Health Care Initiatives

To solve the problem of Texas' high rates of uninsured, state leaders often have to look to other states. As of January 2008, eight states had enacted or announced universal health care plans. Once fully implemented, programs in Vermont, Massachusetts and Maine aim to cover all residents, while plans in Hawaii, Illinois, Pennsylvania, Washington, and Wisconsin will provide coverage to all children.[58] Fourteen other states and the District of Columbia have passed legislation that would increase the availability of coverage for children.[59]

In July 2006, Illinois implemented the All Kids program, the first children's universal coverage program in the country. Using state funds exclusively, all uninsured children in the state are eligible for coverage without regard to income, health status, or citizenship. Between July 2006 and April 2007, 50,000 previously uninsured children were enrolled in the All Kids program.[60]

By passing the Dirigo Health Reform Act in 2003, Maine hoped to make health coverage affordable to every citizen by 2009. Two initiatives were included in the plan. Beginning in

January 2005, the DirigoChoice program offers subsidized insurance for small businesses, self-employed workers, and individuals. The second initiative expanded the state's Medicaid program to include more low-income parents.[61] By September 2006, 11,100 individuals and 700 small businesses were enrolled in the DirigoChoice program and 5,000 additional low-income parents had insurance through Medicaid.[62]

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, thereby perpetuating a provider shortage.[63] As a consequence, there is 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.[64]

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 Organization (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, which have always had disproportionately low Medicaid expenditures per capita, find themselves in a difficult situation. To achieve higher capitation rates, they must spend 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. All of these factors negatively impact Medicaid recipients' access to services.

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

Despite the health crisis and significant health disparities on the Border, and the fact that Texas already trails other states in the allocation of health care resources, lawmakers still made inhumane health and human service budget cuts during the 78th Legislature. Texas shortchanged 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 health care coverage for 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.[65]

Based strictly on the dollar amount being appropriated to them, some health care programs actually received an increase from their 2002-2003 funding levels. 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.[66]

House Bill (HB) 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 CHIP. Additionally, it oversees the four other health and human services departments:

- **The Department of Family and Protective Services** includes the programs previously administered by the Department of Protective and Regulatory Services. DFPS began services February 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 the Interagency Council on Early Childhood Intervention. DARS began services on 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 began services on September 1, 2004.

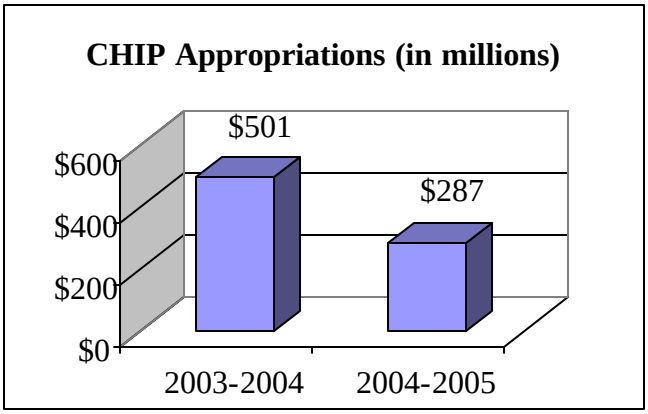
- **The Department of State Health Services** includes the programs provided by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, and the Health Care Information Council, plus mental health community services and state hospital programs operated by the Department of Mental Health and Mental Retardation. DSHS began services on September 1, 2004.

Under the previous 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). HB 2292, however, mandated the use of call centers to determine eligibility for the major health and human services programs, including Medicaid, CHIP, the Food Stamp program, 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

As the chart *CHIP Appropriations (in millions)* shows, the legislative budget cuts reduced CHIP appropriations by 43 percent. The program's budget was $501 million during 2003-2004 and only $287 million in 2004-2005. Program changes also led to stricter eligibility policies, fewer benefits, higher co-pays and premiums, and a 90-day waiting period.[67] These inhumane cuts were made when Texas was already ranked 50th in the percentage of children who have health insurance.[68]



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 had far-reaching ramifications that left many citizens out in the proverbial cold, with no benefits.[69] In 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, enrollment was expected to shrink by 4,000 in 2005.[70] However, if the eligibility policies been left untouched, 350,000 additional Texas children and adults could have potentially been covered by Medicaid.[71]

These cuts also severely affected low-income pregnant women. Medicaid can be used for prenatal care, delivery, and postpartum care for 60 days after delivery. Due to the budget reductions almost 13,000 women were no longer eligible for services. This translates to a loss of approximately $110 million in reimbursement for health care providers in Texas over a two-year budget cycle, and fewer women that could access quality prenatal care.[72]

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 at the local level, for families and in emergency rooms.[73]

Cuts in Texas' Temporary Assistance for Needy Families

Other worthy programs were also reduced through stricter eligibility requirements. TANF is a program that provides cash assistance on a monthly basis for poor Texas families with children under the age of 18. After the 78th Legislative Session, a family of three (mother and two children) could qualify for TANF if their gross income was below $784 a month and their assets were valued at less than $1,000. On September 1, 2003, more than 19,000 adults and 41,000 children in Texas lost all their TANF benefits because of a new full-family sanction policy. This also caused most adults receiving TANF to lose their Medicaid benefits. The state predicted that 75 percent of those who lost assistance were children.[74]

The new legislation that was enacted wiped out coverage for such basic necessities as eyeglasses and hearing aids for adults on Medicaid.[75] 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.[76] Further, the state chose not to maximize its federal matching dollars requested by the HHSC, leaving approximately $1.6 billion in federal Medicaid and CHIP funding "on the table"—$1.6 billion that could have gone toward providing health care to Texans.[77]

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 these programs the most contradicts the 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. In addition, costs passed onto 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. 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.

However, many of the cuts from the previous session remained. 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.[78] The changes made during the 78th Legislative Session that remained include:

- children are only covered for a six month period, not a full year;
- upon initial enrollment, 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 FPL;
- a 2.5 percent cut in the reimbursement rate for CHIP medical providers; and
- a reduction in outreach and marketing funds.[79]

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 general revenue allocation was reduced by $60.0 million for CHIP.[80]

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 coverage for eyeglasses, hearing aids, mental health professional services, and chiropractic and podiatry care for all 863,000 adult Medicaid clients, 78 percent of whom were aged or disabled.[81] Total Medicaid funding was increased by $1.8 billion over the 2006-2007 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.[82] Further, Medicaid provider rates were not increased back to the 2003 levels.[83]

Impact of Spring 2006 Special Session

Unfortunately, Texas' most vulnerable citizens were once again forced to bear the brunt of enormous budget cuts. A 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 during the special session will create an enormous budget deficit and its effects will be felt throughout the state for the foreseeable future. HB 1, the bill designed to cut property taxes, created a huge hole in the state budget that has to be made up somewhere. House Bills 3, 4 and 5 were 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 taxes 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 business taxes will grow from a base of roughly $3.5 billion to replace the property tax cut base of $6.5 billion. Estimations based on

calculations from data provided by the Legislative Budget Board show that Perry's Tax Plan is $2.31 billion short for 2007 and $2.62 billion short for 2008.[84] And, since the constitution requires Texas to balance the books, tax cuts from the special session will mean budget cuts in the future. This will force a 16 percent spending cut in the 2008-2009 budget.[85]

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 House Bills 1, 3, 4 & 5.*

Fiscal Impact of House Bills 1, 3, 4 & 5

	HB 1	HB 3 business tax	HB 4 used cars tax	HB 5 cigarette tax	Net Shortfall
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.

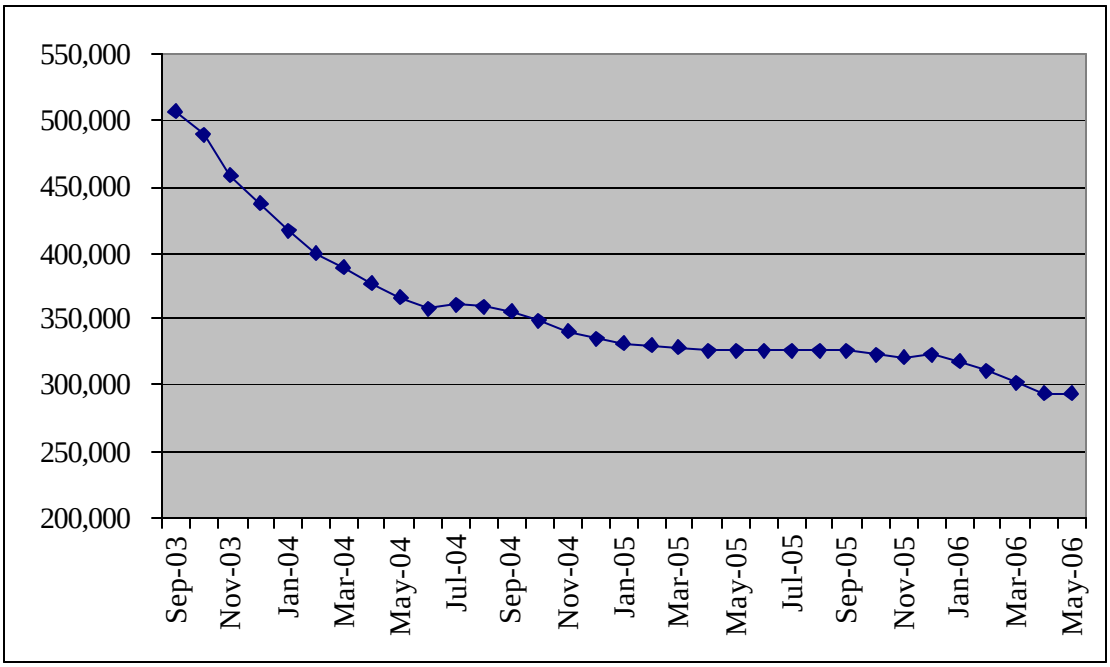
Privatization of Enrollment and Eligibility Services: The Health Care Equivalent of Hurricane Katrina

HB 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, the food stamp program, and TANF.[86]

In November 2005, the Texas Access Alliance (TAA), a consortium of companies led by Bermuda-based Accenture LLP, began processing statewide applications for CHIP and children's Medicaid. In January 2006, 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.[87]

Between November 2005 and May 2006 almost 30,000 children were dropped from the CHIP rolls. In April 2006, enrollment dropped by nearly 10,000 children, bringing the total enrollment to 292,681—the lowest point in five years. Astoundingly, enrollment numbers for May 2006 indicated more than 28,000 clients were declined in that month alone. HHSC responded to the alarming drop by granting a reprieve to more than 28,000 children that would have lost coverage in May.[88] This was 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 were dropped from CHIP between November 2005 and April 2006. In addition, more than 2,700 additional CHIP clients in El Paso would have been disenrolled as of April 30, 2006 had HHSC not intervened.[89] In El Paso, which is the most uninsured large city in the nation, this is especially intolerable.[90]

The Commissioner of HHSC, Albert Hawkins, announced in April 2006 that HHSC was going to temporarily stop the roll-out of the new privatized system, citing the need for technical and operational improvements.[91]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.[92]

In March 2007, the HHSC announced the termination of the contract with Accenture. However, the contract did not officially end until November 2007.[93] HHSC is currently implementing a "transition plan," which once completed is intended to create an enhanced eligibility system. According to HHSC, the final request for proposal was released in January 2008 and a contract is expected to be awarded by September 2008.[94] It is unclear whether awarding a new contract to a different company will have any impact on the backlog problem.

Policy Changes During the 80th Legislature

During the 2007 Legislative Session changes were made to both Medicaid and CHIP programs. If properly implemented, some of the modifications will lead to an increase in service delivery and a simplified enrollment process. However, there is still work to be done to insure that all of Texas' children in low-income families can consistently access quality health care.

Further Restoration of CHIP

A $1 billion increase in funding was approved by the 80th Legislature, thereby bringing the total amount of funding available for CHIP to $2 billion. Some of the additional funding will be allocated to prenatal services, which will allow more women and newborns to be covered under CHIP.[95] This legislation further restores some of the cuts made during the 78th Legislative Session.

Several other changes made to CHIP regulations are expected to increase enrollment by almost 130,000 children. HB 109 eliminated several barriers put in place by the 78th Legislature. This piece of legislation eliminated the 90-day waiting period, restored CHIP enrollment from six months to one year, allows parents to deduct child care expenses when calculating income, and increases the limit for the assets test.[96] Again, these policy modifications return CHIP guidelines to their pre-78th Legislative Session status. However, one important change is that HB 109 places the assets test into statute whereas the act of the 78th Legislature allowed HHSC to use an assets test to determine eligibility, but did not require it.

Medicaid Reform

In the 2007 Legislative Session Senate Bill (SB) 10 was passed with the hope that it will lead to comprehensive reform of the Medicaid program in Texas. The goal is to "optimize investment in health care to ensure more efficient use of available funding and best health outcomes for Texans."[97] This is expected to be achieved through the protection and optimization of Medicaid funding, reduction in the number of uninsured Texans, a focus on keeping Texans healthy, and the establishment of infrastructure to facilitate accomplishment of reform goals.[98]

Even though a reform bill passed during the 80th Legislative Session, it is expected that more reform legislation will be passed in the future to achieve the goals of SB 10. However, SB 10 starts the process through several initiatives:

- The Texas Health Opportunity Pool Trust Fund will be established to provide premium subsidies to eligible Texans. It will also be available to offset uncompensated costs when providers use innovative measures to provide primary and preventative care.

- Implementing pilot programs such as positive incentives for healthy lifestyles, health savings accounts, and an incentive program to encourage routine health care visits in the hopes that they will increase consumer choice and responsibility as well as improve health outcomes.

- The Medicaid Health Insurance Premium Payment reimbursement program is intended to increase employment-based insurance options. In some cases, individuals will be able to opt out of Medicaid in favor of an employer-sponsored insurance program.

- Supporting the use and development of electronic health care information standards and records to increase efficiency and quality of patient care.

- If enrolled in college, former foster care children remain eligible for Medicaid until their 23rd birthday.

- Increasing the quality and efficiency while reducing the costs of providing care to children with special health care needs by using tailored benefits packages.

- Supporting the proper utilization of emergency services by implementing cost sharing for improper use of these services.

- Increase access to appropriate health care services by using outcome-based performance measures in health maintenance organization contracts.[99]

How is the latest attempt at Medicaid reform really going to affect Texans' health? The full impact of this legislation has yet to be seen as most of the initiatives are not scheduled for implementation until 2009.[100] In December of 2007, HHSC submitted a Medicaid 1115 waiver request to the U.S. Health and Human Services Center for Medicare and Medicaid Services for approval to secure federal funding. Many of the plan's details are still quite vague and many unanswered questions remain such as:

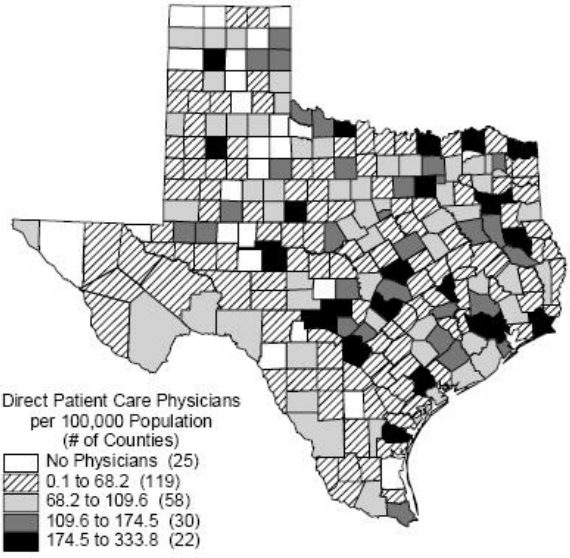
- How will the current social safety net be affected? In particular, public hospitals that currently serve as the safety net for their respective communities?
- Will the minimum standard for health benefits be adequate?
- Will all income levels be able to afford coverage including those whose income is below 100% of the FPL?
- Will it provide sufficient care to those with a higher level of need such as those with acute chronic conditions? The benefits plans proposed to date do not provide catastrophic coverage.
- Will access and availability be the same for all populations throughout the state?
- How will the lack of provider capacity be addressed?
- Will the scale of the program be large enough to meet the needs of most uninsured Texans?[101]
- Will the new plan infringe on enrollee's rights and protections?[102]

Limited Number of Health Care Providers

There is a strong need for physicians in Texas across the state—119 counties are designated as Health Professional Shortage Areas (HPSAs). Another 68 counties have an HPSA designation for part of the county or for a special population in the county. Only 67 counties do not have the HPSA designation.[103]

The chart, *Direct Care Physicians per 100,000 in Texas, 2007,* highlights the fact that physicians are not evenly distributed among the regions of Texas. Metropolitan Border areas had an average of 145.2 physicians per 100,000 residents, non-metropolitan Border areas averaged even less, with only 70.7 per 100,000. Non-border areas have a much higher ratio of physicians with 170.7 per 100,000 in metropolitan areas and 88.7 per 100,000 in non-metropolitan areas.[104]

Direct Care Physicians per 100,000, 2007



Source: Texas Medical Board
Produced By: Health Professions Resource Center, Center for Health Statistics, Texas Department of State Health Services

The shortage of health professionals extends to many other disciplines. The Border counties are also considered medically underserved areas because of the lack of pharmacists, nurses, physician's assistants, dentists, and dental hygienists.[105]

The Texas population has grown from 14.7 million in 1981 to over 23.9 million in 2007.[106] By 2030, the population of Texas will grow to more than 33 million.[107] 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.[108]

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 apparent in the Border Region. These challenges include obesity, mental health, infectious diseases, hunger, and oral health. Each of these issues will be examined in turn.

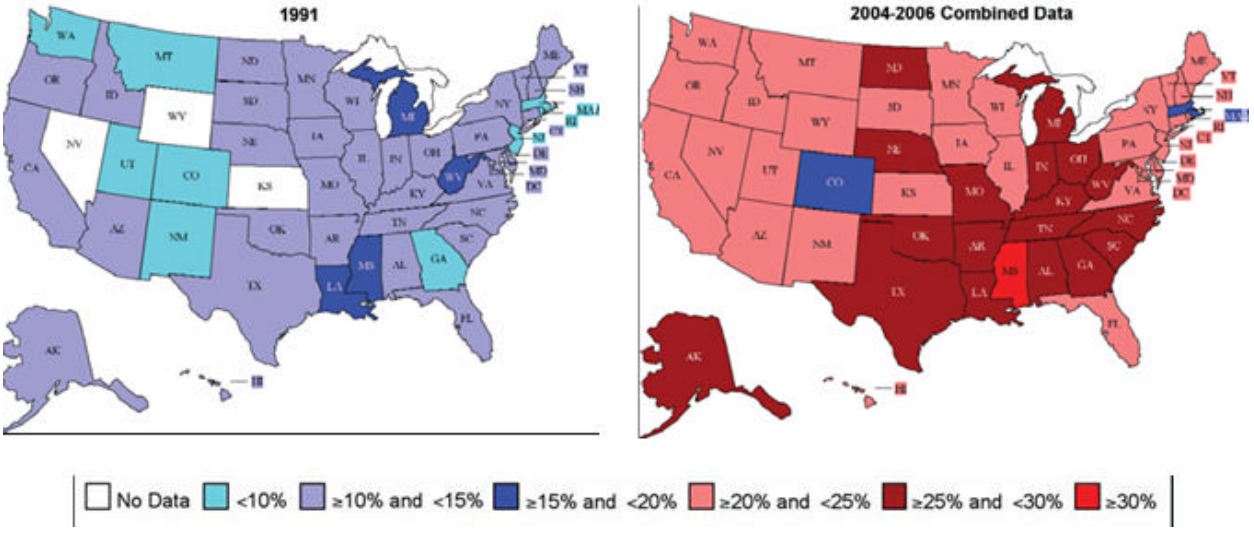
The Obesity Epidemic on the Border

The prevalence of obesity is developing into a nationwide health crisis. Since 1980 the rate of obesity in the United States has more than doubled, increasing from 15 percent to almost 33 percent.[109] Obesity is one of the leading causes of preventable death in the United States.

The Centers for Disease Control and Prevention (CDC) estimates that as many as 112,000 Americans die each year due to an obesity-related cause.[110] 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 $78.5 billion each year.[111]

The obesity problem is particularly serious in Texas, 64 percent of residents are either overweight or obese.[112] As the chart *Number of Obese Texans Has Doubled Since 1991* shows, there was a 119.5 percent increase in the number of obese Texans from 1991 to 2006.

Number of Obese Texans Has Doubled Since 1991

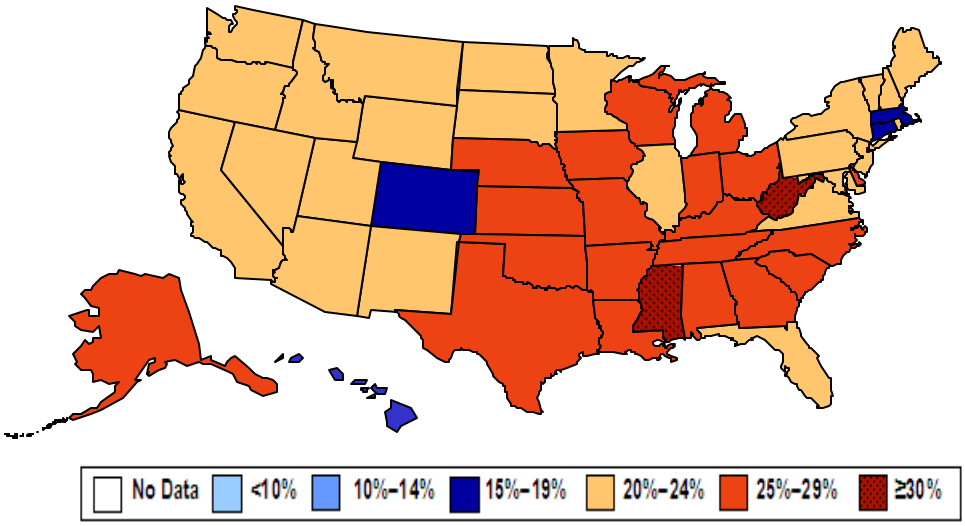


Source: F as in Fat: How Obesity Policies are Failing in America (2007), Trust for America's Health (data from Behavioral Risk Factor Surveillance System, Centers for Disease Control & Prevention).

State health officials estimate that the direct and indirect costs of obesity in Texas are more than $3 billion annually.[113] The problem will continue to accelerate rapidly if not addressed, and costs to the state could potentially rise to $15.8 billion a year by 2025 if no action is taken.[114] The chart *Obesity Trends Among U.S. Adults* shows that Texas has one of the highest rates of obesity in the country.

***Obesity Trends* Among U.S. Adults*, BRFSS (2006)**

(*BMI = 30 or ~ 30 lbs. overweight for 5' 4" person)



Generally, the Border has higher rates of obesity when 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, such as heart disease, in the United States. CDC data indicates that 73 percent of Mexican-Americans are overweight, compared to 62 percent of non-Hispanic Whites.[115] Results from a survey coordinated by the Paso del Norte Health Foundation showed that the proportion of overweight individuals is higher in El Paso than it is for Texas as a whole. Also, more than half of El Paso's population between the age of 45 and 64 are overweight.[116]

What is Obesity?

According to health agencies obesity is a complex chronic disease caused by genetic, environmental, and behavioral factors. Health officials measure obesity using a formula called Body Mass Index (BMI) that compares weight and height. People with a BMI score over 30 are considered obese, and those with a BMI score between 25 and 30 are considered overweight.[117]

People with obesity are significantly more likely to suffer from conditions such as hypertension, osteoarthritis, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea, breathing problems, and even some forms of cancer.[118] The chart *Increased Risk of Obesity-Related Diseases with Higher BMI* illustrates the serious consequences of obesity.

Increased Risk of Obesity-Related Diseases with Higher BMI				
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

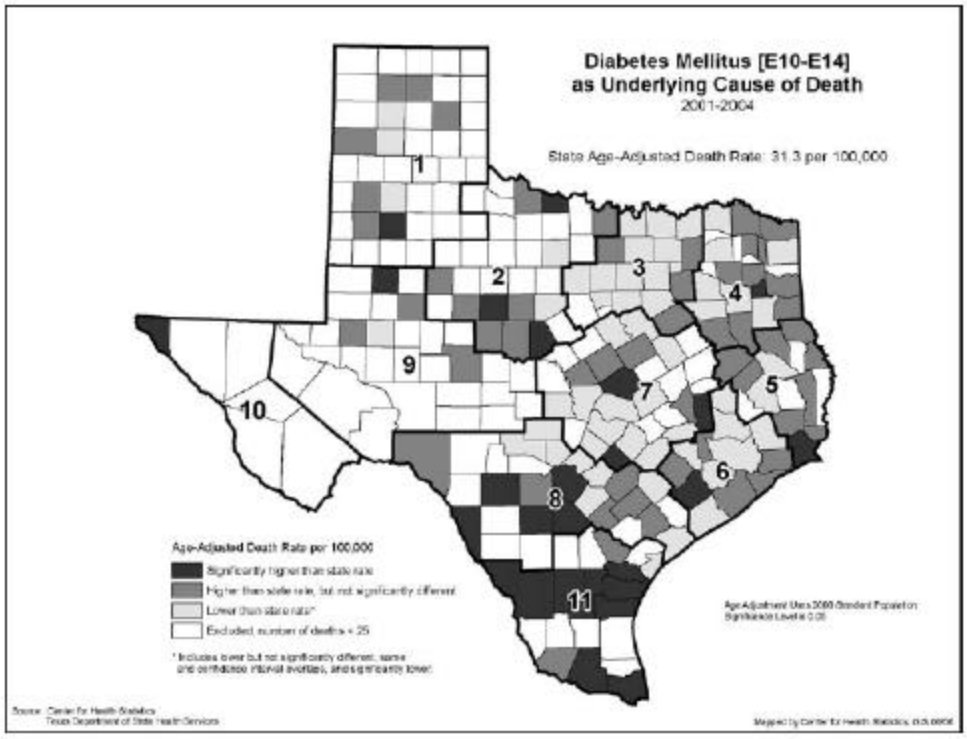
Source: Third National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention. Analysis by The Lewin Group, 1999.

Obesity in our School Children

A particularly serious problem is the increase in obesity among children. Children with obesity are at greater risk of suffering from asthma, type 2 diabetes, cardiovascular disease, and sleep apnea.[119] About 17 percent of U.S. children between 12 and 19 years old are overweight.[120]In Texas, the number of students who are overweight is about 19 percent for children ages 10 to 17. Texas ranks sixth in a state-by-state comparison of childhood overweight rates.[121] According to the CDC, 64 percent of students in Texas do not participate in the recommended level of physical activity, which was defined as 60 minutes of physical activity at least 5 days a week. In addition, 40.5 percent of Texas students watch three or more hours of television every day.[122]

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. In the U.S., 7 percent of the population will be diagnosed with this disease during their lifetime.[123] According to the American Diabetes Association, diabetes is the fifth deadliest disease in the United States and contributed to over 224,000 deaths in 2002.[124] People with diabetes are at higher risk for a stroke, heart disease, kidney disease, blindness, and nerve system damage.[125] The chart *Texas Diabetes Mellitus as Underlying Cause of Death, 2001-2004* shows that, generally, the Border has higher death rates due to diabetes than the rest of the state.



Increases in type 2 diabetes, where the body does not properly use insulin, may be one of the first noticeable consequences of the epidemic of obesity among young people. According to the World Health Organization, almost 90 percent of the diagnosed diabetes cases in the United States can be attributed to increases in weight.[126] Approximately 15 million Americans suffer from diabetes and a staggering 54 million have pre-diabetes symptoms. Of those diagnosed, 176,500 are under 20 years old.[127] Reports have indicated that type 2 diabetes is being diagnosed at higher rates among children and adolescents than previously, particularly among Hispanics/Latinos, American Indians, and African Americans.[128] Type 2 diabetes rates are 1.7 times higher among Mexican-Americans than among non-Hispanic whites.[129] In addition, Mexican-Americans with diabetes are more prone to have retinopathy and end-stage renal disease than other ethnic or racial groups.

The incidence of diabetes is particularly high in the Border Region. The table *Texas Counties with the Highest Diabetes Prevalence Rates* lists all counties in the state with rates of 7.7 percent or above. All of these 16 counties are in the Texas-Mexico Border Region.[130] More than one million Border residents have been diagnosed with diabetes. Diabetes-related emergencies cost El Paso residents approximately $30 million in 2005.[131]

Texas Counties with the Highest Diabetes Prevalence Rates, 2001

County	Number of Persons with Diabetes	Diabetes Prevalence Rate
Starr	2,763	8.0%
Webb	10,141	8.0%
Brooks	437	7.9%
Jim Hogg	289	7.9%
Maverick	2,422	7.9%
Zavala	615	7.9%
Duval	735	7.8%
Hidalgo	29,618	7.8%
Willacy	1,095	7.8%
Cameron	17,531	7.7%
Dimmit	538	7.7%
El Paso	36,151	7.7%
Frio	903	7.7%
La Salle	2,326	7.7%
Presidio	386	7.7%
Zapata	638	7.7%

Source: Texas Department of State Health Services

Economic Costs of Diabetes

In 2007, diabetes cost the United States $174 billion; $12.46 billion in Texas and $515 million in El Paso alone.[132] The annual costs of diabetes exceeds the amount spent repairing the damage caused by Hurricane Katrina ($150 billion). It is also more than has been spent on military conflicts in Afghanistan, Iraq, and the global war on terrorism combined.[133]

Much of the expenditures incurred by individuals with diabetes are indirectly related to the disease. Diabetes often leads to other costly medical complications such as cardiovascular and renal diseases. In addition, individuals with diabetes are likely to experience a loss of productivity through absenteeism, decreased job performance, deceased earnings and participation in the labor force due to permanent disability, and decreased productivity caused by premature mortality.[134]

Each person with diabetes spends an average of $11,744 a year on health care. One out of every five dollars spent on health care goes to treating someone diagnosed with diabetes. Last year, almost a quarter of the money spent on in-patient hospital care went to treat individuals with diabetes. These individuals have an increased rate of hospitalization. Once hospitalized, they stay an average of 50 percent longer than individuals in the same age range without diabetes. According to a spokesman from the American Association of Clinical Endocrinologists, the risk of death is twice as high for people with diabetes than for those of the same age without diabetes. In 2007, 284,000 deaths were attributed to the disease.[135]

Current Diabetes and Obesity 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. An updated plan was later released with plans for 2005 through 2010 keeping the initial goals in mind.[136] In the 77th Legislative Session, the Texas Legislature established the *Texas Pediatric Diabetes Research Advisory Committee*. In late 2002, the advisory committee presented a plan that recommended the state should require physicians to begin reporting childhood diabetes diagnoses. The advisory committee also suggested that the state should establish a Texas Pediatric Diabetes Research Resource.[137]

The *Texas Diabetes Council*, established in 1983 and housed in the Department of State Health Services, produces a biennial state plan dedicated to reducing the prevalence of diabetes and increasing public and professional education regarding the disease. The latest plan, *Diabetes and Despair,* outlines the plan for 2008 and 2009.[138] The CDC has collaborated with other agencies to establish the *U.S.-Mexico Border Diabetes Prevention and Control Project*, which intends to use collaboration between all the Border states to reduce the prevalence of type 2 diabetes in the region. The project is has two phases. The first phase consists of a survey to determine the prevalence of the disease. Phase two includes a community intervention pilot project.[139]

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, the TDA issued a policy to improve nutrition in Texas public schools.[140] The policy limits the availability of food of minimal nutritional value (FMNV) in public schools. FMNVs include food items such as carbonated beverages and most candies. Implementation of this policy began during the 2006-2007 school year and is scheduled to continue through the 2009-2010 school year.[141] Sale of FMNVs are now restricted during the entire school day in elementary schools and half of the school day in middle and high schools.

Other current policy initiatives include reforming the policies regarding vending machines in schools and requiring elementary 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. However, the country's top three soda companies agreed that, beginning in 2006 no more than 30 percent of beverages in vending machines located in high schools with sugary, carbonated soft drinks. By 2009, these types of beverages will not be available to students until after their last scheduled class.[142]

An initiative that has been successful on the Border is the Coordinated Approach to Child Health (CATCH) program, which integrates nutrition, fitness, and faculty and parental involvement in the prevention of obesity. The CATCH program increases awareness of nutrition

in the classroom, increases the amount of physical activity during physical education, serves healthier foods at lunch, and promotes health awareness among the students' families. A CATCH pilot program was introduced in several El Paso schools, and the CATCH program is currently being implemented in the Brownsville, Harlingen and McAllen school districts in the Rio Grande Valley region.[143] Starting in 2007, the state mandated that this type of program be integrated into all elementary schools.

Recent legislative efforts have expanded nutrition and physical activity initiatives. Starting with the 2007-2008 school year, all students in grades 3 through 12 will participate in a physical assessment. In addition, all middle school children (grades 6-8) will be required to participate in at least 30 minutes of daily physical activity.[144]

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 Texas Borderlands, 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 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 mental 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 have made it even more difficult to access mental health services. However, the 80th Legislature restored some funding by allocating $82 million to increase the availability of crisis mental health services.[145]

Poor Access to Mental Health Care

Studies released by the Mental Health Association in Texas have indicated that there is a gap between the need and the availability of services. There are many at risk individuals that are eligible for services but cannot receive them due to a lack of resources.[146]

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 and Mental Retardation (EPMHMR) and the El Paso Psychiatric Center provided for 64 beds. 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. 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.[147] 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.[148]

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.[149] The lawsuit is currently pending in El Paso District Court.[150]

The entire Borderlands region 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. A higher percentage of adults who are at risk and eligible are served than children, 35 percent for adults and 20 percent for children. These statistics are even more shocking when compared to non-border counties who serve 38 percent of their eligible and at risk adults and 26 percent of their children.

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 in life, including involvement in the criminal justice system, which costs the state significantly more in the long-run. For example, in Texas, $682 million is spent annually on individuals that rotate through jail, hospitals, and detoxification centers. Only $92 million is used for treatment in community mental health centers.[151]

Prisons: De Facto Mental Health Care

Over time, a nationwide trend has developed in which mentally ill individuals are sent to prison, contributing to the rising prison population. Only 5 percent of the U.S. population has a mental illness, compared to 16 percent of the prison population.[152] In addition, the resources available in the community are not adequate, often leading to incarceration. Inmates with a mental illness are more than twice as likely to have been homeless prior to incarceration. Almost half of all children in the Texas Youth Commission or the Juvenile Probation Commission have a mental illness.[153]

Once mentally ill prisoners are booked, how do they receive treatment? Screening mechanisms are often inadequate, due to the significant differences across prison systems.[154] 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. 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.[155]

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.[156] In 2004, the federal government authorized $50 million to provide grants to fund programs that facilitated collaborations between mental health service providers, the juvenile justice system, the criminal justice system, and substance abuse treatment providers "to improve access to effective treatment for people with mental illnesses involved with the justice system."[157] In 2006, 27 grants were awarded through this program and, in 2007, 26 grants were awarded.[158]

Unique Challenges of the Borderland

The Mental Health Association in Texas 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.[159]

- 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 comorbid 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.
- Border 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 available.
- Increased collaboration between schools, universities, and 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 generations.
- More Patient Assistance Programs, which provide financial assistance for education.
- 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.[160]

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 high 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. 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 US- 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.[161]

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 *E. coli* infection
Brucellosis	*H. pylori* 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.[162] There is a common misconception that TB has long since been eradicated from the U.S., 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 TB.[163] Between 2003 and 2005, ten Texas counties had incidence rates at least two times higher than the state's average. Seven of the ten counties are located in the Border region.[164] Early detection is a key preventative measure in minimizing TB incidence rates in the state. Dr. Eduardo Sanchez, former Commissioner of the Texas Department of State Health Services stated, "[o]ne person with untreated active TB will infect on average as many as 15 people per year."[165]

Dengue Fever

Dengue fever is a disease of tropical origin that is transmitted through mosquitoes. Those inflicted initially experience flu-like symptoms, but complications can lead to hemorrhagic fever. With four possible serotypes, individuals do not obtain cross-protective immunity and can be susceptible to four dengue infections during their lifetime. Dengue fever was absent in the U.S. for several decades. However, the first U.S. case of locally acquired dengue fever occurred on the Texas Border in 2005. In the last few years, the incidence of dengue fever has increased, especially along the Texas-Mexico border.[166]

West Nile Virus

West Nile virus 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.[167] In 2007, the two counties in Texas with the highest number of West Nile cases were located in the Border region. Statewide there were 219 reported cases with 36 cases in El Paso County alone.[168]

Hepatitis A and C

Hepatitis A (HAV) is a viral infection spread primarily by contaminated food and water and can be prevented with improved sanitation and widespread vaccinations.[169] Some areas of Texas have historically had higher rates of infection than others. As a prevention effort, 40 counties have begun to require vaccination against HAV prior to children enrolling in public school, 37 of these counties are in the Border region. These efforts have paid off, between 1996 and 2004 the number of reported cases of HAV in the state decreased by 85 percent.[170]

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.[171] Because of these modes of transmission, HCV poses a more complicated problem for the Border Region. Education has become the primary prevention strategy; the 76th legislature passed a bill that led to the start of a statewide education and prevention effort.[172] The table, *Preliminary 2003 Infectious Diseases in the 43 Texas-Mexico Border Counties*, shows the number and rate of 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 the ease of 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. During the last legislative session there were several bills passed that increased services available to the patients affected by these diseases. Funding was allocated to increase the number of Texans receiving treatment for TB by 14,000 as well as to provide HIV medications to an additional 735 people.[173]

However, a major obstacle in achieving healthy communities still exists—the weak public health infrastructure in the Border Region. Even if individuals recognize symptoms and seek medical attention, many areas do not have the primary health care professionals necessary to care for these patients. Furthermore, these diseases are very costly for Border hospitals to treat and, if left unaddressed, they will continue to travel north and impact other parts of the state.

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.

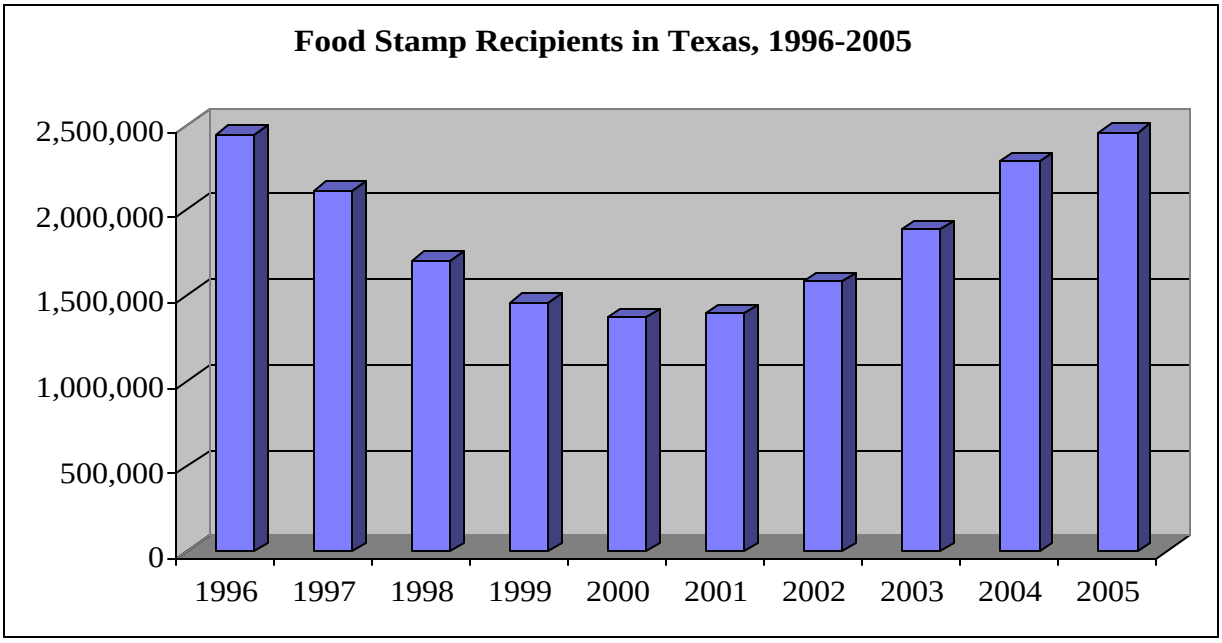
Hunger in the Border Region

Texas ranks first in the nation in the percentage of the population that is food insecure and fifth in the percentage that is food insecure with hunger.[174] 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.[175] Despite the great need, public food resources are limited. The Texas Food Stamp Program (FSP) average benefit per person is only $93.40 per month.[176]

Still, the FSP is one of the key weapons in fighting hunger in our state. It is one of the only programs whose enrollment is closely tied to the health of the economy. The FSP is run by the U.S. Department of Agriculture and administered statewide by the Texas Health and Human Services Commission. Annually, about 2.3 million Texans receive food stamps and, in December 2007, El Paso had 139,936 residents participating in the program.[177]

Problems with the Food Stamp Program

After 1996, the FSP experienced a decline in enrollment as well as a decrease in benefits. Welfare reform in 1996 changed the way food stamps were administered. This legislation has affected Texans more significantly than people in other states. Since 1996, each state averaged a loss of $30 million in benefits. Texas, losing $129 million, is the state with the largest reduction in funding.[178] Despite the changes in program policy, 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. Nationally, only 61 percent of eligible households participate in the program. Participation rates are even smaller among Hispanics with only about 50 percent of eligible individuals receiving benefits. That means that almost 4 million Hispanics who could be receiving assistance are not.[179] As a result, Texas has lost out on $4.5 billion from the federal grant program.[180]

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 in education so that all eligible persons are aware of the program and their access to it.

One of the major changes greatly affecting the Border community is the loss of benefits by legal immigrants. In 1996, the policy changed and legal immigrants were no longer eligible

until they had been U.S. residents for five years. Because of this decision an estimated 300,000 people who would have been eligible under previous eligibility standards are now ineligible.[181] Cuts like these damage the local economy since $1.84 of state economic activity is generated for every food stamp dollar spent.[182] In El Paso alone, legal immigrants lost 21.5 percent of their purchasing power due to cuts in FSP.[183]

The FSP also has low participation due to the stigma associated with receiving government assistance.[184] The use of fingerprinting adds to this stigma.[185] This practice was put in place to cut down 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.[186] Benefits average out to only $1 per meal, which does not come close to feeding a person for an entire month.[187] 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.

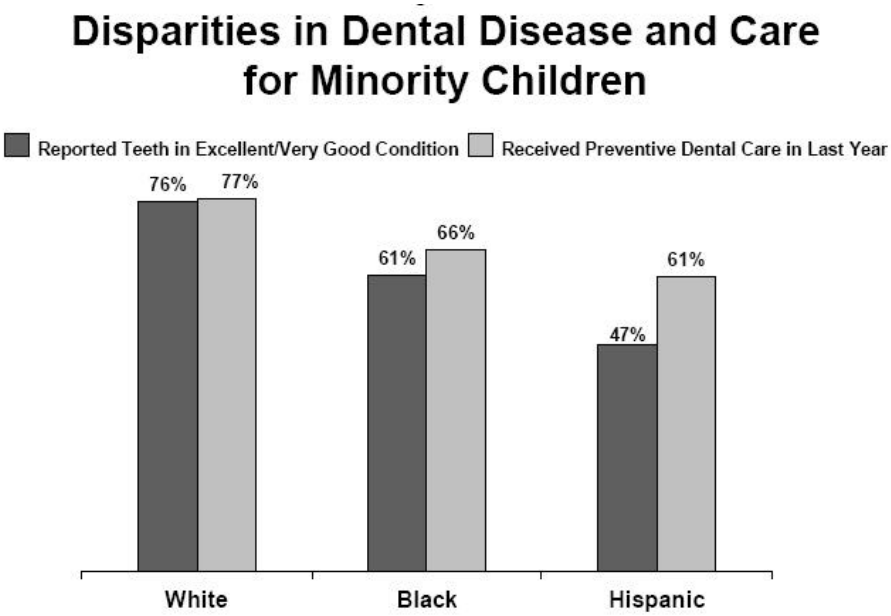
Oral Health Care on the Border

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.[188] Studies have shown a link between oral health and other diseases such as ear and sinus infections, weakened immune systems, diabetes, heart and lung diseases as well as arteriosclerosis, heart attack, stroke, and birth defects.[189] Periodontal organisms can enter the bloodstream and cause inflammation in certain organs, including the liver, major blood vessels, and the placenta.[190]

Along with serious illness, oral diseases can cause debilitation, significant pain, interference with speech and eating, along with poor self-image, nutrition, social development, and quality of life, over use of emergency rooms, valuable time lost from school, and in the worst cases even death. Tooth decay is the most prevalent chronic disease among children in the U.S.[191] It is estimated that children with oral disease miss over 51 million hours of school each year.[192] The Texas Department of State Health Services (TDSHS) reports that dental caries (cavities) are the leading cause of school absenteeism in Texas.[193] Even when they are in class, children with untreated dental problems have trouble concentrating on their schoolwork, thereby 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. Pre-school Hispanic children experience higher dental carie rates than any other race or ethnic group.[194] Hispanic children of all ages are less likely to get dental care than their non-Latino counterparts. The chart *Disparities in Dental Disease and Care for Minority Children* illustrates the high rate of dental decay among Hispanic children.

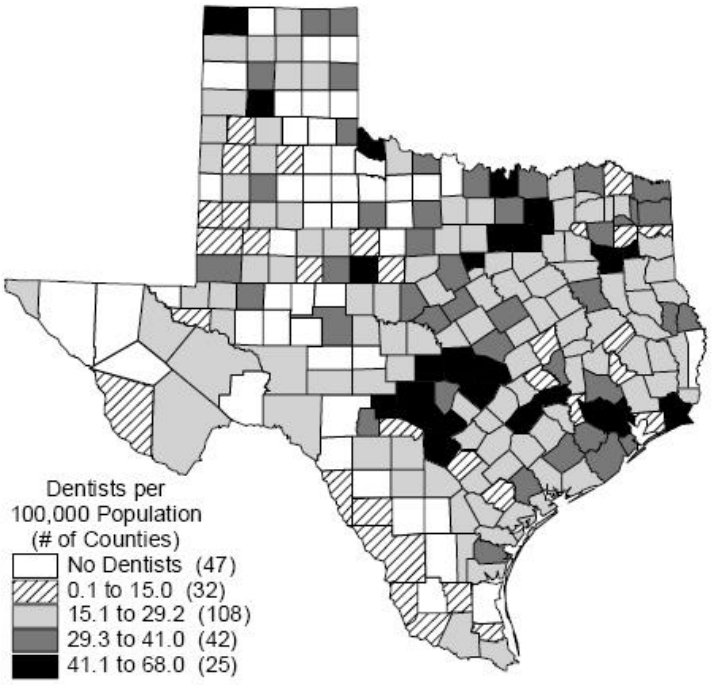


Source: Kaiser Family Foundation Commission on Medicaid and the Uninsured

Expenditures for dental services alone made up 7.5 percent of the nation's health expenditures in 2003—$67 billion.[195] This is a significant increase from 1998 when expenditures on dental services were $53.8 billion or 4.7 percent of total health expenditures.[196] In 2003 30.6 percent of the 22 million Texans spent money on dental services at an average cost of $523 a person.[197]

The chart *Dentists per 100,000 Population, Texas, 2007* shows that the Border region faces an extreme shortage of dentists, falling far short of the state average of 36.5 dentists per 100,000 population. In Border metropolitan areas, there are 15.7 dentists per 100,000 population while non-Border metropolitan areas have 41.1 dentists per 100,000. Even worse, Border non-metropolitan areas have only 11.8 dentists per 100,000 population while non-Border non-metropolitan areas have 25.2 dentists per 100,000.[198]

Dentists per 100,000 Population, 2007



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" (26 whole counties; 3 partial counties).[199]
- 12 counties in the Border region have no dentists, and 15 counties have no dental hygienists. [200]

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.[201]

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

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 FPL and children age 6 to 18 in families with annual incomes up to 100 percent of FPL.[202] The dental program covers a wide array of services and usually pays for as much care as an eligible patient requires.[203] 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.[204] 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 level depends on factors including timely renewal, the amount of time a child has 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. [205]

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.[206]

The Texas Department of State Health Services—Division of Oral 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).[207]

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.[208]

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.[209] In TDSHS Region 8, approximately 1,200 eligible children receive preventive dental sealants each year.[210]

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 population. These include the El Paso Coalition for the Homeless, where over 35 El Paso dentists volunteer to provide comprehensive dental care for needy patients.[211]

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.[212] 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.[213]

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.[214]

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

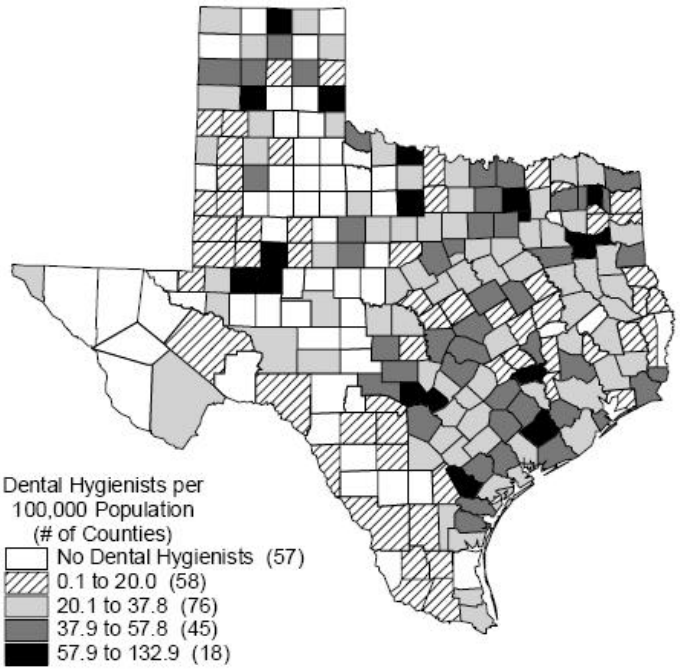
Dental hygienists are uniquely positioned to help close the gap in dental coverage by providing low cost preventive care and educating this population about the need for prevention. Several innovative projects have already been initiated with great success in the Lower Rio Grande Valley by the dental 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.[215]

Access to Dental Hygiene Services

Dental hygiene educators have worked hard to meet the growing oral health needs of Texas citizens, and those of the Border region in particular. Twenty one dental hygiene programs exist in the state, and all continue to take the maximum number of students their capacity allows.[216] There are three dental hygiene programs located in the Border Region.[217] 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.[218]

The chart *Dental Hygienists per 100,000 Population, Texas, 2007* exhibits the ratio of dental hygienists per 100,000 population. The table illustrates that most of the Borderland counties have lower than average numbers of dental hygienists when compared to the state average of 38.7 providers per 100,000 population. For 2007, the number of dental hygienists per 100,000 were 18.6 for metropolitan Border areas, 8.4 for non-metropolitan Border areas, 42.8 for non-border metropolitan areas, and 30.5 for non-metropolitan non-border areas.[219]

Dental Hygienists per 100,000 Population, 2007



Source: Texas Department of State Health Services Health Professionals Resource Center, December 2007

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 pro-active 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.

Conclusion

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. To address these problems and ensure a brighter future for the citizens of the Border region, Texas' state leaders must stop placing the Border behind the rest of the state.

---

[1] U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplement, 2007*, Available at: http://www.census.gov/cgi-bin/broker, last accessed: January 18, 2008

[2] Carole Keeton Strayhorn, Texas Comptroller of Public Accounts *The Uninsured: A Hidden Burden on Texas Employers and Communities,* April 2005.

[3] Ralitsa B. Akins & Gilbert A. Handal, *Children's Access to Healthcare: Awakening Call*, Public Policy Issues Research Trends, Expert Commentary D, 2007.

[4] James M. Branscome, and Beth L. Crimmel, U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, *Chartbook #15: State Differences in Employer-sponsored Health Insurance, 2003* May 2006.

[5] Ronald J. Angel, Jacqueline L. Angel, and Laura Lein, *The Health Care Safety Net for Mexican Americans,* Center for Health and Social Policy Working Paper Series, No. 03-1. Austin, TX: Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 2003.

[6] Paul Krugman & Robin Wells, *The Health Care Crisis and What to Do About It*, New York Review of Books, Vol. 53 (5), March 23, 2006; Paul Krugman, The Conscience of a Liberal, W.W. Norton & Company, New York, 2007.

[7] Gerard F. Anderson, Peter S. Hussey, Blanca K. Frogner & Hugh R. Waters, *Health Spending in the United States and the Rest of the Industrialized World*, Health Affairs, Vol. 24(4), July/August 2005.

[8] McKinsey Global Institute, Accounting for the Cost of Health Care in the United States, January 2007, http://www.mckinsey.com/mgi/reports/pdfs/healthcare/MGI_US_HC_fullreport.pdf (last accessed February 28, 2008).

[9] *The Third Annual IHSP Hospital 200: The Nation's Most—and Least—Expensive Hospitals Fiscal Year 2003/2004*, Institute for Health and Socio-Economic Policy, December 2005, http://www.calnurse.org/research/pdfs/IHSP_Hospital_200_2005.pdf (last accessed February 28, 2008).

[10] James M. Branscome, and Beth L. Crimmel, U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, " Chartbook #15: State Differences in Employer-sponsored Health Insurance, 2003" May 2006.

[11] U.S. Census Bureau, Historical Health Insurance Tables, " Health Insurance Coverage Status and Type of Coverage by Sex, Race, and Hispanic Origin: 1999 to 2006," 2006. Available at: http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html

[12] James M. Branscome, and Beth L. Crimmel, U.S. Department of Health and Human Services Agency for Health care Research and Quality, *Chartbook #15: State Differences in Employer-sponsored Health Insurance, 2003,* May 2006.

[13] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey: MEPSnet/ IC Trend Query,* Available at: http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html

[14] U.S. Census Bureau, Historical *Health Insurance Tables, Health Insurance Coverage Status and Type of Coverage by Sex, Race, and Hispanic Origin: 1999 to 2006*, 2006.Available at: http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html

[15] Mark L. Berk, and Claudia Schur, "The Effect of Fear on Access to Care Among Undocumented Latino Immigrants," *Journal of Immigrant Health*, July 2001.

[16] Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

[17] The Commonwealth Fund, *Commonwealth Fund State Scorecard on Health System Performance, 2007: Texas*, 2007.

[18] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Available at: http://www.census.gov/cgi-bin/broker

[19] Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

[20] The Commonwealth Fund, *Commonwealth Fund State Scorecard on Health System Performance, 2007: Texas*, 2007.

[21] The Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured, A Primer: Key Facts about Americans without Health Insurance*, October 2007.

[22] The Commonwealth Fund, *Commonwealth Fund State Scorecard on Health System Performance, 2007: Texas*, 2007.

[23] The Commonwealth Fund, *Commonwealth Fund State Scorecard on Health System Performance, 2007: Texas*, 2007

[24] Kaiser Commission on Medicaid and Uninsured, "Dental Care and Coverage for Low-income Children: The Role of Medicaid and SCHIP" Kaiser Family Foundation, August 2007.

[25] National Coalition on Health Care, "Health Insurance Coverage, 2007", Online: www.nchc.org/facts/coverage_fact_sheet_2007.pdf

[26] National Coalition on Health Care, "Health Insurance Coverage, 2007", Online: www.nchc.org/facts/coverage_fact_sheet_2007.pdf

[27] National Coalition on Health Care, "Health Insurance Coverage, 2007", Online: www.nchc.org/facts/coverage_fact_sheet_2007.pdf

[28] Task Force on Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas*, 2006, Online: http://www.coderedtexas.org/files/Report.pdf

[29] "Uninsured in America; 'Ground zero' of health-care crisis," *Chicago Tribune*, January 31, 2003.

[30] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," Online: http://www.census.gov/prod/2007pubs/p60-p233.pdf

[31] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," Online: http://www.census.gov/prod/2007pubs/p60-p233.pdf

[32] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[33] Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

[34] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[35] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[36] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[37] Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

[38] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[39]Michelle M. Doty, and Alyssa L. Holmgren, "Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey (2005)," The Commonwealth Fund, August 2006.

[40]Kevin Quinn, "Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans," The Commonwealth Fund, February 2000

[41] The Robert Wood Johnson Foundation, "Preventative Care: A National profile on use, disparities, and Health Benefits," August 2007, Online: http://www.rwjf.org/files/research/ 8-7-07%20-%20Partnership%20for%20Prevention%20Report(1).pdf

[42] Eva DeLuna Castro, Anne Dunkelberg, F. Scott McCown, Miryam Bujanda, Ed Codina, Kevin C. Moriarty, *The Texas Health Care Primer, Revised 2007*, Center for Public Policy Priorities, November 2007.

[43] Susan Combs, Texas Comptroller of Public Accounts, "Texas in Focus: A Statewide View of Opportunities", January, 2008.

[44] Michelle M. Doty, and Alyssa L. Holmgren, "Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey (2005)," The Commonwealth Fund, August 2006.

[45] Marsha Austin, "Hispanics trailing in health coverage," *Denver Post*, October 27, 2003.

[46] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[47] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[48] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker
The 2007 HHS Poverty Guidelines, U.S. Department of Health and Human Services Online: http://aspe.hhs.gov/poverty/07poverty.shtml

[49] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker
The 2007 HHS Poverty Guidelines, U.S. Department of Health and Human Services Online: http://aspe.hhs.gov/poverty/07poverty.shtml

[50] Task Force on Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas*, 2006, Online: http://www.coderedtexas.org/files/Report_Chapter02.pdf

[51] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[52] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2007," Online: http://www.census.gov/cgi-bin/broker

[53] James M. Branscome, and Beth L. Crimmel, U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, " Chartbook #15: State Differences in Employer-sponsored Health Insurance, 2003" May 2006.

[54] Task Force on Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas*, 2006, Online: http://www.coderedtexas.org/files/Report.pdf

[55] Lisa Dubay, "Making Sense of Recent Estimates of Eligible but Uninsured Children," Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, August 2007, Online: http://kaiserfamilyfoundation.org/medicaid/upload/7685.pdf

[56] Michael Perry and Julia Paradise, "Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents," Kaiser Commission on Medicaid and the Uninsured, May 2007

[57] University of Texas Medical Branch, *3-Share Plan*, Online: http://www.utmb.edu/cehd/programs/3share/status.html

[58] Kaiser Commission on Medicaid and the Uninsured, "State Coverage Initiatives for Children," Kaiser Family Foundation, January 2008

[59] Kaiser Commission on Medicaid and the Uninsured, "State Coverage Initiatives for Children," Kaiser Family Foundation, January 2008

[60] Teresa A. Coughlin and Mindy Cohen, "A Race to the Top: Illinois's All Kids Initiative," Kaiser Commission on Medicaid and the Uninsured, August 2007

[61] Debra J. Lipson, James M. Verdier, and Lynn Quincy, "Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms," The Robert Wood Johnson Foundation, December 2007

[62] Debra J. Lipson, James M. Verdier, and Lynn Quincy, "Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms," The Robert Wood Johnson Foundation, December 2007

[63] Ralitsa B. Akins and Gilbert A. Handal, *Disparities in Children's Access to Healthcare in the Border Region: Issues, Solutions and Opportunities for Healthcare Policy Makers*, Public Policy Issues Research Trends, Chapter 2, 2007.

[64] Texas Department of State Health Services, Nick Dauster, "Question on Number of Hospital Beds", Email to David Edmonson, Legislative Analyst, Senator Eliot Shapleigh, June 22, 2006.

[65] Center for Public Policy Priorities, "Losing Ground: The State Budget for 2004-05 Implications for Health Care for Vulnerable Texans," October 2003, Online: www.cppp.org

[66] Center for Public Policy Priorities, "Losing Ground: The State Budget for 2004-05 Implications for Health Care for Vulnerable Texans," October 2003, Online: www.cppp.org

[67] Center for Public Policy Priorities, "Losing Ground: The State Budget for 2004-05 Implications for Health Care for Vulnerable Texans," October 2003, Online: www.cppp.org

[68] "Texas can be leaner without being meaner", *Dallas Morning News*, March 7, 2004

[69] Center for Public Policy Priorities, "Losing Ground: The State Budget for 2004-05 Implications for Health Care for Vulnerable Texans," October 2003, Online: www.cppp.org

[70] Center for Public Policy Priorities, "Losing Ground: The State Budget for 2004-05 Implications for Health Care for Vulnerable Texans," October 2003, Online: www.cppp.org

[71] Center for Public Policy Priorities, " Losing Ground: The Texas State Budget for 2004-2005," January 2004, Online: www.cppp.org

[72] Center for Public Policy Priorities, " Texas' State Budget for 2004-2005 Implications for Health Care for Vulnerable Texans" October 2003, Online: www.cppp.org

[73] "Texas can be leaner without being meaner", *Dallas Morning News*, March 7, 2004

[74] Center for Public Policy Priorities, " Texas' State Budget for 2004-2005 Implications for Health Care for Vulnerable Texans" October 2003, Online: www.cppp.org

[75] Center for Public Policy Priorities, " Texas' State Budget for 2004-2005 Implications for Health Care for Vulnerable Texans" October 2003, Online: www.cppp.org

[76] Center for Public Policy Priorities, " Texas' State Budget for 2004-2005 Implications for Health Care for Vulnerable Texans" October 2003, Online: www.cppp.org

[77] Texas can be leaner without being meaner", *Dallas Morning News*, March 7, 2004

[78] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[79] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[80] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[81] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[82] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[83] Center for Public Policy Priorities, " partial Restoration of Programs Cut in 2004, Some New Investment," July 2005, Online: www.cppp.org

[84] Fiscal impact numbers are based o the Legislative Budget Borard's fis cal notes for HB 1, HB 3, HB4 and HB 5

[85] Center for Public Policy Priorities, Dick Levine, "Man-Made Fiscal Crisis Worse Than 2003," May 2005, Online: www.cppp.org

[86] Center for Public Policy Priorities, Celia Hagert, "HB 2292: Read It and Weep", July 2003, Online: www.cppp.org

[87] Center for Public Policy Priorities, Anne Dunkelberg, "Rocky Road for Children's Health Care," June 2006, Online: www.cppp.org

[88] Center for Public Policy Priorities, Anne Dunkelberg, "Rocky Road for Children's Health Care," June 2006, Online: www.cppp.org

[89] Texas Health and Human Services Commission

[90] "Uninsured in America; Ground zero of health-care crisis" *Chicago Tribune*, January 31,2003.

[91] Texas Health and Human Services Commission, "HHSC Plans New Improvements Before Eligibility Rollout", Press Release, April 5, 2006, Online: http://www.hhs.state.tx.us/news/release/040506_EligibilityRollout.shtml

[92] Texas State Employees Union, "Services Erode as HHSC Fiddles with Privatization", Press Release, June 7, 2006, Online: http://www.cwa-tseu.org

[93] Center for Public Policy Priorities, Celia Hagert "CPPP Statement on Texas' Termination of Accenture Contract", March 2007, Online: www.cppp.org

[94] Texas Health and Human Services Commission, " HB 3575 Health and Human Services Eligibility System Transition Plan", October 2007 Online: http://www.hhs.state.tx.us/consolidation/IE/HB_3575_TransitionPlan.pdf

[95] Albert Hawkins, "Recap of the 80th Texas Legislature", Texas Health and Human Services Commission

[96] Albert Hawkins, "Recap of the 80th Texas Legislature", Texas Health and Human Services Commission

[97] Texas Health and Human Services Commission, *Health Care Reform Goals*, Available at: http://www.hhs.state.tx.us/medicaid/ReformGoals.shtml last accessed: January 24, 2008

[98] Texas Health and Human Services Commission, *Health Care Reform Goals*, Available at: http://www.hhs.state.tx.us/medicaid/ReformGoals.shtml last accessed: January 24, 2008

[99] Texas Health and Human Services, *Senate Bill 10 Sets State for Health Care Reform*, Available at: http://www.hhs.state.tx.us/medicaid/SB10Highlights.shtml, last accessed: January 24, 2008

[100] Texas Health and Human Services Commission, *Health Care Reform Goals*, Available at: http://www.hhs.state.tx.us/medicaid/ReformGoals.shtml last accessed: January 24, 2008

[101] Center for Public Policy Priorities, *CPPP Comments on Texas HHSC Draft Medicaid 1115 Waiver Concept Paper: Submitted to CMS 12/5/07* Available at: www.cppp.org last accessed January 25, 2008

[102] La Fe Policy Research and Education Center, Letter to Senator Eliot Shapleigh, *Comments on Medicaid Reform Concept Paper*, January 2008

[103] Texas Department of State Health Services, "Supply Trends Among Licensed Health Professionals, Texas 1980-2007", Health Professionals Resource Center, December 2007

[104] Texas Department of State Health Services, "Supply Trends Among Licensed Health Professionals, Texas 1980-2007", Health Professionals Resource Center, December 2007

[105] Texas Department of State Health Services, "Supply Trends Among Licensed Health Professionals, Texas 1980-2007", Health Professionals Resource Center, December 2007

[106] U.S. Census Bureau, *Annual Population Estimates, 2000-2007*, Available at: http://www.census.gov/popest/states/NST-ann-est.html, last accessed: January 24, 2008

[107] U.S. Census Bureau, *State Interim Population Projections by Age and Sex: 2004-2030*, Available at: http://www.census.gov/population/www/projections/projectionsagesex.html, last accessed: January 24, 2008

[108] Texas Medical Association, U.S. Department of Health and Human Services, Health Resources and Service Administrations, and the Texas State Board of Medical Examiners, *Where Texas Physicians Went to Medical School*, 2000

[109] Centers for Disease Control and Prevention "Obesity and Overweight: Introduction" 2007, Online: http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm

[110] Centers for Disease Control and Prevention, "Frequently Asked Questions about Calculating Obesity-Related Risks," Online: http://www.cdc.gov/PDF/Frequently_Asked_Questions_About_Calculating_Obesity-Related_Risk.pdf

[111] Centers for Disease Control and Prevention "Obesity and Overweight: Economic Consequences," Online: http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm

[112] Susan Combs, Texas Comptroller of Public Accounts, "Texas in Focus: A Statewide View of Opportunities", January, 2008.

[113] Susan Combs, Texas Comptroller of Public Accounts, "Counting Costs and Calories: Measuring the cost of Obesity to Texas Employers", March 2007

[114] Susan Combs, Texas Comptroller of Public Accounts, "Counting Costs and Calories: Measuring the cost of Obesity to Texas Employers", March 2007

[115]American Obesity Association, "AOA Fact Sheets," Online: http://obesity1.tempdomainname.com/subs/fastfacts/Obesity_Minority_Pop.shtml; Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey. Flegal et. al. JAMA, 2002

[116] Paso del Norte Health Foundation, "El Paso Health Report", Online: http://www.pdnhf.org/detail.asp?dt=topics&id=68&arch=yes&fr=c

[117] Center for Disease Control and Prevention, "Overweight and Obesity: Defining Overweight and Obesity," Online: http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm

[118] Center for Disease Control and Prevention, "Overweight and Obesity: Health Consequences" Online: http://www.cdc.gov/nccdphp/dnpa/obesity/consequences.htm

[119] Center for Disease Control and Prevention, "Childhood Overweight: Consequences," Online: http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/consequences.htm

[120] Center for Disease Control and Prevention, "Childhood Overweight: Overweight Prevalence," Online: http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/prevalence.htm

[121] Laura Segal, "Texas Adults 12th Most Obese in Country; Youth 6th Most Overweight", Trust for America's Health, Online: http://healthyamericans.org/reports/obesity2007/release.php?StateID=TX

[122] National Center for Chronic Disease Prevention and Health Promotion, "Youth Online: Comprehensive Results," Center for Disease Control and Prevention, Online: http://apps.nccd.cdc.gov/yrbss/CategoryQuestions.asp?Cat=6&desc=Physical%20Activity

[123] American Diabetes Association, "All About Diabetes" Online: http://www.diabetes.org/about-diabetes.jsp

[124] American Diabetes Association, "The Dangerous Toll of Diabetes," Online: http://www.diabetes.org/diabetes-statistics/dangerous-toll.jsp

[125] American Diabetes Association, "The Dangerous Toll of Diabetes," Online: http://www.diabetes.org/diabetes-statistics/dangerous-toll.jsp

[126] International Diabetes Federation, "Obesity and Type 2 Diabetes," Online: http://www.eatlas.idf.org/Obesity_and_type_2_diabetes/

[127] American Diabetes Association, " Total Prevalence of Diabetes & Pre-diabetes," Online: http://diabetes.org/diabetes-statistics/prevalence.jsp

[128] American Diabetes Association, " Total Prevalence of Diabetes & Pre-diabetes," Online: http://diabetes.org/diabetes-statistics/prevalence.jsp

[129] American Diabetes Association, " Total Prevalence of Diabetes & Pre-diabetes," Online: http://diabetes.org/diabetes-statistics/prevalence.jsp

[130] Texas Department of State Health Services, "Diabetes Prevalence in Texas, 2001," Online: http://www.dshs.state.tx.us/diabetes

[131] El Paso Diabetes Association, "Faces of Diabetes" Online: http://www.epdiabetes.org/images//2007%20symposium.pdf

[132] American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2007" *Diabetes Care*, Volume 31, Number3, March 2008, Online: www.diabetes.org/costs

[133] Liz Szabo, "Diabetes costs nation more than wars, disasters, study says", *USA Today*, pg 17A, January 24, 2008.

[134] American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2007" *Diabetes Care*, Volume 31, Number3, March 2008, Online: www.diabetes.org/costs

[135] Salynn Boyles, "Diabetes Complications Cost Billions", *WebMD Medical News*, April 2007, Online: http://diabetes.webmd.com/news/20070410/diabetes-complications-cost-billions?print=true

[136] Texas Department of State Health Services, "Strategic Plan for the Prevention of Obesity in Texas: 2005-2010" Online: http://www.dshs.state.tx.us/obesity/pdf/strategic_plan.pdf

[137] Texas Department of State Health Services, "Diabetes Research", Online: http://www.dshs.state.tx.us/diabetes/hcresrch.shtm

[138] Texas Department of State Health Services, "Texas Diabetes Council", Online: http://www.dshs.state.tx.us/diabetes/

[139] Center for Disease Control and Prevention, "Diabetes Projects: U.S. Mexico Border Diabetes Prevention and Control Project" Online: http://www.dshs.state.tx.us/diabetes/hcresrch.shtm

[140] Roger D. Hanagriff, Marcy M. Beverly, and Tim H. Murphy, "2005-2006 School Year Assessment of the Texas Public School Nutrition Policy, School Menu Assessment Report, 2007", Texas Department of Agriculture, Food and Nutrition Division, January 2007

[141] Square Meals, "Texas Public School Nutrition Policy Implementation Schedule, Four Year Plan: 2006-2010", Texas Department of Agriculture, Food and Nutrition Division, 2006

[142] Square Meals, "Texas Public School Nutrition Policy Implementation Schedule, Four Year Plan: 2006-2010", Texas Department of Agriculture, Food and Nutrition Division, 2006

[143] CATCH Texas, " School Health Legislation," Coordinated Approach to Child Health, Online: http://www.sph.uth.tmc.edu/catch/riograndecatch_schools.htm

[144] "Senate Bill 530 Nut Shell Version", Texas Education Agency, Online: http://staffweb.esc12.net/%7Embooth/documents/links_description/sb19_resources.htm

[145] Albert Hawkins, "Recap of the 80th Texas Legislature", Texas Health and Human Services Commission

[146] Mental Health Association of Texas, *Turning the Corner Toward Balance and Reform in Texas Mental Health Services*, 2005, Austin, TX

[147] Plantiff's First Amended Petition, The State of Texas, by and through El Paso County Attorney Jose R. Rodriguez v. Texans Department of State Health Services, et. al. Cause No. 2006-2095, 171st Judicial District Court, El Paso County, TX

[148] Plantiff's First Amended Petition, The State of Texas, by and through El Paso County Attorney Jose R. Rodriguez v. Texans Department of State Health Services, et. al. Cause No. 2006-2095, 171st Judicial District Court, El Paso County, TX

[149] Plantiff's First Amended Petition, The State of Texas, by and through El Paso County Attorney Jose R. Rodriguez v. Texans Department of State Health Services, et. al. Cause No. 2006-2095, 171st Judicial District Court, El Paso County, TX

[150] El Paso County, *Civil Records Detailed Results*, Available at: http://www.co.el-paso.tx.us/JimsSearch/CivilRecordSearch.asp?action%253Dview%26track%253D818031, last accessed January 25, 2008

[151] Texas Mental Health Association in Texas, *A Factsheet from the Texas Partners in Crisis Initiative*, September 2005

[152] Criminal Justice Mental Health Consensus Project, *Compelling Data about People with Mental Illness in the Criminal Justice System*, August 2006

[153] Mental Health Association in Texas, *A Factsheet from the Texas Partners in Crisis Initiative*, September 2003,

[154] Oral Interview with Dee Kippowit, Texas Council on Offenders with Mental Illness, with Andrea Varnell, Director of Projects, Senator Eliot Shapleigh, February 6, 2004

[155] Oral interview with Major Dolores Messick, El Paso County Sheriff's Department, with Andrea Varnell, Director of Projects, Senator Eliot Shapleigh, February 6, 2004

[156] Oral interview with Major David Balagia, Travis County Sherriff's Department, with Andrea Varnell, Director of Projects, Senator Eliot Shapleigh, February 6, 2004

[157] Criminal Justice and Mental Health Consensus Project, *The Mentally Ill Offender Treatment and Crime Reduction Act*, Available at: http://consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA/fed-leg-MIOTCRA-overview, last accessed: January 25, 2008

[158] Criminal Justice and Mental Health Consensus Project, *The Mentally Ill Offender Treatment and Crime Reduction Act*, Available at: http://consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA/fed-leg-MIOTCRA-overview, last accessed: January 25, 2008

[159] Mental Health Association in Texas *Borderland and Mental Health* , March 2004, Austin TX

[160] Mental Health Association in Texas *Borderland and Mental Health* , March 2004, Austin TX

[161] Doyle, TJ and Bryan, RT "Infectious Disease morbidity in the U.S. region Bordering Mexico, 1990-1998" *The Journal of Infectious Diseases*, November 2000

[162] Center for Disease Control and Prevention, "Tuberculosis General Information", Division of Tuberculosis Elimination, July 2007 Online: http://www.cdc.gov/tb/pubs/tbfactsheets/tb.htm

[163] Dr. Eduardo J. Sanchez, "To control the spread of tuberculosis, we must quit being complacent or risk peril", *Austin American Statesman*, March 22, 2004

[164] Texas Department of State Health Services, "Counties with Higher than Average Incidence of Tuberculosis", Online: http://www.dshs.state.tx.us/idcu/disease/tb/statistics/hiprev/

[165] Dr. Eduardo J. Sanchez, "To control the spread of tuberculosis, we must quit being complacent or risk peril", *Austin American Statesman*, March 22, 2004

[166] Center for Disease Control and Prevention, "CDC Health Information for International Travel, 2008: Dengue Fever", Online: http://wwwn.cdc.gov/travel/yelloBookCh4-DenegueFever.aspx

[167] Center for Disease Control and Prevention, "West Nile Virus: What you Need to Know", Division of Vector-Born Infectious Diseases, September 2006, Online: http://www.cdc.gov/ncidod/dvbid/westnile/wnv_factsheet.htm

[168] U.S. Department of the Interior, "Disease Maps, West Nile Virus: Texas- Human" U.S. Geological Survey, 2007, Online: http://diseasemaps.usgs.gov/wnv_tx_human.html

[169] Center for Disease Control and Prevention, "Viral Hepatitis A: Fact Sheet", National Center for HIV/AIDS , Viral Hepatitis, STD, and TB Prevention, Online: http://www.cdc.gov/ncidod/diseases/hepatitis/a/fact.htm

[170] Texas Department of State Health Services, "Epidemiology in Texas 2006 Annual Report: Infectious Disease", October 2007

[171] Center for Disease Control and Prevention, "Viral Hepatitis C: Fact Sheet", National Center for HIV/AIDS , Viral Hepatitis, STD, and TB Prevention, Online: http://www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm

[172] Texas Department of State Health Services, "The Texas Hepatitis C Initiative", Infectious Disease Control Unit, Online: http://www.dshs.state.tx.us/idcu/disease/hepatitis/hepatitis_c/initiative/

[173] Albert Hawkins, "Recap of the 80th Texas Legislature", Texas Health and Human Services Commission

[174] Dr. Stephen Fouriner and Dr. J. L. Brown, "Tables for Food Insecurity and Hunger for 2004" Center on Hunger and Poverty, November 2005

[175] Food Research and Action Center, "State of the States 2007, Demographics, Poverty, and Food Insecurity: Texas", Online: http://www.frac.org/State_Of_States/2007/states/TX.pdf

[176] Food Research and Action Center, "State of the States 2007, Demographics, Poverty, and Food Insecurity: Texas", Online: http://www.frac.org/State_Of_States/2007/states/TX.pdf

[177] Celia Hagert, "The Texas Food Stamp Program", Center for Public Policy Priorities, July 2007, Online: http://www.cppp.org/files/3/FSP%20backgrounder%207_07.pdf
Texas Health and Human Services Commission, "12/2007 Food Stamp Cases and Recipients by County", Online: http://www.hhsc.state.tx.us/research/TANF_FS.asp

[178] Dorothy Rosenbaum, Center on Budget and Policy Priorities, *Families' Food Stamp Benefits Purchase Less Each Year*, March 2007, Available at www.cbpp.org , last accessed January 28, 2008

[179] Center on Budget and Policy Priorities, *Facts about Latinos in the Food Stamp Program*, April 2007, Available at: www.cbpp.org, last accessed January 28, 2008

Dorothy Rosenbaum, Center on Budget and Policy Priorities, *The Food Stamp Program is Growing to Meet Need*, July 2006, Available at: www.cbpp.org, last accessed January 28, 2008

[180] Celia Hagert and Cathy Schecter, Center for Public Policy Priorities, *Ending Hunger in Our Community- Food Security Through Food Assistance*, March 2004, Available at: http://www.cppp.org/files/3/endinghunger.pdf last accessed January 28, 2008

[181] Center on Budget and Policy Priorities, *Facts about Latinos in the Food Stamp Program*, April 2007, Available at: www.cbpp.org, last accessed January 28, 2008

[182] Celia Hagert and Cathy Schecter, Center for Public Policy Priorities, *Ending Hunger in Our Community- Food Security Through Food Assistance*, March 2004, Available at: http://www.cppp.org/files/3/endinghunger.pdf last accessed January 28, 2008

[183] Food Research and Action Center, *Research Perspective on Migration: Highlights Legal Immigrant's Difficulty Accessing the Food Stamp Program*, Available at: http://www.frac.org/html/new/difficutl/html

[184] America's Second Harvest, Issue Brief No. 5: Food Stamps, Available at: http://www.seconharvest.org/export/sites/havest/learn_about_hunger/issue_briefs/issue_foodstamps.pdf

[185] Texas Health and Human Services Commission, *Food Stamp Outreach*, Available at: http://www.hhsc.state.tx.us/programs/FoodStamps/FoodStampFAQ.html

[186] America's Second Harvest, Issue Brief No. 5: Food Stamps, Available at: http://www.seconharvest.org/export/sites/havest/learn_about_hunger/issue_briefs/issue_foodstamps.pdf

[187] Dorothy Rosenbaum, Center on Budget and Policy Priorities, *Families' Food Stamp Benefits Purchase Less Each Year*, March 2007, Available at www.cbpp.org , last accessed January 28, 2008

[188] United States Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: 2000

[189] The Kaiser Commission on Medicaid and the Uninsured *Dental Coverage and Care for Low-income Children: The Role of Medicaid and SCHIP*, August 2007

[190]American Dental Association. *Future of Dentistry*, Chicago: Health Policy Resource Center 2001

[191] The Kaiser Commission on Medicaid and the Uninsured *Dental Coverage and Care for Low-income Children: The Role of Medicaid and SCHIP*, August 2007

[192] The Kaiser Commission on Medicaid and the Uninsured *Dental Coverage and Care for Low-income Children: The Role of Medicaid and SCHIP*, August 2007

[193] Texas Department of State Health Services Oral Health Program, *Oral Health in Texas, 2007*, Available at: http://www.dshs.state.tx.us/dental/pdf/oh_burden_doc.pdf Last accessed January 28, 2008

[194] United States Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General.* 2000

[195] John P. Sommers, Medical Expenditure Panel Survey, *Dental Expenditures in the 10 Largest States, 2003*, January 2003, Available at: http://www.meps.ahrq.gov/mepsweb/data_files/publications/st112/stat112.pdf Last accessed January 28, 2008

[196] United States Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000

[197] John P. Sommers, Medical Expenditure Panel Survey, *Dental Expenditures in the 10 Largest States, 2003*, January 2003, Available at: http://www.meps.ahrq.gov/mepsweb/data_files/publications/st112/stat112.pdf Last accessed January 28, 2008

[198] Texas Department of State Health Services, Health Professionals Resource Center, *Supply Trends Among Licensed Health Professionals, Texas, 1980-2007*, December 2007, Available at: http://www.dshs.state.tx.us/chs/hprc/07trends.pdf last accessed: January 28, 2008

[199] Texas Department of State Health Services, *Dental HPSA Designations, Texas 2007*, Available at http://www.dshs.state.tx.us/chs/hprc/DentalWC.shtm

[200] Texas Department of State Health Services, Health Professionals Resource Center, *Supply Trends Among Licensed Health Professionals, Texas, 1980-2007*, December 2007, Available at: http://www.dshs.state.tx.us/chs/hprc/07trends.pdf last accessed: January 28, 2008

[201] United States Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000

[202] 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.

[203] Texas Department of State Health Services, "Texas Health Steps Dental Program," Online: http://www.dshs.state.tx.us/dental/thsteps_dental.shtm.

[204] Texas CHIP Coalition, "Children's Health Insurance Program Dental Benefits Fact Sheet," Online: http://www.texaschip.org/resources/CHIPDentalFactsheet.pdf.

[205] *Id*.

[206] *Id*.

[207] Texas Department of State Health Services, "Health Service Regions," Online: http://www.dshs.state.tx.us/regions/default.shtm.

[208] Centers for Disease Control and Prevention, "Water Fluoridation," Online: http://www.cdc.gov/oralhealth/waterfluoridation/index.htm.

[209] Texas Department of State Health Services, "Dental Sealant Program," Online: http://www.dshs.state.tx.us/dental/sealants.shtm.

[210] Texas Department of State Health Services, "Oral Health Group - Region 8," Online: http://www.dshs.state.tx.us/region8/oralhealth.shtm.

[211] Texas Dental Journal, *TDA Dentists Donate Services Across Texas*, September 2002.

[212] Texas Dentists for Healthy Smiles. Online: http://www.tdhsmiles.org/.

[213] TDA Today, *Root Tips*, July 2001.

[214] Texas Department of State Health Services, *Medicaid Dental Fee Increase*, (letter from Dr. Jerry Felkner to the Texas Dental Association), September 25, 2001.

[215] Report from the Pilot Project. Division of Oral Health of the Texas Department of Health. 2002.

[216] Texas Department of State Health Services, *Oral Health in Texas, 2007*, Available at: http://www.dshs.state.tx.us/dental/pdf/oh_burden_doc.pdf last accessed, January 28, 2008

[217] Texas Department of State Health Services, *Oral Health in Texas, 2007*, Available at: http://www.dshs.state.tx.us/dental/pdf/oh_burden_doc.pdf last accessed, January 28, 2008

[218] Report from the Pilot Project. Division of Oral Health of the Texas Department of Health. 2002.

[219] Texas Department of State Health Services, Health Professionals Resource Center, *Supply Trends Among Licensed Health Professionals, Texas, 1980-2007*, December 2007, Available at: http://www.dshs.state.tx.us/chs/hprc/07trends.pdf last accessed: January 28, 2008